Care of the Elderly in Sweden Today

2005
Preface

This publication provides an up-to-date view of care of the elderly in Sweden. The aim is to reflect the current status of care of the elderly in Sweden and the trends we can now see regarding interventions, costs, staffing and so on. The documentation is primarily based on official statistics from the National Board of Health and Welfare, Statistics Sweden and the Swedish Association of Local Authorities and Regions. The majority of the statistics cover the period up to the end of 2004.

This publication is intended for all parties who are interested in participating in the debate on care of the elderly, whether on the professional, political or personal level. We hope that this publication will contribute to a richer discussion with a greater understanding of trends and demands for the set-up of care of the elderly.

This document was produced by the Swedish Association of Local Authorities and Regions, Health and Social Care Division. It was written by Josephine Lindgren and Irene Lindström. Other staff in the division have contributed to the sections in the document, as well as Kerstin Ahlén from the Education and Labour Market Division; Jonas Eriksson, Lars Johansson, Elva Palmheden Kalms, Ulf Lennartsson and Björn Sundström from the Finances and Governance Division; Birgitta Söderlund from the Communication and Strategic Intelligence Division; and Lilian Gynne from the Employer Policy Division.

We have chosen to use the phrase ‘medical and social services’ in this document to define the care provided to the elderly by the local authorities and county councils. We have avoided the otherwise common term in the EU, healthcare and long-term care, to avoid any confusion with institutional care.

Stockholm, October 2005

Margaretha Spjuth
Health and Social Care Division
Table of Contents

From Individual to General Measures – Time to Shift Focus? ....... 5
Changed perspective in the debate ................................................................. 5
Changes in care of the elderly .................................................................... 5
How do we view elderly care in the future? .............................................. 6
General preventive measures increasingly important............................. 6

Facts about the Elderly .............................................................................. 7
The demographic trend ............................................................................. 7
Factors that affect demand for medical and social services .................. 9
  The elderly’s finances ............................................................................. 10
  Health and lifestyle of the elderly .......................................................... 10
Elderly with other ethnic backgrounds .................................................. 12
  National minorities ................................................................................ 12
  Foreign-born elderly ............................................................................. 12
  Care of elderly people with other ethnic backgrounds ..................... 13
  The number of OAPs requiring special housing with an ethnic focus is rising ................................................................. 14

Community Support for the Elderly.......................................................... 15
General and preventive measures ............................................................. 15
  Community and housing planning for the elderly .............................. 15
  Measures to prevent injury ................................................................... 17
Housing for the elderly ............................................................................ 17
  Elderly people in regular housing ....................................................... 17
  OAP flats .............................................................................................. 18
Support for the elderly in regular housing .............................................. 19
  Meals on wheels .................................................................................. 19
  Home adaptations ................................................................................ 19
  Transportation service ......................................................................... 20
  Personal safety alarms ......................................................................... 21
  Home help ........................................................................................... 22
  Short-term housing ............................................................................. 24
  Day activities ....................................................................................... 24
Special housing – extent and support .................................................... 25
  Elderly people in special housing ....................................................... 27
  Factors affecting the number of beds in special housing ............... 28
Community home medical services ....................................................... 28
  Scope of community home medical services ...................................... 29
Dementia care................................................................................................................... 30
Number of dementia patients.................................................................................. 30
Assistive devices...................................................................................................... 30
Elderly Receiving Aid under the LSS Act.................................................................. 31
Community support for family and loved ones .................................................... 33
  Trends in support to family members ................................................................. 35
Care allowance.......................................................................................................... 36

Medical Care for the Elderly.......................................................... 37
Medical developments and length of stay.............................................................. 37
Care for more elderly patients.................................................................................. 37
Medical care utilisation by the elderly................................................................. 39
Health care expenditures...................................................................................... 41
Financing................................................................................................................... 42
Use of medications by the elderly........................................................................ 42
  Special housing.................................................................................................... 42
  In regular housing............................................................................................... 43
Where do the elderly die?...................................................................................... 43

Individual Providers of Medical and Social Services............. 45
Various types of individual providers.................................................................. 45
  Contractors ......................................................................................................... 45
  Customer’s choice ............................................................................................... 46
  Non-profit organisations...................................................................................... 46
  Purchase of individual beds in special housing and of home help .................. 47

Staff and Training ..................................................................................... 48
Number of employees........................................................................................... 48
Fewer being recruited............................................................................................. 49
Six of ten have nursing training............................................................................ 50
Many recruits are foreign-born............................................................................ 50
Predominantly female professions........................................................................ 51
Age structure affects the need for recruiting....................................................... 51
Fewer leaving their positions................................................................................. 51
Leave and sick leave............................................................................................... 53
Working hours......................................................................................................... 55
Payroll..................................................................................................................... 56
Skills supply in medical and social services....................................................... 57
From Individual to General Measures – Time to Shift Focus?

Changed perspective in the debate
The number of old-age pensioners in society is growing, and is expected to swell to over one-fifth of the population in a few years’ time. And yet the debate thus far has dealt primarily with the volume, resources and quality of care of the elderly as it is today. The focus is usually on flaws and what does not work in the current system.

Public-funded care of the elderly currently embraces less than 3% of the population, or about 16% of OAPs. The majority of them manage on their own for a long time, even though most do require medical and social services in the end stages of life. The question before us now is whether we need a change in perspective. Do we need a discussion of the demands created by the elderly population – and indeed all of the population – on social economy, housing policy, social planning and range of social services? Should the focus be shifted from individual needs to which tasks society is best at doing and which individuals themselves and the private sector can manage?

Changes in care of the elderly
The organisation and content of the Swedish model of care of the elderly are largely successful in meeting people’s need for extensive, qualified measures in their own homes. It is in fact unparalleled outside the Nordic countries. The ÄDEL reform of 1992 was implemented at the start of a decade that came to be characterised by the steadily growing needs of an ageing population. At the same time, the social economy was faltering. In the past ten years, an advanced organisation has developed that provides personal care round the clock and qualified medical treatment in the home. The ability to remain in one’s own home – even after suffering a stroke or a thigh fracture and with all the frailty and complex morbidity that can result from advanced age – has become a real option for elderly people.

But this has required a shift in interventions – from younger OAPs to older, from elderly people needing limited assistance to those needing exten-
sive interventions, from married and cohabiting people to singles. Children and grandchildren have more responsibility for supervision and practical support to aging parents and other loved ones. Spouses and partners have always been the ones to give support when an individual begins having problems handling joint responsibilities in the home. This makes the provision of support, knowledge, guidance and relief to family members caring for loved ones one of the most important tasks of the healthcare system. We must see family members as a key link in the continuum of care.

How do we view elderly care in the future?

Several long-term inquiries have studied the social economy. All have indicated that public finances will be strained when those born in the 1960s retire at the same time as those born in the 1940s will require increasing healthcare. There is also good reason to believe that the elderly of the future will have other demands and expectations as to how and where they want to live. The question is whether it is reasonable to assume that the core activities in care of the elderly will be the same as they are today, but with the same volume as in the 1970s? Perhaps we should instead see how the community can match and develop elderly people’s own ability to stay healthy, and make it easier for them to organise their daily lives.

General preventive measures increasingly important

Only an insignificant part of the budgets for care of the elderly and healthcare in general is used to enhance people’s ability to take care of their own health. The reason, of course, is that it is financially difficult for the local authorities to both meet today’s needs and invest in the future. It is easy to reject measures that will not pay off until 10 or 20 years down the line. And yet improved health and greater personal responsibility for planning one’s own life as an OAP are just what we all want when we discuss how we will face the future. How would our planning be affected if we put these issues first? Great benefits are to be gained in terms of public health, an increased range of offerings for the elderly and financial stability for the local authorities if we can combine measures for health and self-care with those for planning of housing, cultural and leisure activities. Perhaps ‘new’ funds should be invested to stimulate general measures that allow the elderly to take responsibility for their own health, accommodation, leisure and finances, rather than clinging to the old solutions that we live with today. Let the debate begin!
Facts about the Elderly

Just over 17% of Sweden’s population, or 1.5 million people, are aged 65 and older today. Most are in good health when they retire and can look forward to many healthy years. Care needs usually arise when they are in their 80s and increase as they grow older.

Figure 1  Population trend for 2004 to 2050 for the elderly. Index 2004=100

Source: Statistics Sweden’s population projections

The demographic trend

The number and percentage of elderly in the population will increase over the next few decades, mainly because the baby boomers of the 1940s are reaching retirement age. Over the next ten years the percentage of people aged 65 and older will increase by 27%, or about 327,000 people. This can be compared with the past ten years, when the number of OAPs increased by only one percent. When the care needs of the baby boomers from the 1940s become large between 2020 and 2030, those born in the 1960s will begin to reach retirement age. This means that pension costs will increase at the same time that the percentage of people in the workforce decreases.¹

¹ Statistics Sweden’s population projections
Table 1  Number of people aged 65–74, 75–79, 80–84, 85–89 and 90 and older, for 2004–2014

<table>
<thead>
<tr>
<th>Age group</th>
<th>2004</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–74</td>
<td>757,400</td>
<td>888,900</td>
<td>1,068,900</td>
</tr>
<tr>
<td>75–79</td>
<td>314,600</td>
<td>302,000</td>
<td>330,400</td>
</tr>
<tr>
<td>80–84</td>
<td>265,700</td>
<td>243,700</td>
<td>238,200</td>
</tr>
<tr>
<td>85–89</td>
<td>143,800</td>
<td>165,000</td>
<td>155,300</td>
</tr>
<tr>
<td>90+</td>
<td>72,700</td>
<td>77,600</td>
<td>88,500</td>
</tr>
<tr>
<td>Total 65+</td>
<td>1,554,200</td>
<td>1,677,200</td>
<td>1,881,300</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden’s population projections

For the local authorities, the increase in the number of people in the oldest age groups is most significant, since they are the main group that affects the need for medical and social services. Over the past twenty years we have had a sharp increase in the number of people aged 80 and older. Over the next twenty years it will mainly be the number of people aged 65–79 that will increase, as can be seen in figure 2. After 2020, however, we will see a substantial increase in the number of people aged 80 and older again. The average life expectancy for men is expected to increase more than that of women. Consequently, the proportion of women in the very oldest population group will also gradually decrease. Today women constitute 64%; in 2040 they are expected to constitute 57%.²

Table 2  Number and percentage of people in the population aged 65 and older

<table>
<thead>
<tr>
<th>Year</th>
<th>Number aged 65 and older</th>
<th>Percentage aged 65 and older</th>
<th>Percentage women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>1,554,200</td>
<td>17.2</td>
<td>57</td>
</tr>
<tr>
<td>2020</td>
<td>2,041,200</td>
<td>21.1</td>
<td>54</td>
</tr>
<tr>
<td>2030</td>
<td>2,276,600</td>
<td>22.7</td>
<td>53</td>
</tr>
<tr>
<td>2040</td>
<td>2,423,500</td>
<td>23.6</td>
<td>53</td>
</tr>
<tr>
<td>2050</td>
<td>2,435,500</td>
<td>23.1</td>
<td>53</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden’s population projections

² Statistics Sweden’s population projections
Table 3  Number and percentage of people in the population aged 80 and older

<table>
<thead>
<tr>
<th>Year</th>
<th>Number aged 80 and older</th>
<th>Percentage aged 80 and older</th>
<th>Percentage women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>482,300</td>
<td>5.4</td>
<td>64</td>
</tr>
<tr>
<td>2020</td>
<td>518,800</td>
<td>5.4</td>
<td>60</td>
</tr>
<tr>
<td>2030</td>
<td>749,100</td>
<td>7.5</td>
<td>57</td>
</tr>
<tr>
<td>2040</td>
<td>795,700</td>
<td>7.8</td>
<td>57</td>
</tr>
<tr>
<td>2050</td>
<td>884,700</td>
<td>8.4</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden’s population projections

Figure 2  Population growth for people aged 65 and older and for people aged 80 and older, 1980–2000 and 2000–2020

Factors that affect demand for medical and social services

Many different factors affect the well-being of the elderly and their need for medical and social services. In addition to age, the most important factors are private economy, health and lifestyle, standard of living, whether the person lives alone or as part of a couple, and whether the person has relatives and/or other social networks. Retirement means that life changes completely and the course of life acquires a new structure. Retirement is a major and, for many people, difficult transition from full-time employment to being free all day, every day. Natural social contacts with colleagues...
disappear and with them, a large part of the individual’s social network. Researchers say that traumatic changes such as becoming ill or losing a life partner can also influence health and consumption of medical care. The effects are often more negative for men than for women, since men usually have fewer social contacts.

The elderly’s finances
The financial situation of the elderly mainly depends on the income they had while they worked and how long they worked. Their economy also depends on whether they accumulated wealth. The biggest difference in economy can usually be found between those who live as couples and those who are single. The government survey Senior 2005 showed that the income of about 20\% of one-person households in the age group 65 to 69 would fall below what would be considered a reasonable standard of living and that this would be the case for a long time (20 to 30 years).\(^3\) To a greater extent than men, women worked fewer years during their working years because of childbearing and part-time employment when the children were small. In addition, many women had lower salaries than men, which translates to lower pensions. A poor economy often limits opportunities such as travel or taking part in various activities.

OAPs who were born abroad and came to Sweden during their working years have not worked as many years in the country and therefore have a lower pension.

Health and lifestyle of the elderly
Health is another area where conditions differ greatly among different groups of elderly people. Average life expectancy has increased during the twentieth century by an average of 27 years for men and 29 years for women. When the first Act on general pension insurance was implemented in 1913, the average retirement age was 67, while the average chronological age was just over 55 for men and 57 for women. Those who retire at the age of 65 today have many, hopefully good, years to look forward to – an average of 17 years for men and 20 for women. One reason for the increasing average life expectancy is the substantial improvement in the health of the elderly. Much of the increase in average life expectancy since 1913 is also due to decreased child mortality.

