The Economy Report.

ON SWEDISH MUNICIPAL AND COUNTY COUNCIL FINANCES
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Foreword

The Economy Report illustrates the financial situation and conditions of county councils and municipalities and the development of the Swedish economy over the next few years. It is published twice yearly by the Swedish Association of Local Authorities and Regions (SALAR). The calculations in this issue extend to 2018.

This year's second report looks at the effects of the central government budget for 2015, which was amended at a late stage in the Riksdag, and the challenges facing municipalities in their work to dimension various areas of services in the next few years. We also continue work on explaining how and why healthcare costs are continuing to rise, focusing on somatic care. The report also describes how persons born abroad account for a very large part of the upturn in the labour force and in employment. We analyse, for instance, the implications for the level of unemployment of the fact that policy seems to have contributed to increased labour force participation among persons born abroad. But this has not had an impact in terms of a greater participation rate and lower unemployment.

This is an abridged version of the report. It contains the Summary (supplemented with some diagrams from the main report), and the third chapter looking at three separate questions (see Contents on page 2), as well as the Annex. It has been written by staff at the SALAR Section for Economic Analysis and has not been considered at political level within the Association. The persons who can reply to questions are given on the inside cover page. Other SALAR staff have also contributed facts and valuable comments. The translation is by Ian MacArthur, following slight revisions by Elisabet Jonsson. We are very grateful to the municipalities and county councils that have contributed basic data to our report.

Stockholm, December 2014

Annika Wallenskog
Section for Economic Analysis

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Summary

After several years of relatively good net income for the local government sector as a whole, net income for 2014 will be SEK 9 billion, corresponding to 1.2 per cent of taxes and general government grants. In 2015, a further slight deterioration, to SEK 5 billion, is expected, despite tax increases averaging 0.14 percentage points. However, there are some uncertainties regarding next year, including details of the central government budget for 2015, which is, at the time of writing, being processed by committees of the Riksdag (the Swedish Parliament).

For the subsequent years, 2016–2018, there are both worrying signs and rays of hope. Even though the international economy has not really picked up speed, the real tax base is growing at a relatively good rate. We can see good examples of successful collaboration between municipalities and county councils in healthcare and social care. At the same time there is upward pressure on costs, in a range of areas for a range of reasons. Demographic changes result in growing upward pressure on costs in several services, but also in a need for a transformation between different services.

In order to retain net income of 1 per cent of taxes and general government grants, we expect the local government sector to adjust its tax levy in 2016–2018, resulting in an increase in the average tax rate of 0.69 percentage points in addition to the 0.14 percentage points already adopted for 2015. A further assumption is that central government will provide money in accordance with a trend projection.

Continued weak growth internationally will delay recovery

At the same time as growth in the US and the UK is around 3 per cent, growth in the Euro countries continues to be very weak. In the US, the UK and Germany unemployment has returned to more normal levels. But in several other countries unemployment appears to have got stuck at high levels. The economic situation in Europe has weakened. Both the international and the Swedish economy show clear signs of imbalance. Growth has moderated distinctly since an upturn in the second half of 2013. Despite this, employment and hours worked are increasing at a good rate. The labour force is also

growing rapidly, with the result that unemployment is stuck stubbornly at around 8 per cent. In this mixed picture the tax base does surprisingly well, with real increases of around 2 per cent this year and next year, mainly thanks to a strong increase in the number of hours worked.

Strong increase in employment among people born outside Europe

Productivity in Sweden has grown more slowly in the period 2009–2013. It is now at the same level as before the financial crisis. After the recovery in 2010, GDP and the number of hours worked have changed at the same rate. Despite relatively weak growth, employment has resisted and developed surprisingly well. At the same time, the number of people in the labour force has continued to grow. The increased growth in the economy that we are seeing now will result in higher employment and lower unemployment. But the fact that employment was previously kept up despite weak growth also means that there is plenty of free staff capacity in many companies, and this may make the path to lower unemployment sluggish.

A very large part of the increase in the labour force and in employment in recent years consists of people born outside of Europe. Between 2005 and 2013 the number of people in employment who were born outside Europe increased, and this group accounts for 135,000 of a total increase of 240,000. The strong increase in employment would not have been possible without the increase in employment among people born outside of Europe.

The recovery is giving strong real tax base growth

We are now in the fourth year of strong real tax base growth and see another couple of years with growth rates far above the average ahead of us. Although the number of hours worked grew relatively weakly in 2012 and 2013, the rate of increase of the tax base was maintained thanks to pension indexation. This year the automatic balancing of national pensions will contribute to much weaker growth of pension income, but employment will pick up pace again.

Table 1 • GDP, hours worked, real tax base and expenses
Percentage change

	2013	2014	2015	2016	2017	2018
GDP	1.2	1.8	3.1	3.2	2.3	1.9
Hours worked* (NA)	0.4	2.1	1.5	1.1	0.7	0.4
Nominal tax base	3.4	3.3	5.2	4.7	4.5	4.2
Underlying** tax base	3.6	3.7	4.8	4.5	4.5	4.2
Real tax base	1.5	1.6	2.4	1.8	1.5	1.2
Expenses of activities (FP)	1.4	2.1	2.2	1.9	2.0	1.9

*Data corrected for calendar effects. **Actual growth of the tax base adjusted for effects of changes in tax legislation that have a direct impact on the tax base.

NA = National accounts. FP = Fixed prices.

Source: National Institute of Economic Research, Swedish Tax Agency and Swedish Association of Local Authorities and Regions..