\(^3\) Senior 2004, SOU 2003:91, Äldrepolitic för framtiden (Elderly policy for the future), annex section D
Table 4  Average life expectancy and remaining life expectancy, broken down by sex

<table>
<thead>
<tr>
<th>Years</th>
<th>Average life expectancy at birth</th>
<th>Remaining average life expectancy at age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>1900</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>1925</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>1950</td>
<td>68</td>
<td>71</td>
</tr>
<tr>
<td>1975</td>
<td>72</td>
<td>78</td>
</tr>
<tr>
<td>2004</td>
<td>78</td>
<td>83</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2005, Average life expectancy and remaining average life expectancy

According to the National Board of Health and Welfare’s report ‘Living conditions of the elderly 1988–2002’, OAPs’ subjective assessment of their own health was essentially unchanged between 1988/89 and 2002 or somewhat improved in 2002. Men consistently report improved health, and a health index showed a weak tendency towards improved health. This should be considered in relation to a higher average age among the elderly. Worry and anxiety did not become more common. Even though the number of elderly is increasing, the number in need of help in the population remained unchanged, or was even less in 2002 than previously. However, health did not improve at the same rate as before 1988/89.

Lifestyle has great significance for health, especially habits related to diet, exercise, smoking and alcohol. This also applies to type of housing. Lifestyle also includes social contacts and activity level. For example, OAPs who participate in moderate exercise reduce mortality by between 25 and 33% and add one to two years to their lives. Unfortunately, few elderly are physically active, only 10–20%. It has proven difficult to interest the elderly in pure exercise; however, OAPs who enjoy closeness to nature become more physically active by taking walks in the woods, walking the dog, or engaging in activities such as gardening.

The most important social contacts for many elderly are their partners and their own children. Just over half of all OAPs have both partners and children. Also, more single people have children today than in the late 1980s. An unchanged percentage – 39% – have siblings. Fourteen percent lack both partner and children.

5 Norling Ingmar 2004, Ett gott och friskare liv som äldre (A good, healthier life for the elderly)
Elderly with other ethnic backgrounds

The concept of elderly with other ethnic backgrounds covers both those who belong to one of the national minority groups and those who were born abroad.

National minorities

The national minorities in Sweden are the Sami, the Swedish Finns, the Tornevalers, the Roma and the Jews. The minority languages are Sami, Finnish, Meänkieli (Tornedal Finnish), Romani Chib and Yiddish. According to the national minority policy, Finnish speaking OAPs have the right to receive elderly care completely or partially in Finnish within the administrative area for Finnish, which includes Gällivare, Haparanda, Kiruna, Pajala and Övertorneå. Public services are to be provided in Sami in the administrative area that includes Arjeplog, Gällivare, Jokkmokk and Kiruna. In addition, the needs of OAPs who belong to national minorities must be taken into consideration throughout the country.7

Foreign-born elderly

In 2004 Sweden had 165,000 foreign-born residents aged 65 and older, or 10.6% of the population aged 65 and older. As table 5 shows, the number and percentage of foreign-born residents aged 65 and older is increasing. The number of birth countries is also increasing.

Table 5  Number and percentage of foreign-born individuals aged 65 and older, broken down by age category and number of birth countries represented in 2004

<table>
<thead>
<tr>
<th>2004</th>
<th>55–64</th>
<th>65–74</th>
<th>75–84</th>
<th>85–94</th>
<th>95+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of foreign-born people</td>
<td>145,900</td>
<td>99,200</td>
<td>54,000</td>
<td>11,300</td>
<td>774</td>
</tr>
<tr>
<td>Percentage of foreign-born residents in population</td>
<td>12.4</td>
<td>13.1</td>
<td>9.3</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Number of birth countries represented</td>
<td>169</td>
<td>145</td>
<td>132</td>
<td>91</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2004; Foreign-born population in the country by birth country, age and sex. Year 2000–2004

Half of the elderly foreign-born population in 2004 were born in a Nordic country and 90% in a European country. Only one of ten was born in a country outside of Europe.

Table 6  The ten largest groups of foreign-born residents aged 65 and older, 2004

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Number total</th>
<th>Country of origin</th>
<th>Number total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>51,400</td>
<td>Poland</td>
<td>5,800</td>
</tr>
<tr>
<td>Germany</td>
<td>15,300</td>
<td>Estonia</td>
<td>5,700</td>
</tr>
<tr>
<td>Norway</td>
<td>14,300</td>
<td>Bosnia-Herzegovina</td>
<td>5,200</td>
</tr>
<tr>
<td>Denmark</td>
<td>12,600</td>
<td>Hungary</td>
<td>4,200</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>8,800</td>
<td>Iran</td>
<td>3,100</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2004; *Foreign-born population in the country by birth country, age and sex. Year 2000–2004*

Care of elderly people with other ethnic backgrounds

In Spring 2004, SALA and the National Board of Health and Welfare carried out a survey about initiatives in care of the elderly aimed at these groups. The survey was the third since 2000 that addressed the subject. The results showed that in general, these initiatives have increased since 2000.

In 2004 almost half of the country’s local authorities had people receiving elderly care who had special needs because of ethnic affiliation. An additional 25 local authorities responded that such needs would arise in two to three years. Eighty-eight local authorities stated that they are able to provide staff with language skills for a small group of these people, 48 that they can do so for all or a majority. Many local authorities responded that they are intentionally recruiting or training staff with foreign backgrounds.

Table 7 Percentage of local authorities that have special initiatives for elderly who belong to national minorities and elderly with foreign background, 2004 (percent of those who responded that they have users with special needs because of ethnic affiliation)

<table>
<thead>
<tr>
<th></th>
<th>For all or a majority</th>
<th>For a smaller group</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees who speak users’ home languages</td>
<td>34</td>
<td>62</td>
<td>4</td>
</tr>
<tr>
<td>Employees with cultural skills</td>
<td>27</td>
<td>62</td>
<td>11</td>
</tr>
<tr>
<td>Possibility of receiving special diet because of ethnic affiliation</td>
<td>27</td>
<td>62</td>
<td>11</td>
</tr>
<tr>
<td>Activities adapted to ethnic minority group</td>
<td>7</td>
<td>34</td>
<td>59</td>
</tr>
</tbody>
</table>

Source: SALA 2004, *Äldreomsorg till nationella minoriteter och personer med utländsk bakgrund*

8 SALA 2004, *Äldreomsorg till nationella minoriteter och personer med utländsk bakgrund (Elderly care for national minorities and people with foreign background)*
Most of Sweden’s local authorities have a small percentage of elderly who belong to the national minorities and elderly with foreign background. However, the percentage is higher in urban regions and regions that share borders with neighbouring countries.

The number of birth countries represented by the elderly population varies among the local authorities and as a result they have developed different strategies to meet the needs. Some local authorities offer special housing, home help and/or day centres that are specially intended for or adapted to elderly people with other ethnic backgrounds. Others have employees within the various activities who have various ethnic backgrounds, and who can be matched with users of the same background. Employing relatives is also commonplace. One example of meeting special needs without special housing or home service groups is the day centre, which is aimed at the elderly in both special housing and ordinary housing.9

The number of OAPs requiring special housing with an ethnic focus is rising

The number of people who need special housing that is especially intended for or adapted to the elderly from other ethnic minority groups is increasing. In 2000 there were 20 such housing arrangements, 13 of which were for Finnish-speaking OAPs. In 2002 there were 25, of which 17 were for Finnish speakers. In 2004 this number had increased by another five to 30 housing facilities or departments for OAPs from ethnic minority groups in 23 different local authorities, 19 of which were intended for Finnish-speaking elderly. This means an increase of 10 housing facilities since 2000, which is equivalent to 50%.10

Table 8 Development of special housing intended for/adapted to elderly people from another ethnic minority group

<table>
<thead>
<tr>
<th>Special housing</th>
<th>2000</th>
<th>2002</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>of which for Finnish speakers</td>
<td>13</td>
<td>17</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: SALA 2004, Äldreomsorg till nationella minoriteter och personer med utländsk bakgrund

9 SALA 2004, Elderly care for national minorities and people with foreign background
10 SALA 2004, Äldreomsorg till nationella minoriteter och personer med utländsk bakgrund
Community Support for the Elderly

The goal of community care of the elderly is to allow the elderly and functionally impaired to live a normal, independent life. This means that they should be able to keep living in their own homes. Many surveys show that this is what most elderly people want. As infirmities set in, the elderly can receive support in their own homes, measures such as personal safety alarms, meals on wheels, transportation service and health and social services provided by home help and home medical services.

For elderly individuals to continue living a normal, independent life, they need housing that is suitable for themselves and for the staff who will provide medical and social services to them. The buildings and neighbourhoods must also be designed to allow independent living, so that people who have difficulty with stairs, or must use a walking frame or wheelchair, can get out by themselves.

When the elderly need access to staff round the clock, many must move to special housing. This applies primarily to those with dementia, but includes those with multiple ailments or who for other reasons are unable to live in flats on their own.

General and preventive measures

Community and housing planning for the elderly

Community and housing planning are required to facilitate the daily lives of the elderly and meet their need to live a normal life. Good planning makes it easier for the elderly to get out of the house on their own. The Planning and Building Act has been expanded with stricter regulations on accessibility in the public environment. Access for people with physical disabilities and impaired orientation must always be ensured.

Accessibility in residential areas is crucial to the elderly. Spending time out of doors improves mental and physical health, and contact with nature is vital for well-being and stress reduction. Increased physical activity, such as walks, also enhances physical and mental health.\(^{11}\) Proximity to commercial

\(^{11}\) Norling Ingmar 2004, *Ett gott och friskare liv som äldre*
### Figure 3  Care of the elderly in the local authorities in 2004

#### Home help in regular housing

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>37,000</td>
<td>3.5</td>
</tr>
<tr>
<td>80–84</td>
<td>36,300</td>
<td>13.7</td>
</tr>
<tr>
<td>85+</td>
<td>59,000</td>
<td>27.3</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>132,300</strong></td>
<td><strong>8.5</strong></td>
</tr>
</tbody>
</table>

#### Special housing

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>21,500</td>
<td>2.0</td>
</tr>
<tr>
<td>80–84</td>
<td>24,900</td>
<td>9.4</td>
</tr>
<tr>
<td>85+</td>
<td>58,400</td>
<td>27.0</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>104,800</strong></td>
<td><strong>6.7</strong></td>
</tr>
</tbody>
</table>

#### Elderly granted LSS

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>3,350</td>
</tr>
<tr>
<td>80+</td>
<td>450</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>3,800</strong></td>
</tr>
</tbody>
</table>

#### Day activities

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>In regular housing</td>
<td>11,000</td>
</tr>
<tr>
<td>In special housing</td>
<td>1,500</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>12,500</strong></td>
</tr>
</tbody>
</table>

#### Home medical services under the local authority

Local authorities offering home medical services: 143

<table>
<thead>
<tr>
<th>Age group</th>
<th>Home medical services only</th>
<th>Home help and home medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>5,800</td>
<td>8,800</td>
</tr>
<tr>
<td>80–84</td>
<td>4,000</td>
<td>8,700</td>
</tr>
<tr>
<td>85+</td>
<td>4,800</td>
<td>14,800</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>14,600</strong></td>
<td><strong>32,300</strong></td>
</tr>
</tbody>
</table>

#### Meals on wheels

<table>
<thead>
<tr>
<th>People aged 65+</th>
<th>% of all 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>60,000–70,000</td>
<td>approx. 4</td>
</tr>
</tbody>
</table>

#### Personal safety alarms

<table>
<thead>
<tr>
<th>People aged 65+</th>
<th>% of all 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>140,000–150,000</td>
<td>approx. 9</td>
</tr>
</tbody>
</table>

#### Home adaptations

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants approved</td>
<td>63,300</td>
</tr>
</tbody>
</table>

#### Transportation service

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65–79</td>
<td>91,200</td>
<td>8.4</td>
</tr>
<tr>
<td>80+</td>
<td>209,600</td>
<td>41.2</td>
</tr>
<tr>
<td><strong>Total 65+</strong></td>
<td><strong>300,800</strong></td>
<td><strong>19.4</strong></td>
</tr>
</tbody>
</table>

#### Short-term care/housing

<table>
<thead>
<tr>
<th>People aged 65+</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,000</td>
<td></td>
</tr>
<tr>
<td>Bed-days</td>
<td>227,700</td>
</tr>
</tbody>
</table>

and public services is also important for the elderly to be able to continue living in their homes and handle much of their daily activities themselves.

In a joint project, the Swedish Association of Local Authorities (SALA) and the Swedish Association of Municipal Housing Companies (SABO) developed a model for how local authorities and housing companies can work together to analyse the necessary measures in homes and residential areas to help the elderly live at home longer. The results of the project were summarised in the publication: *Kvarboende + tillgänglighet = god ekonomi (Staying at home + accessibility = Good economics).*

### Measures to prevent injury

Many elderly people suffer various injuries after accidents, which can lead to extensive personal suffering. Many never fully recover from a fall, but require constant medical and social services afterwards. The elderly are over-represented in nearly all kinds of injuries, which is very expensive for society. More than twice as many elderly people die as a result of a fall than die in traffic accidents, and five times as many require hospital care after a fall than after a traffic accident. The Swedish Rescue Services Agency estimated that the costs of falls among the elderly amounted to SEK 4.8 billion in 2002. In 2035, this cost is expected to increase to nearly SEK 7.8 billion.

Many communities provide information to the elderly on the risks of injury in the home and outdoors. Some local authorities have hired a person the elderly can contact for help with jobs that are not covered by home help.

### Housing for the elderly

#### Elderly people in regular housing

Most of the elderly population – 93% of all people aged 65 and older – live in regular housing today. Many live in detached or semi-detached houses. Only about 7% of people aged 65 and older, and about 17% of those who are 80 and older, live permanently in special housing.

In December 2000, the National Housing Board presented a survey on what kinds of homes the elderly of the future had in 2000. As this table shows, as many as 45% of people in the range of 65–74 years of age lived in their own houses, and nearly 30% of people above 75 still did so.

---

12 SABO and SALA 2004, *Kvarboende + tillgänglighet = god ekonomi*

13 Swedish Rescue Services Agency, *Fallolyckor bland äldre – samhällets direkta kostnader (Falls among the elderly – direct costs to society)*
Remaining in one’s regular home will probably be the norm for the elderly in the future as well. It will become easier for the elderly to live at home longer as many homes are improved and made more practical. New technical solutions that make daily activities in the home easier are constantly being developed.

Many of those who live in houses may seek housing in flats that are adapted for accessibility when infirmities set in. They may have problems mowing the lawn, shovelling snow or walking up stairs. The same applies to elderly people who live in flats in buildings with no lift and/or small bathrooms.

In their joint project, SALA and SABO also looked at what measures are needed in older flats to make it possible for elderly people to live at home longer. The report presents a model for how local authorities and housing companies can work together to improve housing to such a level that the elderly and disabled can keep living at home and to provide a good working environment for home help. The demand for such housing is likely to increase as a growing number of elderly people want to move from their houses and inconvenient flats to flats adapted to the elderly and disabled.14

OAP flats

OAP flats are one type of housing for the elderly. These are regular homes for people aged 55 or 65 and older, which are adapted for enhanced accessibility. Some OAP flats have some kind of extra security, such as a superintendent or similar person. There may also be community rooms the residents can use, and perhaps a kitchen and dining area for cooking and socialising in groups. The costs of community areas and a superintendent are usually covered by the rent. Some local authorities and housing companies pay for the superintendent completely or in part.

---

14 SABO and SALA 2004, Kvarboende + tillgänglighet = god ekonomi
In 2003–2005, several local authorities have worked to convert service flats to OAP flats.

Since OAP flats are part of the regular housing supply, no aid grant is required for a person to obtain one. Those who are interested can put themselves on a waiting list with the housing company. The first OAP flats were tenant-owned flats in special buildings. More recently, primarily local-authority-owned housing companies in collaboration with the local authority have begun converting suitable housing into rental OAP flats. In some cases they are in special buildings, but they can also be individual flats in a regular housing area. In many cases, OAP flats have been viewed as a good alternative when elderly people want to move out of their houses.

Support for the elderly in regular housing

A range of supports are available to the elderly who remain in their regular homes. Some examples are meals on wheels, home adaptations, transportation service, personal security alarms and home help. Of these, only home help is included in the national statistics publication Äldre – vård och omsorg (The Elderly – Medical and Social Services).

Meals on wheels

Nearly all local authorities offer deliveries of cooked meals to the elderly and disabled, according to a survey by SALA in spring 2004. Only five local authorities have no food distribution. Most require an aid grant for supplying meals on wheels. 48 local authorities had contracted out food distribution.

In the 255 local authorities that responded to the survey, a total of 52,300 people received meals on wheels. No information was provided by 35 local authorities, most of them smaller and medium-sized and located throughout the country. An estimated 60,000–70,000 people receive meals on wheels, which is about 4% of all people aged 65 and older.

Home adaptations

The local authorities provide grants for certain measures needed for the disabled to use their homes efficiently. This also applies to many elderly. People can apply to the local authority for grants for home adaptations. The grants cover the entire cost, regardless of the applicant’s income. There is no price ceiling for home adaptation grants.

SALA, Äldreomsorgens styrning 2004 (Management of care of the elderly 2004)
The number of approved grants increased from 60,600 in 2003 to 63,300 in 2004. The total cost to the local authorities rose from SEK 823 million in 2003 to SEK 835 million in 2004.

In 2004, local authorities approved on average seven home adaptations per 1,000 residents, which is the same as the previous year. The average cost per resident in each local authority averaged SEK 96, a drop from 2003, when the amount was SEK 98.

Most of the home-adaptation grants were small: about 52% are under SEK 5,000, and about 75% are under SEK 20,000.

The average cost per case was about SEK 13,200 in 2004. Adaptations in houses are more expensive than those in blocks of flats. The average for houses in 2004 was SEK 18,000 and for blocks of flats SEK 9,200.¹⁶

Figure 4  Grants approved per year 1974–2004

Transportation service
Elderly and functionally impaired people who cannot ride regular public transport are entitled to transportation service. The most common transport is a taxi, but special vehicles are sometimes included.

In 2004, 372,900 people had the right to transportation services, or 4.1% of the population. The number of people granted transportation services has dropped steadily from 1994–2004, from 50 to 41 per 1,000 people. Of

¹⁶ National Housing Board 2005
those who are entitled to transportation services, 19% are under age 65, 25% are aged 65–79 and 56% are aged 80 and older. Of those who were entitled to transportation services in 2004, 67% were women.

A total of 12,328,600 one-way trips were made with transportation services. On average, each person entitled to transportation services makes 33 trips per year, which is slightly less than in 2003.\(^\text{17}\)

The costs of transportation services in 2004 amounted to SEK 2.5 billion including the Stockholm County Council, which handles the transportation services for the entire county and pays for them through taxes. The part of individual social security charges that is set aside for transportation services amounts to SEK 178 million.\(^\text{18}\)

Users who must travel between local authorities and outside the range of the local transportation services can be approved for national transportation assistance. The local authorities grant approval and provide funding for the costs in excess of the regular travel costs. This allows for travel by air, rail or other means, or by taxi or special vehicles, at a cost to the traveller corresponding to a standard second-class train ticket.

In 2004, 24,900 people travelled with national transportation assistance. Of them, 41% were under age 65, 23% were aged 65–79 and 36% were over age 80.\(^\text{19}\)

**Personal safety alarms**

Elderly and disabled people can obtain personal safety alarms. The alarm does not prevent accidents or illness, but a person who has one can get help faster if something does happen. Knowing this creates a sense of security.

According to a survey by SALA in 2004, 131,000 people had personal safety alarms in the 258 local authorities that responded. No information was provided by 32 local authorities, most of them smaller and medium-sized and located throughout the country. Sweden has an estimated 140,000–150,000 personal safety alarms for the elderly, which corresponds to 9–9.5% of all people aged 65 and older. Usually an aid grant is required for supplying a personal security alarm. 17 local authorities do not require separate aid grants.\(^\text{20}\)

---

\(^\text{17}\) SIKA (2005), *Färdtjänst och riksfärdtjänst 2004 (Transportation Service and National Transportation Assistance 2004)*

\(^\text{18}\) Statistics Sweden 2005

\(^\text{19}\) SIKA (2005), *Färdtjänst och riksfärdtjänst 2004 (Transportation Service and National Transportation Assistance 2004)*

\(^\text{20}\) SALA, *Äldreomsorgens styrning 2004 (Management of care of the elderly 2004)*
Tracking devices are primarily used for people with dementia. To obtain such a monitor requires a special decision by the local authorities and documentation according to the National Board of Health and Welfare’s regulations.

Home help

Elderly people who are unable to take full care of themselves in the home can receive home help from the local authorities. An evaluator interviews the person and possibly family members to determine the extent of the need for home help, and what services are needed. Even people with extensive need for medical services can remain in their own homes, because home help can be offered round the clock. More and more, elderly people remain in their own homes until the end of their lives, and even the severely ill receive medical and social services in their homes.

In total, 132,300 people aged 65 and older had been granted home help as of 1 October 2004, or 8.5% of the population in this age range. Of these, 72% were aged 80 and older and 70% were women. The number of elderly people granted home help has increased by 3% since 2003 and by 5% since 1998. The oldest age groups account for the increase; in the younger groups home help has decreased.\(^{21}\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>65–74</td>
<td>18,500</td>
<td>2.4</td>
<td>16,600</td>
<td>2.2</td>
<td>16,800</td>
<td>2.2</td>
</tr>
<tr>
<td>75–79</td>
<td>23,300</td>
<td>6.7</td>
<td>20,300</td>
<td>6.4</td>
<td>20,200</td>
<td>6.4</td>
</tr>
<tr>
<td>80–84</td>
<td>33,100</td>
<td>14.1</td>
<td>34,900</td>
<td>13.3</td>
<td>36,300</td>
<td>13.7</td>
</tr>
<tr>
<td>85+</td>
<td>51,100</td>
<td>25.8</td>
<td>56,200</td>
<td>26.5</td>
<td>59,000</td>
<td>27.3</td>
</tr>
<tr>
<td>65+</td>
<td>126,000</td>
<td>8.2</td>
<td>128,000</td>
<td>8.3</td>
<td>132,300</td>
<td>8.5</td>
</tr>
<tr>
<td>65–79</td>
<td>41,800</td>
<td>3.8</td>
<td>36,900</td>
<td>3.5</td>
<td>37,000</td>
<td>3.5</td>
</tr>
<tr>
<td>80+</td>
<td>84,200</td>
<td>19.5</td>
<td>91,100</td>
<td>19.1</td>
<td>95,300</td>
<td>19.8</td>
</tr>
</tbody>
</table>

Table 10 Number and percentage with home help in regular housing


Of all women aged 65 and over, 10.5% had been granted home help in 2004. The corresponding figure for men was 6%. Only in the oldest age group, 95 and older, did men outnumber women in receiving home help.\(^{22}\)


In October 2004, a total of 4,019,700 approved home help hours were reported, a 5% increase from the previous year and a 24% increase from 1999. In 2004, 38% of all people aged 65 and older had been approved 1–9 hours of home help, 23% 10–25 hours and one percent 200 or more hours. The number of help hours has increased more as a percentage than the number of elderly people receiving home help. This means that those who receive home help received more hours per person in 2004 than in 2003.23

Table 11  Absolute and percentual change of the number of approved/estimated home help hours in October 2000–2004. Rounded figures

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of approved home help hours in October</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>3,592,200</td>
</tr>
<tr>
<td>2001</td>
<td>3,617,500</td>
</tr>
<tr>
<td>2002</td>
<td>3,818,400</td>
</tr>
<tr>
<td>2003</td>
<td>3,812,700</td>
</tr>
<tr>
<td>2004</td>
<td>4,019,700</td>
</tr>
<tr>
<td>Percentual change 2000–2004</td>
<td>+ 12 percent</td>
</tr>
</tbody>
</table>


Short-term housing
Short-term housing/care and day activities are a supplement to home help, allowing people to live at home longer.

The terms short-term care and short-term housing refer to temporary accommodation in special types of housing. Short-term housing and short-term care are used for rehabilitation, nursing, home-hospital care and relief of family members (usually a spouse who is an informal care provider).

As of 1 October 2004, 9,000 elderly people had been approved short-term care or short-term housing, 54% of them women. This corresponds to 1% of the population aged 65 and older, in increase of about 100 people since 2003. Since this figure refers to the number of residents on a given day, the results are somewhat random. Several beds may have been empty at the time. Therefore, the figure indicating the number of bed-days in October is a better indicator. In 2004, a total of 227,700 bed-days were registered in October. Since 1999, the number of bed-days has increased by about 19%.\(^{24}\)

Table 12  Number of registered bed-days in 1999, 2003 and 2004

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed-days</td>
<td>191,433</td>
<td>221,100</td>
<td>227,700</td>
</tr>
</tbody>
</table>


Day activities
Home help can also be complemented with day activities, which make it easy for elderly people to keep living in their own homes. Day activities can also be provided as a supplement to special housing. Day activities

---

are primarily intended for elderly and disabled people with age-related dementia and mental impairment. They are also open to people who for other reasons need activation and rehabilitation.

As of 1 October 2004, about 11,000 people aged 65 and older and living in regular housing had been granted day activities. At the same time, 1,500 elderly people in special housing were entitled to day activities. About 65% were women. The number of elderly people in regular housing with day activities has increased in the past few years, while the number of elderly in special housing with day activities has decreased. One reason for this is that day activities are often integrated into the regular activities in special housing.25

<table>
<thead>
<tr>
<th>Year</th>
<th>Elderly people in regular housing</th>
<th>Elderly people in special housing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>10,500</td>
<td>3,000</td>
<td>13,500</td>
</tr>
<tr>
<td>2000</td>
<td>11,700</td>
<td>3,800</td>
<td>15,500</td>
</tr>
<tr>
<td>2001</td>
<td>10,200</td>
<td>4,100</td>
<td>14,300</td>
</tr>
<tr>
<td>2002</td>
<td>10,400</td>
<td>2,600</td>
<td>13,000</td>
</tr>
<tr>
<td>2003</td>
<td>10,600</td>
<td>2,100</td>
<td>12,700</td>
</tr>
<tr>
<td>2004</td>
<td>11,000</td>
<td>1,500</td>
<td>12,500</td>
</tr>
</tbody>
</table>

Source: National Board of Health and Welfare Äldre – vård och omsorg, the stated years

**Special housing – extent and support**

According to the Social Services Act, the local authorities are responsible for ensuring that special housing is available for people with extensive need for medical and social services and round the clock access to staff. These residences are allocated by the local authority according to need and the assessment of the need for aid. Most people in special housing have their own flats, and almost always a rental contract. The local authorities are responsible for health care interventions up to the level of registered nurse.

In connection with the ÄDEL reform in 1992, an umbrella concept was established for all types of special housing for the elderly under the Social Services Act: special housing for service and nursing. Previous designations, such as service flats, retirement homes, nursing homes and group housing are, however, still used by the local authorities.

A study in the county of Kalmar found two main reasons for moving to special housing. The first is impaired orientation, combined with limited capacity for family and friends to assist, which is behind 45% of moves. The other is a need for nursing at critical intervals, also combined with a limited capacity of family and friends to help; this is behind 35% of moves. These two conditions lie behind 80% of moves to special housing. In general all moves are spurred by a need for social services; the need for medical care by itself is not a factor for moving. Shortcomings in home medical services do not usually lead to a move; this occurs first when the maximum amount of home help is insufficient.²⁶

Figure 7  Stays in special housing in 2002 (including short-term housing)

The amount of time spent in special housing (including short-term housing) has decreased successively, since the elderly can now receive support and care from home help and home medical services in their own homes much longer. One reason for remaining at home is that the elderly have better homes now than previously, with more technical and other aids that allow them to live at home longer.