Net lending by the general government sector increases from 1.4 per cent of GDP in 2013 to 2.1 per cent this year. The increase is explained by the protracted recovery of the economy in combination with the expansive fiscal policy pursued in order to counter the weak demand. When the recovery picks up more pace in 2015, we expect the deficit to be almost halved in relation to GDP. Public consumption will only increase half as quickly as GDP in 2015.

The technical assumptions we make for our calculations are that the level of benefits in social transfers will be retained and that, as of 2016, local government consumption will increase in line with demography plus a historical trend of 0.8 per cent per year. For the local government sector we assume that municipalities and county councils will adapt their tax levy to achieve net income of 1 per cent of taxes and government grants as of 2016. This makes local government tax 0.83 percentage points higher in 2018 than it is today, reinforcing revenue by SEK 19 billion.

Weaker net income expected in the local government sector

After several years of relatively good net income for municipalities and county councils, net income is expected to only reach SEK 9 billion in 2014. This corresponds to 1.2 per cent of taxes and general government grants, which is less than the 2 per cent considered to be consistent with healthy finances.

Aggregate net income for the **municipalities** is expected to be SEK 5 billion in 2014. This is a deterioration of SEK 10 billon compared with 2013 and the lowest net income since 2004. The net income expected for this year corresponds to 1.1 per cent of taxes and government grants. The main reason for the poorer level of net income is that this year there are no temporary revenue items such as the repayment of insurance premiums from the AFA Försäkring insurance company and no increases at all in the general government grant.

For the **county councils**, net income is estimated at SEK 4 billion in 2014. This net income corresponds to 1.5 per cent of taxes and government grants. However, more than half is explained by a non-recurring event, the sale of the Ulleråker area by Uppsala County Council to the Municipality of Uppsala. Most of the county councils that expect net income of more than 2 per cent of taxes and government grants do so thanks to a higher tax rate in 2014. These increases correspond to 0.10 percentage points on the average tax rate and are the equivalent of a revenue enhancement of almost SEK 2 billion in 2014.

According to preliminary data the tax rate will be increased in 25 municipalities in 2015, at most by 0.80 percentage points. The average tax rate will rise by 0.05 percentage points to 20.63. Four county councils are going to increase their tax rate. As a result the average tax rate will be increased by 0.09 percentage points to 11.35.

Given our assessment of the development of government grants and costs, this means that aggregate net income in municipalities and county councils is expected to fall to SEK 5 billion. See table 22 in the Annex.

Demographic pressure will intensify in the coming years

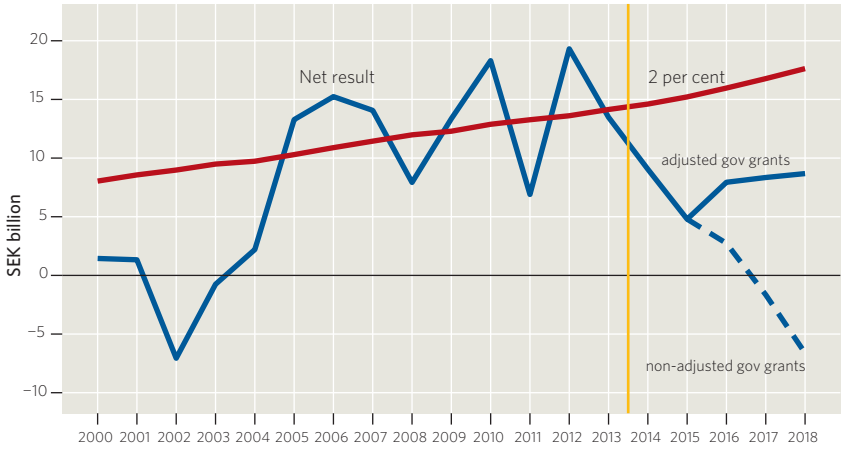
Municipalities' costs are expected to rise rapidly in the coming years, partly on account of demographic developments. It is the number of children of compulsory school age (7-16 years) that is increasing most, but the number of young people in upper secondary school is also starting to increase after falling for a long period. The volume increase is around 2 per cent in 201–2015 and 1.7 per cent for 2016–2018. To achieve net income of 1 per cent of taxes and general grants, the tax rate needs to be increased by 0.24 percentage points up to 2018 compared with 2015.

For 2016–2018 we assume that the county councils will continue to develop and improve healthcare. Experience shows that this increases costs – despite continuous increases in efficiency – at least over a period of a few years. Our calculation assumes that costs grow in line with population changes and an estimated historical cost trend, about 1 per cent over and above demography

viewed over a business cycle. Since the demographic pressure is high during the period, 1.3 per cent per year, this assumption leads to an aggregate cost increase of 2.0 per cent for healthcare. The historical cost increases have been even faster in public transport. Overall, this means that we expect costs to increase by 2.3 per cent per year for the county councils.

Our calculations for the county councils show that such a cost increase can only take place at the expense of continued tax increases and poorer financial outcomes. In 2016–2018 the average tax rate needs to increase by 0.45 percentage points just to reach net income of 1 per cent of taxes and government

Diagram 1 • Net income in municipalities and county councils
SEK billion



Sources: Statistics Sweden and the Swedish Association of Local Authorities and Regions.

grants. In this situation further tax increases to comply with the rule of thumb of 2 per cent do not appear to be very likely.

Challenges for municipalities and county councils

In addition to demographic change in the next few years, there are further challenges for both municipalities and county councils. This applies, for example, to a greater need for investments, increased reception of asylum seekers and refugees and, for the county councils, costs for new, expensive medicines.