Elderly people in special housing

According to the annual inquiry on 1 October each year, 104,800 people – or 7% of all people aged 65 and older – were permanently living in special housing in 2004. This is a reduction of 6,100 people compared with 2003. Of people aged 80 and older, 83,300 or 17% lived in special housing, a drop of 4,400 people. The decrease has occurred in all age groups. Of those who lived in special housing on 1 October 2004, some 79% were aged 80 and older and 70% were women.

Table 14  Number and percentage of permanent residents in special housing in 1998, 2003 and 2004

<table>
<thead>
<tr>
<th>Age</th>
<th>1998</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>65–74</td>
<td>10,900</td>
<td>1.4</td>
<td>9,400</td>
</tr>
<tr>
<td>75–79</td>
<td>17,000</td>
<td>4.9</td>
<td>13,800</td>
</tr>
<tr>
<td>80–84</td>
<td>27,900</td>
<td>11.9</td>
<td>26,200</td>
</tr>
<tr>
<td>85+</td>
<td>62,900</td>
<td>31.7</td>
<td>61,500</td>
</tr>
<tr>
<td>65+</td>
<td>118,700</td>
<td>7.7</td>
<td>110,900</td>
</tr>
<tr>
<td>65–79</td>
<td>27,900</td>
<td>2.5</td>
<td>23,200</td>
</tr>
<tr>
<td>80+</td>
<td>90,800</td>
<td>21.0</td>
<td>87,700</td>
</tr>
</tbody>
</table>


Figure 8  Percentage of the population permanently living in special housing as of 1 October 2004

Of the 104,800 people who lived permanently in special housing, about 3,000 shared their home with someone other than a spouse, partner or family member. This is a reduction of over 600 people in comparison with 2003.27

Factors affecting the number of beds in special housing
The need for special housing depends in part on how much support home help and home medical services can provide in the home, how the home is designed and the availability of short-term care, short-term housing and day activities in the community. The drop in the number of people in special housing has several reasons:

- More and more elderly people receive home medical services for a much longer period. According to table 10, the number of people receiving home help has increased by 4,300 people.
- Stays in special housing have become shorter, and more people have access to this limited resource than before.
- Better housing, more assistive devices and interventions in health services all contribute to the elderly being able to live in their homes longer.
- The local authorities have reported 6,600 more bed-days in short-term housing in 2004.
- Many service flats have been converted into OAP flats.
- Special housing in multiple-bed rooms has decreased by 600 beds.

Community home medical services
Developments in health and medical care lead to changed conditions for the local authorities and county councils. Medical science is advancing, making it possible for more and more elderly patients to recover and be operated on even at advanced ages. This also leads to increasing opportunities for people to receive care in their home environments from primary care and the community. Because of this, home medical services, in collaboration with home help services, are becoming increasingly important. Community home medical services involve health and medical care, including rehabilitation up to the level of doctors in special housing, short-term housing, day activities and even in regular housing in half of the communities.

Since the ÄDEL reform in 1992, the local authorities have assumed the responsibility for health and medical care, including rehabilitation, up to and including the level of registered nurse in special housing. The reform also gave the local authorities the opportunity to take on these responsibilities for patients in regular housing, through a contract with the county councils. About half of the local authorities had done so in 2004.

Scope of community home medical services
As a step towards improving the ability to monitor trends in community health and medical care, SALA, in collaboration with the Association of Local Authorities in the County of Jämtland and some communities in Jämtland and Värmland, has pursued a project on the scope and costs of local-authority health and medical services. All local authorities in the project have taken over responsibility for health and medical care in regular housing. ‘The scope of local-authority health and medical services’ is defined as the percentage of working hours that the affected care staff spend on health and medical tasks.28

The most health and medical services – 28% of the time – were provided in short-term housing/care, while home help spent 26% of its working hours on such tasks.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Scope as a percent of the total working time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term housing/care</td>
<td>28</td>
</tr>
<tr>
<td>Home help</td>
<td>26</td>
</tr>
<tr>
<td>Special housing</td>
<td>18</td>
</tr>
<tr>
<td>LSS housing</td>
<td>7</td>
</tr>
<tr>
<td>Day activities</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Swedish Association of Local Authorities

Relatively large differences existed in the scope of health and medical service tasks between the participating communities. In general, the local authorities in Jämtland County provided more health and medical care than those in Värmland County. This concurs with the structural differences between the counties – differences in age distribution and health in the populations. However, structural conditions cannot explain all differences between the communities. Other factors that affect the scope of health and medical

---

28 Nurses, occupational therapists, physiotherapists, assistant nurses and nurses’ aides.
services include organisation and administration, political priorities, local contracts and collaboration with the county council.\footnote{Swedish Association of Local Authorities}

## Dementia care

### Number of dementia patients

The largest group of elderly in need of round-the-clock supervision are those with dementia. The number of people with dementia was calculated by the Dementia Inquiry in 2003:

<table>
<thead>
<tr>
<th>People suffering from dementia</th>
<th>2003</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>aged under 65</td>
<td>8,700</td>
<td>9,700</td>
</tr>
<tr>
<td>mild dementia</td>
<td>41,000</td>
<td>44,000</td>
</tr>
<tr>
<td>moderate dementia</td>
<td>66,000</td>
<td>72,000</td>
</tr>
<tr>
<td>severe dementia</td>
<td>32,000</td>
<td>34,000</td>
</tr>
</tbody>
</table>

Source: Dementia Inquiry: På väg mot en god demensvård (Ds 2003:47) (On the path to good dementia care)

The risk of developing a dementia disorder increases with age. According to the Dementia Inquiry, we can roughly say that the risk doubles every five years from age 60 and up. If the average life span increases, so will the number of dementia sufferers. About 8% of people aged 65 and older develop moderate or severe dementia.\footnote{Dementia Review 2003: På väg mot en god demensvård (Ds 2003:47) (On the path to good dementia care)}

In 2003, SALA and the Ministry of Health and Social Affairs initiated a joint effort to improve dementia care in Sweden. The endeavour includes two consecutive Breakthrough Projects with dissemination activities. Breakthroughs are a method for continuous improvement measures. The projects are completed, but the improvement work continues, as does the dissemination of the results.

## Assistive devices

The responsible authorities for health care – the local authorities and county councils – are required to provide assistive devices for the disabled. These activities are regulated by the Act on Health Services. The local authorities

\footnote{Dementia Review 2003: På väg mot en god demensvård (Ds 2003:47) (On the path to good dementia care)}
are responsible for assistive devices to the elderly and people with physical disabilities living in special housing in all communities, and in regular housing in communities where the local authority has taken over or is taking over home medical services.

The Handicap Inquiry presented at the end of 2004 proposed that:

- Each patient or user who approaches the health and medical services for a personal aid device shall, as soon as possible, be given an assessment of his or her need for a device, unless the need is obvious.

- The county council or local authority is not entitled to charge the patient for such personal assistive devices, other than with a regular appointment fee in connection with the prescription, fitting, adaptation of or training in the use of the aid. These fees shall be covered by the cost ceiling offered by the national insurance, which is proposed to be raised from SEK 900 to SEK 1,000 for all citizens.\(^{31}\)

The inquiry has been sent for review, but no propositions based on it have been made as yet.

**Elderly Receiving Aid under the LSS Act**

The Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) is intended for people with major, long-lasting functional impairments. The law defines which people with disabilities are entitled to interventions:

1. People with learning disabilities, people with autism or autism-like conditions (group 1).

2. People with significant, permanent intellectual impairments or brain damage caused by physical trauma or disease in adulthood (group 2).

3. People with lasting physical or mental impairments that are obviously not the result of normal ageing and that are severe enough to cause significant difficulties in activities of daily living, leading to extensive need for support or service (group 3).

In 2004, about 3,800 people aged 65 and older had been granted aid under the LSS act, or 2.4% of the population in this age group. Support under LSS is somewhat more common among men than women. Of the older men, 2.7% received aid under LSS in 2004, compared with 2.2% of women. In total some 6,500 interventions were recorded for people aged 65 and older,

\(^{31}\) Assitive Devices, Report by LSS and Handicap Inquiry, SOU 2004:83, Hjälpmedel (Assitive devices)
about 6% of all recorded interventions. Of those who were aged 65 and older, 60% received only one measure under LSS.

Figure 9  People aged 65 and older grouped by the number of interventions as of 1 October 2004

The number of elderly people with interventions has increased by 6% as compared with last year, and by 27% since 1999.

Figure 10  Number of people aged above 65 with LSS interventions in 1999–2004

The most common interventions among people over 65 in 2004 were a home with special service, contact person, escort service and daily activities. After a change in legislation in 2001, people who have been granted a personal assistant before the age of 65 may keep the assistant after 65. This also applies to other LSS interventions.32

Table 17  Number of people aged 65 and older granted LSS interventions in 1999, 2003 and 2004 (note that the same person may be granted more than one intervention)

<table>
<thead>
<tr>
<th>LSS intervention</th>
<th>1999</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal assistant</td>
<td>49</td>
<td>260</td>
<td>236</td>
</tr>
<tr>
<td>Escort service</td>
<td>741</td>
<td>875</td>
<td>918</td>
</tr>
<tr>
<td>Contact person</td>
<td>1,016</td>
<td>1,157</td>
<td>1,296</td>
</tr>
<tr>
<td>Relief service</td>
<td>54</td>
<td>44</td>
<td>59</td>
</tr>
<tr>
<td>Short-term stay</td>
<td>63</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Housing, adults</td>
<td>1,853</td>
<td>2,130</td>
<td>2,238</td>
</tr>
<tr>
<td>Day activities</td>
<td>944</td>
<td>963</td>
<td>914</td>
</tr>
</tbody>
</table>


Community support for family and loved ones

Family and friends provide a vital part of the care and nursing to the elderly and disabled, but it is difficult to obtain precise data on how extensive these measures are. The local authorities aim to support family members in many different ways, and new types of support are constantly being developed.

The National Board of Health and Welfare report Äldres levnadsförhållanden 1988–2002 (Living conditions of the elderly, 1988–2002) describes patterns of assistance and the balance between formal and informal care, as well as changes over the years. Loved ones – spouse and/or children – were the predominant informal care providers in 1988/89 and in 2002. The small group that also needed help with personal grooming received home help just as often at both times. Public assistance for personal grooming has not decreased to the same degree as for ‘service measures’.

The responsibility of family and friends for practical tasks has increased between 1988/89 and 2002, while assistance from home help has decreased. Regarding help with personal grooming, family and friends also provide

much assistance, but they are more often aided by public care of the elderly in this. Both interventions by family and friends and by home help have increased in this field between 1988/89 and 2002.

The patterns of assistance to men and women differ. Table 18 shows the patterns of aid to elderly who need varying degrees of practical assistance.

Table 18  Personal care patterns among elderly women and men. Percentage of women and men, living alone or with a partner, who receive assistance from external forces. Elderly people aged 75 and older, still living at home, who need practical help. Year 2000

<table>
<thead>
<tr>
<th></th>
<th>Living alone</th>
<th>Married/living together</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women (n=265)</td>
<td>Men (n=133)</td>
</tr>
<tr>
<td>Help from spouse alone</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Help from other family/friends</td>
<td>63</td>
<td>51</td>
</tr>
<tr>
<td>Home help</td>
<td>43</td>
<td>49</td>
</tr>
<tr>
<td>Private contractor/other help</td>
<td>21</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: SOU 2005:66 Szebehely Marta, research report, Anhörigas betalda och obetalda äldreomsorgsinsatser (Paid and unpaid interventions by family and friends in care of the elderly)
The table indicates that the differences between the sexes are minimal among people living alone. Women have a tendency to be helped a bit more by family than men. Married elderly people make limited use of home help; the partner is the most important care provider. However, it is more common for a wife to help her husband than the reverse. Three-quarters of married men who need assistance receive it from their wives, while half of the married women are assisted by their husbands.33

Trends in support to family members
To meet the family members’ wishes and needs, local authorities have a range of support measures and flexible solutions. Some examples are relief in the home, short-term care/housing, day activities, family support groups, family support consultants, family support centres, training, individual talks and more. The most common types of family support are measures for supporting and facilitating the situation of family members with extensive responsibility for the care of the individual. Such interventions – short-term care/housing, day activities and relief in the home – are available in nearly all communities/districts and have increased somewhat since 2002.

Table 19  Percentage of communities/districts that stated they offered some kind of support to family members in 2002 and 2004

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Percent with this support in 2004</th>
<th>Change since 2002, percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term care/housing</td>
<td>99</td>
<td>+4</td>
</tr>
<tr>
<td>Day care/day activity</td>
<td>92</td>
<td>+2</td>
</tr>
<tr>
<td>Relief in the home</td>
<td>91</td>
<td>+4</td>
</tr>
<tr>
<td>Individual support talks</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Family support groups</td>
<td>72</td>
<td>-2</td>
</tr>
<tr>
<td>Family support consultants</td>
<td>50</td>
<td>-2</td>
</tr>
<tr>
<td>Family support centres</td>
<td>32</td>
<td>-11</td>
</tr>
<tr>
<td>Training of informal care providers</td>
<td>33</td>
<td>-11</td>
</tr>
</tbody>
</table>


In 2004, 75% of the local authorities stated that they are working to develop family support. A special position has been created for co-ordinating and developing family support in 69% of local authorities – a drop from 76% in 2002.