As 2014 is drawing to a close, it is clear that more than 80,000 refugees will have sought asylum in Sweden during the year. This has highlighted the way in which the Swedish reception system works. The reception of asylum seekers, unaccompanied minors, newly arrived refugees and their close relatives is a matter both for government agencies, municipalities and county councils and for the business sector and civil society. A reception system that works is of crucial importance for integration and the introduction of new arrivals but is also a challenge that demands better cooperation between actors in society. To better meet the need for support and action and to be able to make use of the resources of new arrivals, better collaboration is needed between central and local government, as is a more even distribution of asylum and refugee reception and more accurate central government compensation systems. The county councils are responsible for two of the most expansive services in the Swedish public sector: public transport and healthcare. County council investments have more than doubled in the past ten years. The explanation is

the generational shift under way in healthcare premises and the ongoing centralisation of highly specialised care.

At the same time, public transport is expanding, which requires investments in trains and buses, for example. As a result, county council investments are expected to increase by 10 per cent in 2014. County council budgets and plans for the next few years point to a continued rise in investments. The cost increase for public transport in the past ten years is mainly due to the expansion of tracked traffic, where services have increased most.

The development of medicines for hepatitis C, and therefore of costs for them, has advanced quickly, and so far in 2014 the county councils' aggregate costs total more than SEK 500 million. These costs are expected to increase in the next few years.

One issue that seems to be increasingly difficult for municipalities and county councils to handle is the large number of central government reforms and the poorer planning conditions that follow from specific grants.

Collaboration, differences and cost growth

In this chapter we set out the position for two central questions in municipalities and county councils. One concerns work to improve the interplay between county councils and municipalities in order to increase quality and efficiency in the care of older people with great needs of care. The other concerns the question of what differences in services offered and quality are actually allowed between different municipalities and different county councils, i.e. the tension between local self-government and national equity. We also present our results from the work started in the spring edition of the *Economy Report:* providing a better and systematic explanation of how and why healthcare costs are continuing to increase.

Joined-up healthcare and social care

Many people, especially many older people, need interventions both from municipal elderly care and from county council health care. If, for example, the intervention by the county council is provided too late or not at all, this has consequences, not only for the individual, but also for the municipality. Municipalities and county councils must therefore put in place an organisation and a way of working that maximises the possibilities of providing joined-up healthcare and social care for people who need interventions from both services. The new ways of working that have emerged in recent years are successful, both for patients' security and health and also in economic terms.

This is a challenge that municipalities and county councils have been wrestling with for decades. In recent years municipalities and county councils have addressed this challenge in a joint initiative called A better life for the frail elderly. The purpose of this initiative has been to provide support for long-term improvement work focusing on better quality and more joined-up healthcare and social care of the frailest elderly people.

To provide a framework for a long-term approach, municipalities and county councils have set up joint management and governance at county level, both for the political leadership and for senior officials. These levels of management have produced action plans for the joint improvement work. SALAR has run a programme for managers called Leadership [Ledningskraft] to provide support for mangers from municipalities and county councils in realising the action plans.

In many places new ways of working with a better interplay between municipalities and county councils have taken shape. One shared feature is that patients are quickly given support in the home to avoid repeated visits for them to the emergency department followed by admission to hospital.

One of the most successful examples is in the Skaraborg area, where a new way of working has led to a reduction of 80 per cent in emergency visits and a reduction of 90 per cent in days of hospital stays for people with access to local healthcare teams, see the fact box "An example of collaboration" on page 10.

This work has been part of a government programme (SEK 1.7 billion per year) and an agreement between SALAR and central government. Criteria for allocating these incentive grants to municipalities and county councils have included the development of the number of emergency readmissions within 30 days to hospital and avoidable inpatient care for people above 65 years of age. The government programme runs to the end of 2014.

The costs of municipal elderly care and county council healthcare for people over 65 add up to 25 per cent of the total costs, corresponding to more than SEK 210 billion. Using these resources more efficiently is of strategic importance. The new ways of working that have emerged in recent years are so successful, both for the security and health of patients and in economic terms, that there is every reason for them to continue even without financial incentives from the government.

However, collaboration is not straightforward. There can be a conflict between, on the one hand, the demands for cooperation between municipa-

An example of collaboration

One practical example of successful collaboration is **Local Healthcare in West Skaraborg** [Närvård västra Skaraborg] (the Municipalities of Lidköping, Götene, Skara, Grästorp, Vara and Essunga) which was started in 2001 in order to strengthen collaboration between primary healthcare, hospital care and municipal healthcare to ensure care users good and safe care.

Today there are thee healthcare models in close interaction:

The first is the **local healthcare team**, which is a permanent service that is part of the county council in organisational terms. This service is aimed at patients with complex needs of medical care and nursing, where the care requires close collaboration between municipal home healthcare, primary care and inpatient care. Care is also given in the form of home visits.

The other is the **mobile doctor for home healthcare** in the Municipality of Lidköping, which was introduced in 2011. The purpose was to improve medical planning and treatment with pharmaceuticals, to provide more security for the individual and to make better assessments in the individual's home setting in cooperation with the municipal home healthcare service.

The third is the **mobile palliative team**, which consists of doctors and nurses. This team helps to provide advanced healthcare in the home in cooperation with the municipality's nurses and home healthcare. The palliative team is intended to be a link between the various care providers and the home/special housing provision in close cooperation with palliative inpatient care.

The results are good. Frail elderly people can be cared for at home and feel security thanks to the continuity of their relationship with their healthcare. Stays in hospital and visits to the emergency department have decreased for this group. The staff are committed and feel satisfaction in their work.

Economic calculations have shown that this way of working is cost-effective. Emergency visits and inpatient care decrease sharply after enrolment in the local healthcare team. This reduces the costs per user and year by almost SEK 200,000. Similar results can be noted from the mobile doctor in home healthcare. The number of hospital admissions to the local hospital, Skaraborgs Sjukhus, fell by 80–90 per cent compared with a control group

lities and county councils so as to reduce the importance of organisational boundaries and, on the other hand, models of centralised governance, which are aided by clear organisational boundaries.

At present a review is also being conducted of the Payment Liability Act, which regulates the obligation of municipalities to pay for certain healthcare. The purpose of this review is to keep the lead times between hospital inpatient care and health care and social care in the home or in special housing provision as short as possible and to avoid unnecessary stays in hospital for patients who are ready to be discharged. One starting point for the review is to be to specify the forms for cooperation between healthcare authorities. It is important for the new act to contain incentives for both municipalities and county councils. The review is to presented its report in March 2015.

What differences are allowable?

There are always differences in both the services offered and in quality between different municipalities and different county councils. Often the differences are greater within municipalities and within county councils. This is not unique to county councils and municipalities; it also applies to central government systems in Sweden such as the court system, the Swedish Social Insurance Agency and the universities. Nor is it unique to Sweden. In all countries, whatever their system, there are differences between different parts of the country and between providers.

These differences are generally described as negative and as a sign of inequality as people living in different parts of the country do not have access to the same services. Often central government takes action to address these differences; sometimes by targeting government grants to reduce the differences.

The background to the differences also varies. Sometimes they are an effect of conscious prioritisation with different municipalities and county councils taking different views of local people's needs or of what is most efficient. Sometimes the differences arise because the hospitals in a county council or elderly care services in a municipality have varying success in, for example, preventing falling accidents. Some differences are part of positive development in which some bodies are working in a new way and achieving better results. Gradually others also learn these lessons in a beneficial spiral. Other differences are more of a manifestation of an inability to absorb new, more efficient methods. So differences can be positive and drive developments, but can also be negative and unjust.

SALAR's Programme Committee "What differences are allowable?" has analysed the tension between local self-government and national equity. In its final report the Programme Committee looks at differences in quality and service within municipal and county council services and tries to assess when they are good and when they are unacceptable.

The Programme Committee makes the argument that differences in and between municipalities and county councils are necessary and mainly positive. The differences reflect differing views among local residents about how to organise services and variations in individual needs. They also arise because some municipalities and county councils improve their performance more than others, and do so more quickly. So these differences should not automatically be seen as problems that require central government intervention. Regulation intended to achieve uniformity is more likely to lead to less efficiency and to inhibit local development capacity and initiative.

However, there are differences that are not part of a positive development but are unjust and that need to decrease; moreover they are often a sign that the general situation is unsatisfactory and in need of improvement. This is equally true of differences within and between municipalities and county councils. The Programme Committee's discussion leads to recommendations as to how central government should balance self-government and equity. Here national objectives and guidelines have to provide scope for variation

and for checks of effectiveness and compliance. This can also be achieved through 'soft governance' that creates incentives and provides support for handling problems and improving services. But the Programme Committee also points to the responsibility that municipalities and county councils have both individually and together for addressing unacceptable levels and establishing common practice where required.

SALAR's Programme Committee is not alone in arguing that targeted government grants can sometimes have the wrong effect. The Swedish National Audit Office has audited targeted government grants and their effects and the Office takes the view that they have indeed led to the county councils focusing on the questions formulated in agreements, which has resulted in a general increase in performance. However, the Office also points out that the targeted government grants risk being a short-term remedy and that they also have crowding-out effects with the result that other important action risks been given too low a priority.

So targeted grants risk reducing innovation and development capacity, while increasing the risk of sub-optimisation. With them, it is not the local needs that steer priorities; for example, a municipality that already has a high teacher–pupil ratio may feel obliged to put more resources into its teacher-pupil ratio in order to improve its results on account of earmarked funding, instead of using the money where it will do more good. Generally targeted government grants are only available for a few years, which shortens horizons. Moreover, central government initiatives are accompanied by a large administrative burden for municipalities and county councils.

So how can municipalities, county councils and central government work on tackling differences and levels that are not acceptable? The first step is to follow quality systematically across the range of services. This can be about understanding why all pupils do not get pass grades in all subjects at school, why staff continuity is low in home-help services and why processing times in individual and family care can be unreasonably long.

Since quality began to be compared more openly, knowledge about different variations in healthcare quality between county councils and hospitals, for example, has increased. The annual reports on Open Comparisons are analysed and discussed both at national level and in the county councils. It has been possible to identify medical areas with particularly great needs of joint action, and the county councils have been able to initiate work on improvement in the light of their own analyses. Toa great extent, this work is being conducted in collaboration between national and regional level and with the participation of the profession and patient organisations. Examples of areas where improvement work is under way are cancer, mental health, diabetes, stroke, chronic obstructive pulminary disease (COPD) and asthma as well as the accessibility of healthcare.

But we can also get even better at developing analytical capacity and using the data available to produce an overall picture. Greater equity can be established and any targeted government grants can be steered to areas where the sector has identified a need for national coordination and can be used in a more efficient way in these activities.