33 SOU 2005:66 Szebehely Marta, research report, Anhörigas betalda och obetalda äldre-omsorgsinsatser (Paid and unpaid interventions by family and friends in care of the elderly)
Most local authorities continued developing collaboration with volunteer organisations in 2004. Some have created a new type of position in the local authority, volunteer co-ordinator, to intensify collaboration with organisations and individual volunteers.

Care allowance
In some cases, a patient receiving informal care can obtain a care allowance from the local authorities. A care allowance is a cash grant that local authorities may give to the elderly and disabled under certain circumstances to pay a family member for assistance in the home. Each local authority decides on the guidelines for direct financial support to informal care givers. As of 1 October 2004, nearly 5,300 people had been granted such an allowance. This is an increase of about 700 people as compared with 2000.

In special cases, the local authorities can employ the family care provider. On 1 October, about 1,900 old-age pensioners were receiving assistance from a family member or friend who had been hired or was employed on a task basis by the local authority. This is a reduction of 500 people compared with 2000.34

A person who chooses to leave gainful employment in order to care for a severely ill person can also receive benefits from the regional social insurance office; this is called a family care provider allowance.

Medical Care for the Elderly

Medical developments and length of stay

Medical developments have made it easier to treat various diseases and injuries even in older patients, which in turn entail increasing demands on and expectations of the health care system. The county councils have accelerated the flow through the inpatient care system, while a growing portion of medical care is provided on an outpatient basis through home care. Rapid medical developments and the higher percentage of trained specialists have made these changes possible.

Over the past ten years the average length of stay for inpatient care has decreased by 25%, while more care is provided on an outpatient basis. Length of stay for inpatient care has decreased from an average of 7.9 days per year in 1992 to 6.0 days per year in 2003. Over the past ten years the number of beds has decreased by 50%, while utilization has increased by 30%.

Care for more elderly patients

These structural changes, which have meant shorter lengths of stay in inpatient care and more outpatient care, have made it possible to carry out more surgeries on all elderly patients. The demographic trend is important since care needs increase with rising age.

Sweden has the oldest population in the EU, with 5.2% of the population aged 80 and older, as can be seen in the following diagram. With rising age as an indicator of care needs, the Swedish health care system handles the greatest care needs in the EU.

A growing percentage of elderly in the population leads to an increased need for resources, since care needs become greater with age. Care needs also increase even more due to medical and technological developments that allow interventions to be carried out at a more advanced age. Consequently, care needs increase even more than the demographics indicate. This trend

---

35 Swedish Association of Local Authorities and the Federation of Swedish County Councils 2004, Utvecklingen i svensk hälso- och sjukvård (Developments in Swedish medical care)
36 SALA and the FCC 2004, Utvecklingen i svensk hälso- och sjukvård
37 SALAR 2005, Svensk sjukvård i internationell belysning (Swedish medical care in an international spotlight)
can be seen in statistics showing how the number of hip replacement operations performed in Sweden has grown. Between 1992 and 2003 the number of people older than 85 increased by 32% at the same time that the number of hip replacement operations for this age group increased by 200%, from 800 to 2,400 per year. Sweden ranks fourth compared with other EU countries, as can be seen in figure 14.\textsuperscript{38}

\textbf{Figure 14} Number of hip replacement operations per 100,000 inhabitants 2002

Source: SALAR 2005, \textit{Svensk sjukvård i internationell belysning}
The number of cataract operations, which are now almost always done as outpatient procedures, has increased from 30,000 per year in 1990 to 82,000 per year in 2002. In Sweden 850 cataract operations were done per 100,000 inhabitants in 2002, which means Sweden ranks second in the EU behind Belgium, as can be seen in the following chart.

**Figure 15 Number of cataract operations per 100,000 inhabitants 2002**

![Bar chart showing the number of cataract operations per 100,000 inhabitants in different EU countries, with Belgium having the highest number, followed by Sweden.]

Source: SALAR 2005, *Svensk sjukvård i internationell belysning*

**Medical care utilisation by the elderly**

Of all care episodes in 2003, 30% involved people over the age of 75, including 20% in the age group 75–85 and 10% of people over the age of 85.

**Figure 16 Distribution by percent of care episodes per patient in different age groups, 2003**

![Bar chart showing the distribution of care episodes per patient in different age groups, with a higher number of episodes for older patients.]

Figure 17 Average length of stay in different age groups 1994–2003

Source: SALAR 2005, Sjukvårdsdata i fokus (Focus on health care data)

Figure 18 Percentage of the population in various age groups and bed-days in 2003

Source: SALAR 2005, Sjukvårdsdata i fokus
Health care expenditures

In international comparisons it is most common to compare costs based on per capita expenditure and year, expressed in dollars, taking into account purchasing power (PPP) in each country. Based on this premise, the cost for 2002 in Sweden was USD 2,517 PPP. Health care expenditure in the United States was more than twice as high and even three times greater than in Spain and Portugal. Of the 17 countries included in the comparison, seven countries have higher costs than Sweden and nine lower.39

Figure 19 Per capita health care expenditure 2002. USD PPP

Source: SALAR 2005, Svensk sjukvård i internationell belysning

39 SALAR 2005, Svensk sjukvård i internationell belysning
Costs are rising in all countries, as can be seen in figure 20.

Figure 20 Per capita increase in health care expenditure 1994–2002. PPP. Index 1994 = 100

Source: SALAR 2005, Svensk sjukvård i internationell belysning

Financing

Most public financing of county council activities comes from county taxes, which cover 70% of health care expenditures. Central government grants cover about 20% of the costs. Health care for the elderly and people with disabilities that is provided in private or special housing is financed mainly by municipal taxes. Patient fees cover about 3% of total medical expenses. Private insurance covers expenditures for less than 1% of the population and accounts for about two per thousand of financing.

Use of medications by the elderly

Special housing

Medications dominate completely among various medical treatment modalities for the elderly.

The National Board of Health and Welfare has carried out studies on the use of medications by the elderly. One of them covers 3,705 people aged 65 and older in special housing in Jönköping. The health care consumers used

\[40\] SALAR 2005, Svensk sjukvård i internationell belysning
an average of 10 different medications per person. There were no major differences between people who lived in housing for patients with dementia and those who lived in retirement homes. Of the medications used, 2.1 were prescribed to take when needed. On average, men and women took the same number of medications. Four of five people used psychotropics and almost one in three took several such medications concurrently.  

In regular housing
Göteborg surveyed medication use among the elderly in ordinary housing. The survey included 4,823 people aged 65 and older. The study shows similar results. The elderly used an average of ten drugs per person; in other words, medication usage proved to be as extensive among the elderly in special housing in Jönköping as in ordinary housing in Göteborg. However, the use of psychotropics was somewhat lower in regular housing, while the use of certain cardiovascular medications was somewhat higher.

Where do the elderly die?
Medical care of the elderly and where they die has changed since the ÄDEL reform was carried out. For example, the number of people ready for discharge in the hospital has decreased. At the same time the number of beds in hospitals decreased by 48% between 1992 and 2003. The change in medical care has entailed increased pressure on community elderly care with increased demand for trained medical staff. This can be seen in a study that the National Board of Health and Welfare recently carried out on where the elderly die – in hospital, in special housing or at home.

According to the report, “medical care of seriously ill and dying patients has gradually moved from hospital to special housing, or to the patient’s own home. The possibility of receiving advanced medical help at home has increased over the past two decades.” Moreover, it can be seen that approximately 35,000 elderly patients received home care from district nurses and assistant nurses before the ÄDEL reform, while more than 80,000 elderly people received home medical services at the end of the 1990.

41 National Board of Health and Welfare 2005, Vård och omsorg om äldre, lägesrapport (Medical and social services for the elderly, status report 2004)
42 National Board of Health and Welfare 2005, Vård och omsorg om äldre, lägesrapport 2004
The report also shows that over half (about 63%) of people aged 65 and older have died outside the hospital since implementation of the ÄDEL reform in 1992. This figure can be compared with about one-quarter who died outside the hospital before the ÄDEL reform. Between 1997 and 2003 a somewhat larger percentage of men (42–45%) than women (34–38%) died in hospital. It is more common for the ‘younger elderly’ to die in hospital, while the ‘older elderly’ die at home.\(^3\)

\(^3\) National Board of Health and Welfare 2005, *Var dör de äldre – på sjukhus, särskilt boende eller hemma? (Where do the elderly die – in hospital, special housing or at home?)*
Individual Providers of Medical and Social Services

From the late 1990s until 2002, care of the elderly was increasingly farmed out. Many local authorities also made it possible for the elderly to choose providers of home help and special housing. The goal was mainly to increase diversity and increase competition in care of the elderly. The percentage of individual providers of care of the elderly did not change in 2003 and 2004.

Table 20 shows trends in home help, special housing and short-term housing under the aegis of the local authorities and individual providers between 2000 and 2004. About 90% of care of the elderly is run by the local authorities. About 13% of special housing was run privately in 2004 and 9% of the elderly received home help from individual providers.

Table 20 Number of people aged 65 and older receiving care from local authorities and individual providers in 2000 and 2004

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home help</td>
<td>112,400</td>
<td>120,400</td>
<td>8,600</td>
<td>11,900</td>
<td>121,000</td>
<td>132,300</td>
</tr>
<tr>
<td>Special housing</td>
<td>105,000</td>
<td>90,600</td>
<td>12,900</td>
<td>13,900</td>
<td>117,900</td>
<td>104,500</td>
</tr>
<tr>
<td>Short-term care</td>
<td>7,500</td>
<td>8,300</td>
<td>900</td>
<td>700</td>
<td>8,400</td>
<td>9,000</td>
</tr>
<tr>
<td>Total</td>
<td>224,900</td>
<td>219,300</td>
<td>22,400</td>
<td>26,500</td>
<td>247,300</td>
<td>245,800</td>
</tr>
</tbody>
</table>


Various types of individual providers

Contractors
Individual providers can have different operating methods; the most common is a limited company or foundation running private health and social care. Other options are a co-operative or non-profit association.

44 An additional 244 people are provided beds in special housing run by another local authority or county council. Rounded figures
45 An additional 67 people were receiving short-term care provided by another local authority or county council. Rounded figures
In total, 92 local authorities had individual providers of care of the elderly in 2004. Seventy-four of the 269 local authorities that responded to a questionnaire from SALA that year stated that they had special housing run by individual providers. Sixty-two local authorities had individual providers of home help. Most commonly, there was one provider outside the local authority, both in home help and special housing. About ten local authorities had 5–10 providers. One local authority that offers freedom of choice has over 40 companies providing home help.

Twenty of the 96 responding local authorities participate in tenders for such contracts.46

Customer’s choice
Several local authorities have developed a customer’s choice system that aims to give care recipients a greater choice of care providers. The local authorities specify the goals and quality required and sign contracts with multiple care providers. The care recipients, sometimes with the aid of family members, choose their own care provider based on their own perception of who offers the best care.

According to the 2004 questionnaire from SALA, 15 local authorities have implemented freedom of choice in home help services. Twelve of those communities are in Stockholm County. Another four have decided to implement customer’s choice in home help. Seven local authorities have options for special housing, and one more has decided to implement this system.47

Non-profit organisations
Several non-profit organisations provide health and medical services. They are co-operative, volunteer and grassroots organisations as well as non-profit and values-based organisations.

In care of the elderly, employee or user co-operatives are most common. A number of non-profit associations also provide home help as a complement to that provided by the local authorities. User co-operatives are mainly found in sparsely populated areas, while employee co-operatives are found nation-wide and are usually small units. There are about 30 co-operative housing facilities for the elderly in Sweden.48

46 SALA, Äldreomsorgens styrning 2004 (Management of care of the elderly 2004)
47 SALA, Äldreomsorgens styrning 2004 (Management of care of the elderly 2004)
48 SALA 2002, Kooperativ äldreomsorg – en del i mångfalden (Cooperative care of the elderly – one of many alternatives)
Purchase of individual beds in special housing and of home help

In addition to external contracts, local authorities sometimes purchase beds in privately owned special housing and short-term housing. They can also purchase services from other local authorities, both for special housing and home help, but only on a very limited scale. In these cases as well, the home community always has the ultimate responsibility to the elderly care recipient.

In 2004, 244 beds in special housing and 67 cases of short-term care were purchased from other local authorities or county councils nation-wide.49

Staff and Training

Number of employees
In November 2004 a total of 254,300 people (with a monthly salary) were employed in medical and social services in the local authorities. That is a reduction of 4,400 from the previous year. However, compared with 1995, the number of employees has increased by 32,500 people or nearly 15%, a significantly higher number than the total increase of employees in the local authorities, which is just over 5%. This calculation takes into account transfers between local authorities and county councils.

The personnel statistics for the Swedish Association of Local Authorities and Regions differentiate between employed and working. The concept of employed includes those who are off-duty and on sick leave; working does not. Of the total number of people employed in 2004 by SALAR, 37,700 were on some kind of leave – parental leave, sick leave or on a leave of absence to pursue studies – leaving 216,600 people who were working. In addition, 74,700 hourly paid employees worked in the sector.