Explanations of cost increases in healthcare

Healthcare is complex and is developing rapidly, making it difficult to attribute the development of costs to a few factors. Here we make an attempt to do so on the basis of the trends we have observed since 2008: that healthcare use is decreasing (except among the very elderly), that the population is increasing and that there is a larger proportion of older people in healthcare. We also see that progress is being made in medical technology and that doctors make up a greater share of healthcare professionals. All of this affects costs.

The structures for the provision of healthcare are in constant change. This is bound up with changes in medical technology and pharmaceuticals, but also with other new knowledge about what benefits patient recovery. The clearest structural change is to do with the decrease in the number of hospital beds in recent decades, from around 50,000 at the start of the 1990s to around 25,000 today. This decrease is a manifestation of changes in medical technology that have made it possible to reduce hospital stays and have also made it possible to treat patients in outpatient care. It is also a manifestation of changes in ways of working to include more prevention. Many county councils and regions have also done a great deal of work on improving patient flows. At the same time healthcare is wrestling with sluggish structural problems that drive costs, for example in the interfaces between primary care and hospitals and between county council healthcare and municipal healthcare and social care.

On top of this, the possibilities of treating older and older patients have improved greatly and the outcomes of the interventions are getting better and better.

How has this affected costs in specialised somatic care? To try to understand the development of costs we study how healthcare volumes in the form of inpatient discharges, doctors' consultations and consultations with other categories of professionals in specialised somatic care have changed between 2008 and 2013, how patient flows have changed and how the structure of the population has changed. The reason why we have chosen specialised somatic care is that this is where we have the fullest data on costs at diagnosis and patient level. Specialised somatic care also accounts for the largest share of the costs of healthcare, 54 per cent.

More and more people are living longer and longer... Between 2008 and 2013 the total population increased by over four per cent. It is mainly among older people that numbers have increased. The number of people aged 65+ increased by almost 15 per cent and in 2013 they accounted for more than 19 per cent of the population. Young people also increased by more than one per cent per year. Average life expectancy increased by 0.6 years for women to 83.7 years and 1 year for men to 80.1 years. Mortality has decreased. More and more people are living longer and longer, and more people are reaching a very high age. A number of new pharmaceuticals and treatments have appeared that both prevent illness and help to keep diseases in check. Living conditions have changed, for example levels of education have increased and many are better off financially.

Sources for the analysis

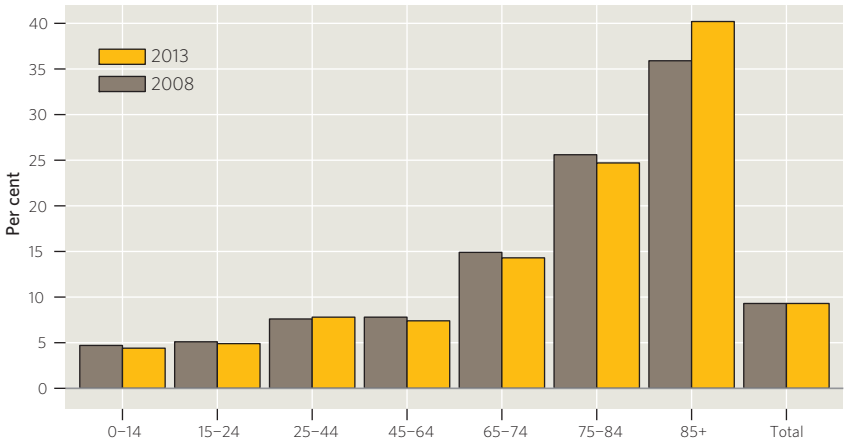
The data used about costs in specialist somatic care come from the Swedish Case Costing (KPP) database, which SALAR administers and is responsible for.

To be able to make comparisons over time we have used 32 hospitals for costs in inpatient care (7 regional hospitals and 25 county/sub-county hospitals) and 23 hospitals for costs in outpatient care (4 regional hospitals and 19 county/sub-county hospitals).

Inpatient discharges and outpatient visits in specialist somatic care come from the National Patient Register, for which the National Board of Health and Welfare is responsible. We have also used service statistics collected by SALAR.

...and this has resulted in more healthcare for the very old Being an older person today is not a reason not to be looked after by the health services.
In somatic outpatient care we can also see that the proportion of older people with doctors' consultations has increased and that this also applies to older people's contacts with other categories of professionals. Doctors' consultations and contacts with other categories of professionals can relate to preventive treatments to reduce the risk of illness or to keep chronic diseases in check, with the result that patients live longer. Other categories of professionals include nurses, psychologists, speech and language therapists, occupational therapists and physiotherapists, for example.

Diagram 15 • Proportion of the population in various age groups who have been patients in inpatient somatic care
Per cent



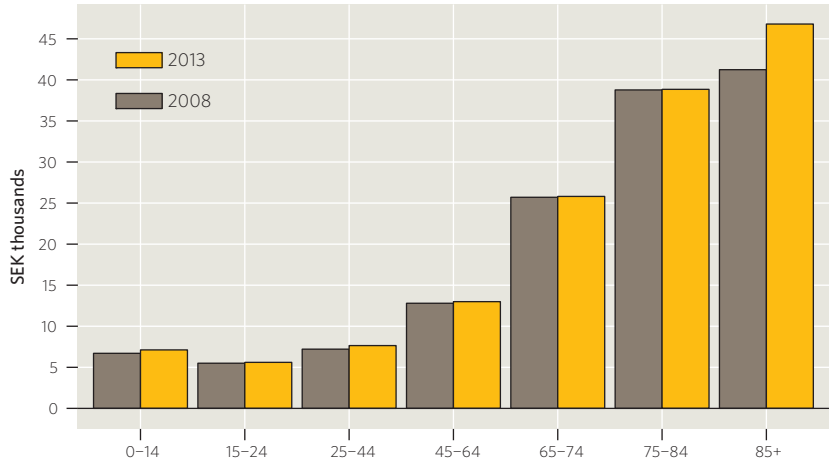
Sources: National Patient Register and the Swedish Association of Local Authorities and Regions.

The proportion of the total population who have been patients in somatic inpatient care has not changed, even though the population has become older, except among the very oldest, where the proportion has increased. In all other age groups the proportion of the population who have been patients in somatic inpatient care has decreased.

More healthcare contacts in specialised somatic care for older people leads to higher costs. The largest shift in costs per inhabitant in constant prices has been for the very oldest.

Inpatient care accounts for 58 per cent and outpatient care for 42 per cent of the total costs of specialised somatic care. Between 2008 and 2013 the costs

Diagram 16 • Cost per inhabitant in specialised somatic care, 2013 prices
SEK 000s



Source: The Swedish Association of Local Authorities and Regions.

The cost increase in specialised somatic care per inhabitant between 2008 and 2013 was SEK 6,000 on average for the very oldest expressed in 2013 prices.

of specialised somatic care increased by 10 per cent in constant prices. The costs of somatic inpatient care increased by 7 per cent and the costs of somatic outpatient care by 13 per cent.

Explanations of the development of costs

Healthcare is both complex and development-intensive, so it is no simple matter to make a clear attribution of the development of costs to a few factors. Nevertheless an attempt is made here on the basis of the above description. We see that healthcare use is decreasing, except among the very oldest. The population in increasing and there is an age shift in the direction of a larger proportion of older people in healthcare. Progress is being made in medical technology and doctors make up a greater share of healthcare professionals. All of this affects costs.

More and more diseases and injuries can be treated, even at a high age. Milder methods shorten periods of care and many interventions can now be carried out without admission to hospital. People with chronic diseases are given new medicines and advice about changing their life style that mean that they do not get worse in their diseases, and this reduces the need for healthcare. As more and more patients are older people, it is important to ensure better coordination of interventions in the interface between primary care and hospital and between county council healthcare and municipal healthcare and social care. This is illustrated in the section called Joined-up healthcare.

Table 17 • Cost increase of various components in somatic care, change between 2008–2013
Contributions in percentage points, constant prices

	Somatic care	Inpatient care	Outpatient care
Volume of healthcare	5.1	3.2	6.3
whereof healthcare use	–1.5	–2.6	0.1
whereof age structure	2.0	2.2	1.6
whereof population	4.2	4.2	4.2
Healthcare costs	4.9	3.8	6.7
Total volume increase	**10**	**7**	**13**

Note: The development of costs is explained by changes in the size and structure of the population and by changes in the need for healthcare and in the costs of the various treatments provided. By looking at the development over the past five years for each 'component', but otherwise holding prices and structures at the 2008 level, an estimate is obtained of how large a part of the growth of costs up to 2013 is explained by each variable. The method is not exact, but it does give a good picture of the relative importance of the different components for the development of costs..

Source: The Swedish Association of Local Authorities and Regions.

The costs of somatic care increased by 10 per cent in constant prices between 2008 and 2013. More than half is explained by a greater volume of healthcare in the form of a population increase and a change in the population structure, with a greater number of older people and more children. The reduction in the use of inpatient care, except among the very oldest, has a restraining impact on the development of costs. Parts of this care have been moved out to outpatient care, leading to a marginal increase there in healthcare use. The other half of the cost increase, which consists of increased costs for healthcare, is explained by the development of medical technology in the form of new treatment possibilities, a greater proportion of doctors, etc. The effect of the age structure on cost growth with a larger number of older people and more children, explains a larger proportion of the cost increase in inpatient care since that care is becoming ever more advanced while it can be provided for older and older patients.

The population is getting older, partly as a result of healthcare interventions, and this affects the costs of healthcare. The population has also increased, and this results in greater costs as more patients have to be looked after.

There has been a shift in healthcare use in the direction of outpatient care and professional categories other than doctors, especially among the very oldest. Healthcare is being conducted to a greater extent at a lower level of healthcare, which leads to cheaper care. The patient has been given a more active role in healthcare and leaves hospital quickly so as to start their rehabilitation. Today the active participation of the patient is viewed as important not

only for the patient's own recovery but also for increasing the efficiency of healthcare as a whole.

New knowledge is emerging and being developed among both care providers and patients, and this is leading to changes in care that create conditions for more efficient healthcare and, of course, a healthier population. Patients today are increasingly involved, from prevention to treatment and rehabilitation.

The possibilities provided by the new information technology for communication within healthcare, between healthcare and the patient and between patients is important ingredient in realising this. However, here there are deficiencies in the IT support currently provided.

In the next section we take a closer look at three diagnoses; heart attack, stroke and hip fracture. Heart attack and stroke are two common causes of death and hip fractures are common among older people. Here we look at inpatient care since we cannot follow diagnoses in outpatient care in the same way as in inpatient care.