Table 21 Number of employees in the local authority, per profession. Salaried and on leave. Rounded figures

<table>
<thead>
<tr>
<th>Social services for the elderly and disabled</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisors, incl. home help insp. and assistants</td>
<td>9,800</td>
</tr>
<tr>
<td>Assistant nurses, nurse’s aides, medical attendants and mental health support workers</td>
<td>187,000</td>
</tr>
<tr>
<td>Nurses</td>
<td>12,200</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>2,700</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1,300</td>
</tr>
<tr>
<td>Other nursing staff, incl. personal assistants</td>
<td>29,300</td>
</tr>
<tr>
<td>Other staff</td>
<td>12,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>254,300</strong></td>
</tr>
</tbody>
</table>

Source: SALAR

SALAR’s staff and payroll statistics are always measured on the first of November each year. For staff employed at an hourly rate, the figure shown is the number of people who receive pay in November. Other staff includes primarily food staff, cleaning staff, porters and office staff.
Table 22 Number of people working in the local authority per profession, and changes in staffing between 1995 and 2003. Salaried, not including those on leave. Rounded figures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisors, incl. home help insp. and assistants</td>
<td>8,900</td>
<td>*</td>
<td>300</td>
</tr>
<tr>
<td>Assistant nurses, nurse’s aides etc</td>
<td>157,900</td>
<td>−1,500</td>
<td>−2,700</td>
</tr>
<tr>
<td>Nurses</td>
<td>10,600</td>
<td>1,800</td>
<td>200</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>2,300</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1,100</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Other nursing staff, incl. personal assistants</td>
<td>25,000</td>
<td>17,100</td>
<td>1,100</td>
</tr>
<tr>
<td>Other staff</td>
<td>10,700</td>
<td>2,600</td>
<td>−800</td>
</tr>
<tr>
<td>Total</td>
<td>216,600</td>
<td>20,200</td>
<td>−1,700</td>
</tr>
</tbody>
</table>

Source: SALAR
* It is not possible to estimate the change in supervisors since 1995

Table 22 shows the number of people working. The reduction in the number of people working between 2003 and 2004 was lower than the reduction of the number of employees. One reason for the drop is that the number of people living in special housing decreased by 6,100, while the number receiving home help increased by 4,200 in 2004. This affects basic staffing, which is always higher in special housing.

Compared with 1995, the number of people working has increased by 20,200, or 10%. In the whole period 1995–2004, the number of people working has increased less than the number of employees. This is because sick leave increased dramatically between 1998 and 2000. One reason that the number of people working did not decrease as much as the number of employees between 2003 and 2004 is a drop in sick leave.

Fewer being recruited
In 2004, the local authorities recruited 18,200 new employees for medical and social services, a decrease as compared with the 1998–2002 period, when 25,000–30,000 people were recruited annually. The drop in the number of people working in 2004 is the main reason for the reduction in recruiting. In addition, sick leave has decreased, particularly the number of people being granted sick leave, which results in less need for recruiting. Another reason is that fewer assistant nurses and nurse’s aides left their positions in 2004.
Six of ten have nursing training
The staff have a good basic education to build on. Nine of ten assistant nurses and nurse’s aides have upper-secondary education, and more than six of ten have nursing training.

Of the 11,400 assistant nurses and nurse’s aides who were recruited in 2004, 53% had nursing training, and 27% of them had studied nursing subjects in adult education, 19% in upper-secondary school, and 7% had some other nursing training. Of those who had no nursing training, 37% had other upper-secondary schooling and 10% had not attended upper-secondary school.

Figure 21 Educational focus of staff (salaried and on leave) and recruited assistant nurses, nurse’s aides and others in 2004

Many recruits are foreign-born
20% of the 18,000 new employees recruited to community medical and welfare services in 2004 were born outside of Sweden. That percentage has doubled since 1995, when only 10% were foreign-born. The increase has mainly consisted of staff born outside the Nordic countries and the EU. In 2004, 14% of employees were born elsewhere. In 1996 that figure was just 5%.

Among the total number of employees in care of the elderly and disabled, the percentage who are foreign-born increased from just over 9% in 1995 to over 12% in 2004. The growth has consisted mainly of those born outside the Nordic countries and the EU, from just under 4% in 1995 to 6.9% in 2004.
Predominantly female professions

Over 90% of those working with care of the elderly and disabled are women, although the amount of men has grown from 6–9% since 1996. Among permanent staff, the number of men doubled between 1995 and 2004 from 9,600 to 19,400.

The percentage of men was higher among temporary fill-ins, 15% in 2004. The largest concentration of men is among physiotherapists, personal assistants and supervisors.

Age structure affects the need for recruiting

The age distribution provides information on expected retirements, mobility, sick leave and more. Of the total number of permanent employees in community medical and social services, 23% are aged 55 and older, which is lower than the figure for all local authority employees.

There are great variations between different professions. For example, 16% of assistant nurses are aged 55 and older, while 31% of nurse’s aides are. The percentage aged 55 and older is also high among nurses, 30%.

Table 23  Age distribution of permanent staff in certain medical and social services in November 2004. Percentage

<table>
<thead>
<tr>
<th>Age group</th>
<th>Assistant nurses</th>
<th>Nurse’s aides</th>
<th>Nurses</th>
<th>All in care of elderly</th>
<th>All local auth. employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–24</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>25–34</td>
<td>21</td>
<td>14</td>
<td>10</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>35–44</td>
<td>31</td>
<td>25</td>
<td>25</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>45–54</td>
<td>29</td>
<td>27</td>
<td>35</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>55–59</td>
<td>11</td>
<td>17</td>
<td>19</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>60+</td>
<td>5</td>
<td>14</td>
<td>11</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: SALAR

Fewer leaving their positions

Mobility varies with age. Usually, younger people are more mobile than older ones, aside from those who leave due to retirement. Considering all permanent local authority employees, regardless of age, the leaving rate is 4.9%.
Mobility among assistant nurses and nurse’s aides
The number of assistant nurses/nurse’s aides who leave their positions continued to drop in 2004; in the 2003–2004 period, the figure dropped for the 16–34 and 35–54 age groups, while increasing somewhat in the 55 and older age group. Altogether, departures are higher for assistant nurses/nurse’s aides than the average for all local authority activities.

Figure 22  Percentage of permanently employed assistant nurses/nurse’s aides who left their positions between 1996 and 2004, by age

Greatly reduced mobility among nurses
The job market for nurses has been good for several years. This is reflected in the mobility figures, which have been much higher than the average for local authority professions. In recent years, however, nurse mobility has dropped drastically. In total, 6.7% of permanently employed nurses left in 2004. Departures decreased in all age groups.
Leave and sick leave

Absence continues to decrease

The percentage of employees who were completely absent – on parental leave, study leave or sick leave – decreased for the third year in a row in 2004. This applies to all employees in the local authorities, not just those working with care of the elderly and disabled, although the decrease was larger for this group than in the rest of the local authorities’ activities.

Absence is higher in care of the elderly and disabled than in schools, childcare and other areas. In November 2004, 16% of permanent employees in community medical and social services were completely absent for at least a month, a reduction of one percentage point since 2003. The corresponding figure in schools and child care was 11.5%. Of all local authority employees, 12.4% were absent. This means that absenteeism varies per department, profession and age.

In 2004, 16.7% of assistant nurses and nurse’s aides were absent from work, which is 1.4 percentage points lower than in 2003. Absenteeism is particularly high for younger workers, which is due to both parental leave and various types of continuing professional development. In November 2004, just over 27% of all permanently employed assistant nurses and nurse’s aides under age 35 were absent from their jobs for at least one month. The figure is significantly lower for older employees, 12.1% in 2004. Sick leave is the most common reason for older employees to be absent.
There are variations between women and men: among all employees in the local authorities, absenteeism was 13.9% for women and just 6.3% for men in 2004. One explanation is that mainly women take parental leave. Another important explanation is that women and men rarely work in the same professions. It is also more common that women work in professions with higher absenteeism due to illness. In care of the elderly and disabled, the total absenteeism was 16.5% among women and 9.9% among men.

**Sick leave decreased**

Sick leave began increasing among employees throughout the Swedish labour market in 1997, but more among women than men, and more among women in the local authorities than women in other sectors. National data from Statistics Sweden’s labour market surveys show that sick leave among both women and men began going down in 2004.

Statistics from SALAR in November\(^{52}\) of various years also show that the percentage of local authority employees who were on *full-time sick leave* for at least 30 days has decreased since 2002, both among employees in total and among staff in care of the elderly and disabled. The reduction has been mainly in the number of new cases. The percentage of very long sick-leave periods has continued to grow.

The percentage of working people who are on part-time sick leave has continued to grow for all employees in the local authorities and for staff in medical and social services. The total absenteeism – the sum of people on full-time and part-time sick leave converted into FTE – decreased in 2004, both among all employees in the local authorities and among employees in care of the elderly and disabled.

### Table 24: Percentage of permanent employees on full sick leave in November 2004

<table>
<thead>
<tr>
<th>Age group</th>
<th>All local authority employees</th>
<th>All employees in welfare</th>
<th>Assistant nurses/nurse’s aides</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–34</td>
<td>3.4</td>
<td>4.8</td>
<td>5.1</td>
<td>3.2</td>
</tr>
<tr>
<td>35–54</td>
<td>6.0</td>
<td>8.1</td>
<td>8.6</td>
<td>6.3</td>
</tr>
<tr>
<td>55+</td>
<td>7.2</td>
<td>9.9</td>
<td>10.4</td>
<td>8.9</td>
</tr>
<tr>
<td>All</td>
<td>5.9</td>
<td>7.9</td>
<td>8.3</td>
<td>6.8</td>
</tr>
</tbody>
</table>

Source: SALAR

---

\(^{52}\) These statistics are not comparable with Statistics Sweden’s labour market surveys
The percentage of people on full-time sick leave is higher in the medical and social services than the average for local authority employees regardless of age. Nurses are an exception; the differences in sick leave among them are relatively small compared with all employees.

The picture is different for people on part-time sick leave. The percentage of people on part-time sick leave in the medical and social services is no different than for all employees. At the same time, the percentage of people on part-time sick leave somewhat is higher among nurses than among assistant nurses/nurse’s aides.

Table 25  Percentage of permanent employees on partial sick leave in November 2004

<table>
<thead>
<tr>
<th>Age group</th>
<th>All local authority employees</th>
<th>All employees in welfare</th>
<th>Assistant nurses/nurse’s aides</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–34</td>
<td>1.6</td>
<td>1.6</td>
<td>1.7</td>
<td>2.2</td>
</tr>
<tr>
<td>35–54</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>55+</td>
<td>6.0</td>
<td>5.7</td>
<td>5.6</td>
<td>6.2</td>
</tr>
<tr>
<td>All</td>
<td>4.1</td>
<td>3.9</td>
<td>3.9</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Source: SALAR

Working hours

The percentage of full-time employees in care of the elderly and disabled has increased successively to just over 44% in 2004. The percentage among all local authority employees is nearly 67%.

Table 26  Number and percentage of full-time employees in health and social services

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Percentage of all employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>92,500</td>
<td>38.0</td>
</tr>
<tr>
<td>2001</td>
<td>101,300</td>
<td>40.3</td>
</tr>
<tr>
<td>2002</td>
<td>108,700</td>
<td>42.5</td>
</tr>
<tr>
<td>2003</td>
<td>112,200</td>
<td>43.4</td>
</tr>
<tr>
<td>2004</td>
<td>112,200</td>
<td>44.1</td>
</tr>
</tbody>
</table>

Source: SALAR

In practice, 37.8% of people working in the medical and social services work full time. This is because some full-time employees have an agreement with the employer to work part time, for example while their children are small.
Another way to express the scope of work time is to calculate the average activity level. In 2004, this figure was 83%, calculated on the total number of people working in community medical and social services. For part-time workers in these fields, the corresponding figure is 73%. Two-thirds of part-time nurse’s aides and assistant nurses work at least 75% of full time. The average activity level for hourly employees is about 40% of full time.

When the average activity level increases as more part-time employees expand their working hours, the need for recruiting decreases.

Many local authorities are pursuing various projects in which the employees can influence their working hours and in many cases also choose their activity level. These measures have contributed to bringing down part-time unemployment.

Payroll
Table 27 shows pay levels and pay distribution in full-time salaries for a number of caring professions. Since work in medical and social services goes on 24 hours a day, seven days a week, a relatively large percentage of staff receives additional pay for unsocial working hours. For example, 91% of assistant nurses receive an average of SEK 1,784 a month in additions for unsocial working hours.

Table 27  Salary levels for full-time employees in certain health and social services professions in November 2004, plus additions for unsocial working hours (U.hrs)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Monthly pay for full time, minus floating additions</th>
<th>Percent w/U.hrs</th>
<th>Average U.hrs/mo, SEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant nurse</td>
<td>16,300 17,600 18,600</td>
<td>91%</td>
<td>1,784</td>
</tr>
<tr>
<td>Nurse’s aid</td>
<td>15,200 16,900 18,100</td>
<td>87%</td>
<td>1,666</td>
</tr>
<tr>
<td>Nurse</td>
<td>20,700 22,700 26,200</td>
<td>75%</td>
<td>1,531</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>19,900 22,000 24,400</td>
<td>1%</td>
<td>341</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>19,400 21,200 23,500</td>
<td>2%</td>
<td>484</td>
</tr>
<tr>
<td>Supervisor</td>
<td>21,500 25,500 29,600</td>
<td>4%</td>
<td>932</td>
</tr>
</tbody>
</table>

Source: SALAR

Median pay means that 50% of the individuals in the group have equal or lower pay. The 10th and 90th percentiles mean that 10% or 90% of the individuals in the group have the same or lower pay, respectively.
Skills supply in medical and social services

Currently, the focus must be on the greatest needs for skills. Nearly 40% of existing staff need to enhance their skills to correspond to the nursing programme, and new staff who lack skills need additional training.

90% of the staff have a good educational background: upper-secondary school or equivalent, which is a good starting point for continued development.

It is important at this stage to develop the validation tool in order to spare both the individual and the employer time and money. A good quality evaluation forms the basis of an individual training plan, where studies ideally are pursued in flexible formats. It is crucial to resolve the financing of studies and training for this extensive commitment.

Calculations for the national long-term survey show that the generation shift, when the baby boomers of the 1940s leave the labour market, has the potential to create regional imbalances. Projections by Statistics Sweden, however, show future staff shortages in the medical and social services as we near the 2020s, when the majority of the 1940s baby boomers pass age 80.
The Local Authorities’ Finances

This section gives an overall image of costs and financing of the local authorities’ activities. The aim is to place the care of the elderly into a broader community perspective.