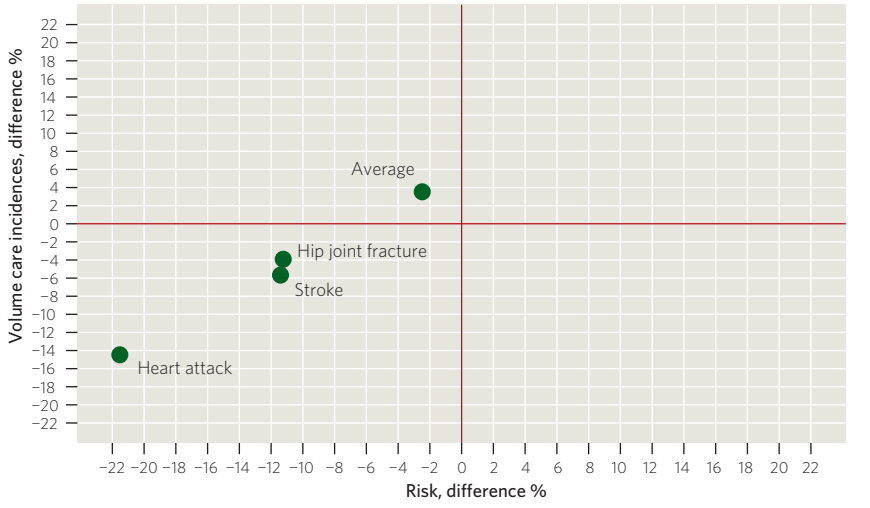
Fewer new cases of heart attacks, strokes or hip fractures

Age-adjusted new cases in one of the diagnoses heart attack, stroke and hip fracture have decreased. And fewer people getting a heart attack and stroke now die as a result of their disease. Healthcare is doing more preventive work and new treatment possibilities have come along. As an example, it can be mentioned that preventive medicines that reduce blood pressure and blood fat levels and that inhibit the coagulation of blood are in common use in the treatment of cardiovascular diseases. For these medicines the number of daily doses per 1000 inhabitants has increased from 401 daily doses in 2008 to 458 in 2013. The cost of these medicines was SEK 1.9 billion in 2013, a decrease of almost 36 per cent since 2009, partly thanks to patent rights expiring.

Heart attack An annual report from the National Board of Health and Welfare about heart attacks shows that new cases and mortality have decreased.

Diagram 17 • Inpatient somatic care, development of number of inpatient discharges (volumes) and new cases (risk), 2008–2013

Per cent



Sources: National Patient Register and the Swedish Association of Local Authorities and Regions.

Age-adjusted new cases of heart attacks have decreased sharply, by 21 per cent, and the number of inpatient discharges has decreased by 14 per cent between 2008 and 2013. For stroke, new cases decreased by 11 per cent and the number of inpatient discharges decreased by 6 per cent. New cases of hip fractures decreased by 8 per cent and the number of inpatient discharges by 4 per cent.

Since the start of the 2000s, balloon expansion has been a high priority method that individuals over the age of 80 also benefit greatly from, and that treatment has increased for patients over 79 years of age, both for women and for men. The proportion of women treated within the recommended period has also increased according to Open Comparisons. The period of sick leave has also decreased sharply according to Swedeheart's annual report for 2013.

Age-adjusted new cases of heart attacks decreased by 21 per cent between 2008 and 2013, decreasing even more for the very oldest. The number of inpatient discharges with heart attacks decreased by 14 per cent, the reduction was larger for women than for men. The cost per inpatient discharge increased by 1 per cent to SEK 66,700. The costs in inpatient care for heart attacks was SEK 1.1 billion in 2013. Compared with 2008 these costs have decreased by 14 per cent in constant prices.

Stroke Even though the number of older people in the population is increasing, the number of inpatient discharges for stroke has decreased, which indicates that primary and secondary prevention has been successful, according to the annual report of the Swedish Stroke Register for 2013. The severity of the new cases has also decreased. The number of inpatient discharges with stroke decreased by 6 per cent, here again the reduction was larger for women than for men. Age-adjusted new cases decreased by 11 per cent. The costs per inpatient discharge increased by 14 per cent in constant prices to SEK 100,800.

The large cost increase is due to particularly expensive inpatient discharges in 2013.

The cost for stroke care were SEK 2.1 billion in 2013, and in constant prices they increased by 6 per cent.

Hip fractures Age-adjusted new cases of hip fractures decreased by 8 percent between 2008 and 2013 and the number of inpatient discharges decreased by 4 per cent. Inpatient discharges for women decreased. Out of hip fracture patients, 67 per cent were women and 33 per cent were men. For the oldest men the number of hip fracture inpatient discharges increased. Among hip fracture patients who had a prosthesis operation for their hip fracture the proportion aged over 65 years has increased. The average length of stay has decreased because a larger proportion of patients are given rehabilitation at another healthcare institution or in their regular home, according to the annual report for 2013 from the Swedish National Registry of hip fracture patient care. The waiting time for a hip fracture operation decreased by 6 hours to 21 hours, according to Open Comparisons. For hip fractures the average cost increased by 1 per cent to SEK 91,000. In inpatient care the cost of hip fractures was SEK 1 billion in 2013. A comparison in constant prices with 2008 shows a cost decrease of 4 per cent.

ANNE X

This annex presents some key indicators and the overall income statements of municipalities and of county councils, as well as an aggregate income statement for the sector to give an overall picture.

For diagrams showing the distribution of costs and revenue for municipalities and county councils separately, tables presenting overviews of central government grants and other data that we usually present in the Annex to the *Economy Report,* we refer to our website, a page called Sektorn i siffror (The sector in figures). Go to www.skl.se, choose Ekonomi, juridik, statistik/Ekonomi/ Sektorn i siffror.