The local authorities had a somewhat better net surplus/deficit in 2004 than in 2003, a surplus of SEK 2.4 billion. The average tax increase in 2004 was 0.1 percentage points (to 20.80%). A lower net cost increase, some one-time revenues and a better net financial income (lower interest) are factors that have resulted in a better net surplus. Even adjusted for the one-time revenues and for the negative final settlement of the 2003 tax revenues, last year’s net surplus/deficit was surprisingly good.

The local authorities’ assessments for 2005 are relatively positive. Five of six expect a surplus. Their financial forecasts for 2006 are also expected to be good; however, after that the positive trend is expected to end. One key reason is that State contributions to the sector do not increase at the same rate as price and salary increases, while costs are expected to increase an average of 0.9% in 2005–2008 as a result of demographics and national reforms. The two largest cost drivers are care of the disabled and expanded staffing in the schools.

The local authorities’ expenses

Figure 24 show how the local authorities’ expenses are allocated. The total expenses for local authorities in 2004 amounted to SEK 398,000 million, an increase of 2.3% over the previous year. In fixed costs, this is a reduction of just over 0.5%.

The local authorities’ resources go mainly to providing welfare services such as childcare, education, medical and social services. These services make up 79% of the total expenses. Costs for commercial operations account for 6% and other core activities account for 15%. Care of the elderly has

---

53 Profit/loss before extraordinary items
54 SALA 2005, Financial report May 2005
55 Costs refer to gross costs minus internal revenue and sales to other local authorities and county councils; The Local Authorities’ Accounts Summary 2004, Statistics Sweden
56 Commerce, housing, transport, energy, water and waste
57 Other tax-financed activities include political activity, infrastructure, protection, culture and leisure, labour market measures and measures for refugees
amounted to about 20% of the local authorities’ total costs since 1999, when the costs for the elderly were separated from costs for the disabled.

Figure 24 Distribution of local authority costs for operations in 2004, percentage. Total SEK 398 billion

The local authorities have much larger welfare tasks than ten years ago. To handle these tasks, the local authorities have cut back on costs in both mandatory and optional activities. The net costs, adjusted for inflation, increased by about 11% during the period. At the same time, the local authorities’ areas of responsibility have increased significantly. The increase in needs due to demographics, new legislation and other changes in society has been much higher than the 11% volume increase in costs.

**Financing of the local authorities’ activities**

Local authority revenues amounted to SEK 399 billion in 2004. In gross amounts, this is an increase of 2.5% compared with the previous year. Local income tax makes up 70% of the revenues, while general and specially earmarked State grants make up about 14%. Fees amount to 7% and other revenues amount to 9%.

Fees constitute a relatively small amount of the costs of tax-financed activities. The majority of costs in local authority business activities are financed by fees.
Figure 25 Distribution of local authority revenues for operations in 2004, percentage. Total SEK 399 billion

- Tax revenues, 69.4%
- General State grants, 9.7%
- Earmarked State grants, 4.4%
- Rates and fees, 7.3%
- Rents, sales of businesses, 4.5%
- Other revenues, 4.7%

Costs for care of the elderly

The total costs for care of the elderly in 2004 amounted to SEK 79.5 billion.\textsuperscript{58} This is an increase in gross amounts of 1.5%. Fixed costs have gone down by 1.5% – a decrease in volume between 2003 and 2004. Figure 26 shows the development of costs for care of the elderly between 1999 and 2004.

\textbf{Figure 26 Costs of care of the elderly between 1999 and 2004, fixed and gross amounts}

Figure 27 shows the allocation of costs for care of the elderly in 2004. Most of the costs, 67%, went to medical and social services in special housing, 31% to medical and social services in regular housing, and 2% to preventive activities.\textsuperscript{59} In the past few years, a slight shift has occurred from special to regular housing.

\textsuperscript{58} This does not include transportation service, which cost the local authorities a total of nearly SEK 1.7 billion. Transportation services cannot be divided up between the elderly and disabled

\textsuperscript{59} Preventive activities were previously called preventive measures
Cost per care recipient
The average cost per care recipient in regular housing increased in gross amounts by SEK 6,300 (3%) between 2003 and 2004. In special housing, the average cost in gross amounts has increased by SEK 18,200 (4.3%). As table 28 shows, the cost per care recipient is approximately twice as much in special housing as in regular housing.

Table 28  Cost per care recipient in regular and special housing between 2000 and 2004, gross amounts

<table>
<thead>
<tr>
<th>Year</th>
<th>Regular housing</th>
<th>Special housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>169,100</td>
<td>335,100</td>
</tr>
<tr>
<td>2001</td>
<td>183,700</td>
<td>363,500</td>
</tr>
<tr>
<td>2002</td>
<td>198,900</td>
<td>389,800</td>
</tr>
<tr>
<td>2003</td>
<td>208,500</td>
<td>421,400</td>
</tr>
<tr>
<td>2004</td>
<td>214,800</td>
<td>439,600</td>
</tr>
</tbody>
</table>

Source: SALA key figures on the web: www.webor.se

Differences between local authorities
Table 29 shows the median value of the costs per care recipient living in regular housing and special housing, and the spread of costs between local authorities.

In 2004, the cost difference between local authorities was greatest in regular housing. Ten percent of the local authorities had a cost per care recipient in regular housing that was SEK 140,300 or lower (10th percentile) and 10% had costs of SEK 301,500 or higher (90th percentile). That’s a

60 Unweighted mean, exclusive of facility costs
61 The median value is the cost level at which an equal number of local authorities lie under as over
difference of 115% between local authorities. The corresponding difference in special housing was 52%.

The median value in gross amounts has increased by 4.1% in regular housing as compared with the previous year. In special housing the increase was 4.7%.

Table 29 Spread of costs per care recipient between local authorities in 2001–2004, SEK, gross amounts

<table>
<thead>
<tr>
<th>Year</th>
<th>10th percentile</th>
<th>Median</th>
<th>90th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regular housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>111,000</td>
<td>178,000</td>
<td>260,000</td>
</tr>
<tr>
<td>2002</td>
<td>126,500</td>
<td>189,000</td>
<td>279,000</td>
</tr>
<tr>
<td>2003</td>
<td>139,100</td>
<td>200,700</td>
<td>285,000</td>
</tr>
<tr>
<td>2004</td>
<td>140,300</td>
<td>209,000</td>
<td>301,500</td>
</tr>
<tr>
<td></td>
<td>Special housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>288,000</td>
<td>363,000</td>
<td>447,000</td>
</tr>
<tr>
<td>2002</td>
<td>313,500</td>
<td>388,000</td>
<td>476,000</td>
</tr>
<tr>
<td>2003</td>
<td>330,700</td>
<td>421,000</td>
<td>504,300</td>
</tr>
<tr>
<td>2004</td>
<td>348,000</td>
<td>441,000</td>
<td>529,000</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden, Accounting summary for each year; National Board of Health and Welfare, Äldre – vård och omsorg (Elderly – Medical and Social Services) for each year.

One key explanation is that different local authorities have different proportions of residents over 80, different gender distributions, different proportions of people living alone and with a partner. The elderly individuals' previous professional backgrounds and the social and geographical structure of the community also affect the total costs. Other explanations include political goals and ambitions, and differences in how well resources are used; productivity varies between local authorities. None of these factors alone can explain the differences.

What does home help cost per hour?

In collaboration with several local authorities, SALA has developed a model for calculating the cost of an hour's home help for a care recipient in regular housing. It is a two-step calculation. The first step is to calculate how many hours of home help a full-time nurse's aide or assistant nurse produces in a year. This is calculated by subtracting from the year's total working hours

---

62 The 10th percentile means that 10% of local authorities fall below the stated value. 90th percentile means that 10% of local authorities are above the stated value.

63 The cost of housing (rent) for the elderly is not included.
all hours that are not spent directly with care recipients – such as travel
time, administration and planning, documentation and continuing profes-
sional development.

In the next step, the remaining working hours are divided by the aver-
age annual salary. Next, the costs of administration and management on
the unit level and the central level are added in, plus the costs of rehabili-
tation/work adaptation, continuing professional development and other
operative costs.

Calculated in this way, the cost of producing an hour of home help at
a care recipient’s home is SEK 350–450.64

Financing of care of the elderly
Of the total costs for care of the elderly, SEK 79.5 billion, the majority were
financed by taxes and general allowances.

Only 4% of the costs were not financed by fees. This is the same as last
year. Even if fees only contribute to a small part of the actual costs, they
can reduce demand somewhat, which helps to keep costs down.65

The fees are not intended to have a controlling effect. However, when
the National Board of Health and Welfare reviewed costs, it found that
some people may choose to do without home help even though it would
cost them little or nothing, due to the rules about fees and the guaranteed
amount left to live on. The maximum amount an individual pays for home
help, including community home medical services and regardless of scope,
was SEK 1,576 per month in 2005.

One purpose of the tax reform was to protect care recipients with low
pensions from excessive fees. This has been met to such a degree that the
number of care recipients who do not pay fees at all has increased from 14%
in May 2002 to 33% in September 2004.

---

64 SALA 2003, Hemtjänsttimmen (Home help hour)
65 Swedish Association of Local Authorities and Regions 2005
New Technology in Medical and Social Services

New technologies in the field of care are constantly being developed. Telemedicine makes it possible to take tests and perform treatments in the home and transfer the results to doctors in another place. This is an on-going development that will be increasingly used in the medical and social services. It makes it easier for the elderly if they do not have to travel to various health centres for examinations. The new technology also makes it possible to transfer information to everyone in the continuum of care, making treatments and other medical and social services more effective and easier. Information can be provided to doctors in both inpatient and outpatient care and to caring staff in home medical services and social services. The technology can contribute to creating security, accessibility and high quality for individuals and to facilitate for family members and staff.

National IT policy for medical and social services

In collaboration with the Association of Swedish Local Authorities and Regions, the Government began developing a national IT policy for medical and social services in 2005. The aim is to support all players who are important to the continued expansion of IT support for the medical and social services. This work is expected to be finished before the end of 2005.

Three areas of particular interest have been highlighted:

- A nationally co-ordinated (‘compatible’) electronic patient records system that can provide the same information to everyone in the continuum of care
- Access to medical and social services over the Internet
- Increased use of IT support for the prescription, use and retrieval of drugs (ePrescriptions).

A national IT policy for medical and social services will ensure a better exchange of information and better interaction in general between the different players in this sector. Care of the elderly is one of the areas where the need for improved information exchange is greatest. A national IT
policy may therefore be important to the continued development in the care of the elderly.

**At home with IT**

The Swedish Handicap Institute has received financing from the State Inheritance Fund to pursue a project in 2004–2007 to facilitate independent living for people with cognitive disabilities. The project is a joint effort by the Coordination Committee for the Swedish Associations for Disabled Persons and three local authorities.

People with cognitive disabilities often have difficulty remembering things, orienting themselves in time and space, solving problems and more.

The project involves testing new technological solutions. Local trials will be held in Hudiksvall, Tierp and Stockholm (Hässelby–Vällingby).

Another goal of the project is to boost understanding of the opportunities the new technology offers decision makers in the local authorities and county councils, housing companies and staff in home help and primary care.
The percentage of elderly people over the age of 65 is somewhat lower on average in the European Union than in Sweden. In the EU 16% of the population is aged 65 or older, which is the equivalent of about 74 million people. The EU’s population has become younger with the addition of the ten new member countries in 2004, though this is a short-term trend. The EU countries will have an ageing population, for better or for worse.

The demographic trend
The percentage of elderly people in Europe will increase over the next few decades, mainly in the 15 ‘old’ member countries. For example, the percentage of people aged 80 and older will increase an average of 50% over the next 15 years. At the same time that Europeans are living longer, the birth rate is declining. During 2003, natural population growth in Europe was 0.04%. In the new member states, with the exception of Cyprus and Malta, the population actually decreased. Birth rates with an average of 1.4 children per woman are below reproduction level, which is 2.1 children per woman. In many countries in Europe, immigration is crucial for population growth. Despite continued immigration, the EU’s population is stagnating and even decreasing, unlike countries such as the USA. The trend in Japan is similar to that in the EU, with low birth rates and little immigration.