An aggregate picture of municipalities and county councils

Table 21 • Key indicators for municipalities and county councils, 2013–2017
Per cent and thousands of people

	Outcome	Forecast		Calculation		
	2013	2014	2015	2016	2017	2018
Average tax rate, %	**31.73**	**31.86**	**31.99**	**32.16**	**32.35**	**32.68**
municipalities, incl. Gotland	20.61	20.65	20.69	20.72	20.78	20,93
county councils*, excl. Gotland	11.17	11.26	11.35	11.49	11.62	11.80
No of employees, thousands**	**1,093**	**1,101**	**1,117**	**1,132**	**1,149**	**1,163**
Municipalities	825	832	845	855	868	878
County councils	268	270	273	277	281	285
Volume change, %	**1.3**	**2.0**	**2.2**	**2.0**	**2.0**	**1.9**
Municipalities	1.2	1.7	2.0	1.8	1.7	1.7
County councils	1.5	2.5	2.7	2.3	2.4	2.3

*The tax base of Gotland is not included, which is why the totals do not add up.

**Average number of people in employment according to the National Accounts.

Sources: Statistics Sweden and the Swedish Association of Local Authorities and Regions.

Table 22 • Aggregate income statement for the sector, 2013–2017
SEK billion

	Outcome	Forecast		Calculation		
	2013	2014	2015	2016	2017	2018
Income of activities*	173	172	180	189	198	208
Expenses of activities	-833	-868	-908	-948	994	1,043
Depreciation	-28	-29	-30	-32	-33	-35
Net expenses of activities	**-687**	**-724**	**-758**	**-791**	**-830**	**-870**
Tax revenue	584	604	636	671	706	742
Gen. gov. grants and equalisation	123	127	124	127	133	139
Net financial income	-7	3	2	1	-1	-3
Net income before extraordinary items	**13**	**9**	**5**	**8**	**8**	**9**
Share of taxes and grants, %	*1.9*	*1.2*	*0.6*	*1.0*	*1.0*	*1.0*

Note: Purchases between the sectors have been consolidated.
*The non-recurring effect of a repayment of AFA premiums of SEK 10 billion is included in Income of activities for 2013.
**The non-recurring effect of a reduction of the RIPS-rate (the interest rate used in pension calculations) amounting to SEK –10 billion is included in Net financial income.

Table 23 • Income statement for the municipalities, 2013–2017
SEK billion

	Outcome	Forecast		Calculation		
	2013	2014	2015	2016	2017	2018
Income of activities*	128	124	131	137	143	150
Expenses of activities	-552	-573	-599	-626	-656	-687
Depreciation	-19	-20	-20	-21	-22	-23
Net expenses of activities	**-443**	**-469**	**-488**	**-510**	**-534**	**-560**
Tax revenue	379	392	411	433	454	476
Gen. gov. grants and equalisation	77	80	79	81	85	90
Net financial income	2	3	2	2	1	0
Net income before extraordinary items	**15**	**5**	**4**	**5**	**5**	**6**
Share of taxes and grants, %	*3.4*	*1.1*	*0.7*	*1.0*	*1.0*	*1.0*

*The non-recurring effect of repayments of AFA premiums of SEK 7.4 billion is included in Income of activities for 2013.
**The non-recurring effect of the reduction of the RIPS-rate (see table 25) of SEK –2 billion is included in Net financial income.

Table 24 • Income statement for the county councils, 2013–2017
SEK billion

	Outcome	Forecast		Calculation		
	2013	2014	2015	2016	2017	2018
Income of activities*	47	49	51	53	56	59
Expenses of activities	-282	-296	-310	-324	-340	-357
Depreciation	-8	-9	-10	-11	-12	-12
Net expenses of activities	**-244**	**-256**	**-269**	**-282**	**-295**	**-310**
Tax revenue	205	212	225	239	252	266
Gen. gov. grants and equalisation	46	47	46	46	48	49
Net financial income	-9	1	0	-1	-1	-2
Net income before extraordinary items	**-2**	**4**	**1**	**3**	**3**	**3**
Share of taxes and grants, %	*-0.7*	*1.5*	*0.4*	*1.0*	*1.0*	*1.0*

*The non-recurring effect of repayments of AFA premiums of SEK 2.8 billion for 2013 is included in Income of activities.
**The non-recurring effect of the reduction of the RIPS-rate (see table 25) of SEK –8.3 billion is included in Net financial income.

Source: The Swedish Association of Local Authorities and Regions.

The Economy Report. December 2014

On Swedish Municipal and County Council Finances

is a series published twice yearly by the Swedish Association of Local Authorities and Regions (SALAR). In it we deal with the present economic situation and developments in municipalities and county councils. The calculations in this issue extend to 2017.

This year's second report looks at the effects of the central government budget for 2015, which was amended at a late stage in the Riksdag, and the challenges facing municipalities in their work to dimension various areas of services in the next few years. We also continue work on explaining how and why healthcare costs are continuing to rise, focusing on somatic care.

The report also describes how persons born abroad account for a very large part of the upturn in the labour force and in employment. We analyse, for instance, the implications for the level of unemployment of the fact that policy seems to have contributed to increased labour force participation among people born abroad. But this has not had an impact in terms of a greater participation rate and lower unemployment.

We expect net income or the sector to fall to around SEK 9 billion this year, corresponding to 1.2 per cent of taxes and general government grants. After dropping, net income is expected to return to around SEK 9 billion in 2018. But this will require tax increases of 0.83 percentage points even though we assume that government grants will be increased by SEK 15 billion.

The report is not for sale, but it can be downloaded from the website of Sveriges Kommuner och Landsting: www.skl.se. Choose In English and then Publication and reports.

Download at www.skl.se/In English, Publications and reports.
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