Staffing
The average pension age in the EU is 60. It is 63 in Ireland, 62 in Sweden and 57 in Belgium. The dependency ratio for the elderly, or the relationship between the number of people aged 65 and over and the number of people of working age, is an average of 24 in the EU. This means that 100 people of working age have to support 24 people aged 65 and older. In 2010, Sweden, Germany, Italy and Greece will have a dependency ratio for the elderly of between 28 and 31, which means fewer people of working age per person
over the age of 65. Moreover, the working-age population must also support
the younger portion of the population that is not employed. 66  

The working-age population will begin to decrease after 2010 and the
labour market will have to rely on the older workforce to a greater degree.
This is a problem, especially for the medical and social services sector, where
the average age is already high. Many countries are addressing staffing is-
sues for medical and social services; today 10% of the EU’s total workforce
is employed in this sector. 67

66 Eurostat 2005, The social situation in the European Union
67 European commission 2005, Green paper ‘Confronting demographic change: a new solidarity
between the generations’

<table>
<thead>
<tr>
<th>Country</th>
<th>Dependency ratio for the elderly 2003</th>
<th>Dependency ratio for the elderly 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>26.9</td>
<td>31.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>26.6</td>
<td>28.1</td>
</tr>
<tr>
<td>Greece</td>
<td>26.0</td>
<td>29.2</td>
</tr>
<tr>
<td>Belgium</td>
<td>26.0</td>
<td>26.7</td>
</tr>
<tr>
<td>Germany</td>
<td>25.9</td>
<td>30.3</td>
</tr>
<tr>
<td>Spain</td>
<td>25.1</td>
<td>26.8</td>
</tr>
<tr>
<td>France</td>
<td>25.1</td>
<td>25.5</td>
</tr>
<tr>
<td>Portugal</td>
<td>24.7</td>
<td>24.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>23.7</td>
<td>24.2</td>
</tr>
<tr>
<td>Estonia</td>
<td>23.5</td>
<td>–</td>
</tr>
<tr>
<td>Latvia</td>
<td>23.3</td>
<td>–</td>
</tr>
<tr>
<td>Finland</td>
<td>22.9</td>
<td>24.9</td>
</tr>
<tr>
<td>Austria</td>
<td>22.8</td>
<td>26.3</td>
</tr>
<tr>
<td>Hungary</td>
<td>22.4</td>
<td>–</td>
</tr>
<tr>
<td>Denmark</td>
<td>22.3</td>
<td>24.6</td>
</tr>
<tr>
<td>Lithuania</td>
<td>22.0</td>
<td>–</td>
</tr>
<tr>
<td>Slovenia</td>
<td>21.0</td>
<td>–</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>20.9</td>
<td>23.6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>20.3</td>
<td>22.3</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>19.7</td>
<td>–</td>
</tr>
<tr>
<td>Poland</td>
<td>18.4</td>
<td>–</td>
</tr>
<tr>
<td>Malta</td>
<td>18.2</td>
<td>–</td>
</tr>
<tr>
<td>Cyprus</td>
<td>17.6</td>
<td>–</td>
</tr>
<tr>
<td>Slovenia</td>
<td>16.5</td>
<td>–</td>
</tr>
<tr>
<td>Ireland</td>
<td>16.4</td>
<td>17.3</td>
</tr>
<tr>
<td>EU 15</td>
<td>25.0</td>
<td>27.3</td>
</tr>
<tr>
<td>EU 25</td>
<td>24.1</td>
<td>–</td>
</tr>
</tbody>
</table>

Source: Eurostat 2005, The social situation in the European Union
Medical and social services in the EU

Major differences in medical and social services for the elderly can be found within the European Union. There is a difference between northern and southern countries, Catholic and Lutheran traditions, insurance-financed and tax-financed systems, as well as between urban and rural communities within the countries.

In all EU countries, residents have a general or near-general right to medical care. This means that most EU residents are covered by existing systems, although the scope of coverage varies among the countries. One reason for these variations is whether medical care is financed by taxes or insurance. The insurance systems are often based on labour market participation. There are variations in how different occupational groups are treated, such as employees and self-employed. All systems have restrictions on the extent to which they cover the cost of treatments or the different types of treatments.

Differences in supply of care for the elderly are greater among the EU countries than for medical care. In some countries the family is still responsible for providing or paying for care for the elderly. In these countries society only intervenes when the family can no longer provide care.

More and more countries are shifting to a broader distribution of responsibilities for care of the elderly. It is common for local authorities to have this responsibility, as in Sweden. All countries have an infrastructure for professional care of the elderly, but its significance varies, depending on factors such as the family’s role and the scope of services.\(^6\)

In Italy, volunteer organisations and cooperatives play a major role in caring for the elderly. The Netherlands focuses on planning and accessibility. The UK carries out a considerable amount of prevention work, targeting issues such as fall injuries and nutrition. Sweden is unique because of the high percentage of the population that receives home help, as well as good access to assistive devices and short-term care.\(^6\)

Community care or informal care?
Most EU citizens agree that home help is a better choice for older citizens than special housing. However, EU citizens are not at all in agreement over who or what should be responsible for the long-term care needs of the elderly. The basis of public medical and social services differs greatly

---

\(^6\) European Commission 2003, *Proposal for a joint report: Health care and care for the elderly: Supporting national strategies for ensuring a high level of social protection*

\(^6\) European Commission 2003, *The Long-Term Care Expenditure in an Ageing Society*
among the EU countries. Over 80% of Swedes believe that society should be responsible for the elderly population by providing home help and special housing. In Poland, Spain and Greece, the relationship is the reverse: 80% or more believe that informal care by a relative is preferable. In general, dependent relative care is more popular in southern Europe and in Catholic countries, while northern Europe prefers social solutions.\textsuperscript{70}

Figure 28  Percentage who prefer social solutions to informal care for their own parents

A larger percentage of the elderly population lives alone in northern Europe than in southern Europe. In Denmark and Sweden, over 60% of those aged 80 and older live alone, compared with only 30% in Spain and Portugal. In Spain, 30% of people aged 65 and over live in households with more than two family members, while the corresponding figure in Sweden is less than 5%.\textsuperscript{71}

\textsuperscript{70} European foundation for the improvement of living and working conditions 2004, \textit{Health and care in an enlarged Europe}

\textsuperscript{71} Eurostat 2005, \textit{The social situation in the European Union}
The EU and the ageing population

The demographic trend within the EU involves a major strain on the social welfare system, as it does for pensions, medical care and care of the elderly. These common challenges for EU member countries helped to place medical care issues high on the European agenda during the 1990s.

As early as 1989, the EU established a European research centre for social, demographic and family issues to monitor developments in member countries. In the early 1990s various EU documents described a common challenge in the increasing percentage of elderly people in society. This challenge is described based on several aspects, including the relative reduction of the working-age population and the ageing labour force, pressure on pension systems and general government finances, increased need for medical and social services, and the increased differences among the elderly in matters involving health, housing, education and family situation.

Since social policy is a national priority, the EU cannot possibly harmonise laws or regulations in medical and care of the elderly. However, a more extensive collaboration has begun in line with the open method of coordination. According to this model, in this case all of the countries' ministers of social affairs and health shall agree on objectives and how to measure them at the EU level, after which each country finds its own path to achieve these objectives. The process includes an array of reports, analyses, new reports and evaluations. The aim is to help each member country to develop its own social policy. The common objectives for medical and social services are: Access to medical and social services for all, regardless of income or wealth; high-quality and financially sustainable medical care. These three objectives have been broken down into a number of proposals for measures that member countries can use. However, if a country does not fulfil the objectives or submit reports on time, no sanction system is in place, though some moral pressure is created.72

The EU can support projects that study various aspects and consequences of ageing within the union through its public health programme or its research programme. For example, a database (SHARE) encourages interdisciplinary nationwide studies on people over the age of 50 and their health, socioeconomic status, social network and family situation.73

---


73 European commission, SHARE project QLK6-CT-2001
## Tables and Figures

**Figure 1** Population trend for 2004 to 2050 for the elderly. Index 2004 = 100  
8
**Table 1** Number of people aged 65–74, 75–89, 80–84, 85–89 and 90 and older, for 2004–2014  
8
**Table 2** Number and percentage of people in the population aged 65 and older  
8
**Table 3** Number and percentage of people in the population aged 80 and older  
9
**Figure 2** Population growth for people aged 65 and older and for people aged 80 and older, 1980–2000 and 2000–2020  
9
**Table 4** Average life expectancy and remaining life expectancy, broken down by sex  
11
**Table 5** Number and percentage of foreign-born individuals aged 65 and older, broken down by age category and number of birth countries represented in 2004  
12
**Table 6** The ten largest groups of foreign-born residents aged 65 and older, 2004  
13
**Table 7** Percentage of local authorities that have special initiatives for elderly who belong to national minorities and elderly with foreign background, 2004  
13
**Table 8** Development of special housing intended for/adapted to elderly people from another ethnic minority group  
14
**Figure 3** Care of the elderly in the local authorities in 2004  
16
**Table 9** Types of housing for various age groups by the age of the owner. Percentage of households in each type of housing  
18
**Figure 4** Grants approved per year 1974–2004  
20
**Table 10** Number and percentage with home help in regular housing  
22
**Figure 5** Percentage of the population in regular housing who had been granted home help as of 1 October 2004  
23
Figure 6 People aged 65 and older with home help, per number of hours in 2004
Table 11 Absolute and percentual change of the number of approved/estimated home help hours in October 2000–2004. Rounded figures
Table 12 Number of registered bed-days in 1999, 2003 and 2004
Table 13 Number of people aged 65 and older who were approved day activities as of 1 October between 1999 and 2004
Figure 7 Stays in special housing in 2002 (including short-term housing)
Table 14 Number and percentage of permanent residents in special housing in 1998, 2003 and 2004
Figure 8 Percentage of the population permanently living in special housing as of 1 October 2004
Table 15 Extent of health and medical care in various operations
Table 16 Number of people aged 65 and older who were approved day activities as of 1 October between 1999 and 2004
Figure 9 People aged 65 and older grouped by the number of measures as of 1 October 2004
Figure 10 Number of people aged above 65 with LSS interventions in 1999–2004
Table 17 Number of people aged 65 and older granted LSS interventions in 1999, 2003 and 2004 (note that the same person may be granted more than one intervention)
Figure 11 Who helps with shopping, laundry and cooking?
Figure 12 Who helps with getting up, getting dressed, showering?
Table 18 Personal care patterns among elderly women and men. Percentage of women and men, living alone or with a partner, who receive assistance from external forces. Elderly people aged 75 and older, still living at home, who need practical help. Year 2000
Table 19 Percentage of communities/districts that stated they offered some kind of support to family members in 2002 and 2004
Figure 13  Population aged 80 and older as a percentage of total population in 2002 38
Figure 14  Number of hip replacement operations per 100,000 inhabitants 2002 38
Figure 15  Number of cataract operations per 100,000 inhabitants 2002 39
Figure 16  Distribution by percent of care episodes per patient in different age groups, 2003 39
Figure 17  Average length of stay in different age groups 1994–2003 40
Figure 18  Percentage of the population in various age groups and bed-days in 2003 40
Figure 19  Per capita health care expenditure 2002. USD PPP 41
Figure 20  Per capita increase in health care expenditure 1994–2002. PPP. Index 1994 = 100 42
Table 20  Number of people aged 65 and older receiving social services from local authorities and individual providers in 2000 and 2004 44
Table 21  Number of employees in the local authority, per profession. Salaried and on leave. Rounded figures 47
Table 22  Number of people working in the local authority per profession, and changes in staffing between 1995 and 2003. Salaried, not including those on leave. Rounded figures 48
Figure 21  Educational focus of staff (salaried and on leave) and recruited assistant nurses, nurse’s aides and others in 2004 49
Table 23  Age distribution of permanent staff in certain medical and social services in November 2004. Percentage 50
Figure 22  Percentage of permanently employed assistant nurses/nurse’s aides who left their positions between 1996 and 2004, by age 51
Figure 23  Percentage of permanently employed nurses who left their positions between 1996 and 2004, by age 52
Table 24  Percentage of permanent employees on full sick leave in November 2004 53
Table 25  Percentage of permanent employees on partial sick leave in November 2004 54
Table 26  Number and percentage of full-time employees in health and social services

Table 27  Salary levels for full-time employees in certain health and social services professions in November 2004, plus additions for unsocial working hours

Figure 24  Distribution of local authority costs for operations in 2004, percentage. Total SEK 398 billion

Figure 25  Distribution of local authority revenues for operations in 2004, percentage. Total SEK 399 billion

Figure 26  Costs of care of the elderly between 1999 and 2004, fixed and gross amounts

Figure 27  Allocation of costs for care of the elderly in 2004

Table 28  Cost per care recipient in regular and special housing between 2000 and 2004, gross amounts

Table 29  Spread of costs per care recipient between local authorities in 2001–2004, SEK, gross amounts

Table 30  Dependency ratio for the elderly within the European Union

Figure 28  Percentage who prefer social solutions to informal care for their own parents
References

Dementia Inquiry (2003): På väg mot en god demensvård (Ds 2003:47) (On the path to good dementia care)


European Commission, SHARE project QLK6-CT-2001

European foundation for the improvement of living and working conditions (2004) Health and care in an enlarged Europe

Eurostat (2005) The social situation in the European Union


National Board of Health and Welfare (2000), Stöd och service till vissa funktionshindrade den 1 juni 1999 (Support and service to specific disabled people 1 June 1999)


National Board of Health and Welfare (2005) Var dör de äldre – på sjukhus, särskilt boende eller hemma? (Where do the elderly die – in hospital, special housing, or at home?)

National Board of Health and Welfare (2005), Äldre – vård och omsorg år 2004 (The Elderly – Medical and Social Care in 2004), official Swedish statistics

National Board of Health and Welfare (2005), Funktionshindrade personer – insatser enligt LSS år 2004 (Functionally Impaired People – Interventions under LSS in 2004), official Swedish statistics
National Board of Health and Welfare (2005), *Kommunernas anhörigstöd 2004* (Community support to family members 2004)


Norling I & Larsson E-L (2004) *Ett gott och friskare liv som äldre* (A good, healthy life in old age), Health Care Research Unit, Sahlgrenska University Hospital


SABO and SALA (2004), *Kvarboende + tillgänglighet = god ekonomi* (Staying at home + accessibility = Good economics)

SALA (2002) *Kooperativ äldreomsorg – en del i mångfalden* (Cooperative care of the elderly – one of many alternatives)

SALA (2004) *Äldreomsorg till nationella minoriteter och personer med utländsk bakgrund* (Care of elderly national minorities and people with foreign background)


SALAR (2005) *Svensk sjukvård i internationell belysning* (Swedish medical care in an international perspective)

SALAR (2005), Financial report May 2005
SIKA, the Swedish Institute for Transport and Communications Analysis (2005), *Färdtjänst och riksfärdtjänst 2004* (Transportation Service and National Transportation Assistance 2004)

SOU 2003:91, *Äldrepolitik för framtiden, bilagedel D* (Elderly policy for the future, annex section D)


Swedish Rescue Services Agency (2003), *Fallolyckor bland äldre – samhällets direkta kostnader* (Falls among the elderly – direct costs to society)
Care of the Elderly in Sweden Today

This publication can be ordered from:
Printed materials department
Phone +46 (0)20-31 32 30
Fax +46 (0)20-31 32 40

Price:
1-4 copies SEK 75 each,
5-9 copies SEK 50 each,
10 or more copies SEK 25 each.
VAT, postage and a service charge will be added.

This publication is available in PDF-format on:
www.skl.se/aldre

ISBN 91-7164-123-8