Swedish Association
of Local Authorities
and Regions

Care of the Elderly in Sweden Today

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Preface

The Swedish Association of Local Authorities and Regions, SALAR, continuously monitors trends in the care of the elderly. The aim of this document is to reflect the current status of care of the elderly in Sweden and the trends we can now see regarding interventions, expenditures and staffing. Since 2001, we have published annual reports on the current situation in care of the elderly. The publication is a summary of information from all the official statistics from Statistics Sweden, the National Board of Health and Welfare and SALAR. The majority of the statistics cover the period up to the end of 2005.

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 publication was developed in SALAR's Health and Social Care Division, under project managers Josephine Lindgren and Irene Lindström. The underlying data and other contributions to its writing were provided by other staff in the department, as well as Kerstin Ahlsén from the Education and Labour Market Division and Lars Johansson, Bo Legerius and Rolf Ström from the Finances and Governance Division.

Stockholm, November 2006

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Care of the Elderly Nationwide

Sweden is one of the best countries in the world to grow old in. But naturally, things can always be improved. There are also flaws and problems that must be taken care of.

Sweden from an international perspective

Sweden offers more publicly financed care of the elderly than any other country. A report from the OECD (2005) compares data from several countries expressed as a proportion of the GDP. Sweden tops the list with 2.8 percent, followed by Norway, which spends 1.8 percent. After this come several countries, such as the UK, Japan, the USA and Spain, which spend between one-half and one percent. Few countries outside the Nordic region have publicly financed care of the elderly; the support needed by senior citizens is based on input from family members, their own funding, insurance solutions and volunteer organisations.

Were things better before?

Many believe that things were better "in the old days". Home help services had the time to fill their charges' homes with the scent of stuffed cabbage and fresh-baked bread, to take walks with them, wash windows and chop wood. It's easy to forget the thousands of elderly people in those days who, early in their twilight years or with a dementia disorder, spent decades in mental hospitals and long-term care, sharing a room with strangers, deprived of their own furniture and clothing – who lacked any kind of control over their daily lives. And rarely did an elderly patient receive coronary surgery, a new hip or cataract surgery.

Care of the elderly has changed greatly in the past 25 years and now sees greatly expanded resources. From 1980 to 2005, public expenditures for care of the elderly increased by some 60 percent when adjusted for inflation, while the number of care recipients has decreased by about 40 percent. In 1980, over 400,000 elderly people received home help services or resided in an old people's home or a nursing home. Today, the corresponding figure is 245,000 people. The decrease in people receiving aid can be explained in part by the fact that the need for help has decreased in people over the

age of 80 since the late 1980s. At the same time, this means that the cost per care recipient has more than doubled in the same period. We need to understand this development and the reallocation of the resources. One explanation may be that today's care recipients have much more extensive care needs, that those receiving health and social care today are a somewhat different group than in the 1980s.

What do the users say?

Never has so much public funding been put into care of the elderly; at the same time, we are constantly fed images of misery and deficits in the field. How is this possible, and what do the users themselves say?

In a survey, 221 Swedish local authorities state that they conduct user surveys in care of the elderly (SALAR 2006). At first glance, the overall impression is distinct satisfaction, which is also confirmed by the collectively processed results of quality surveys, which have been conducted on five occasions between 1998 and 2005 and are based on the responses of some 12,000 users in nine Southern Swedish local authorities (Users and their families on the quality of care of the elderly, National Board of Health and Welfare 2006). The primary result is that the majority of users and their families during this period give positive assessments of community medical and social care. Various quality aspects are usually met, if not always. Not every aspect is as important, either – honesty and decency are valued more than keeping to schedules. Knowledgeable staff is important, but a personal approach and treatment is even more important. These results contradict the common perception of poor quality in community medical and social care in several ways.

On some levels, the assessments were more critical: The care recipients are not given enough information and don't really understand the content of their formal decision on aid or how and where to lodge complaints. They lower their expectations and are grateful to get any help at all. They do not consider it worthwhile to try to change schedules or interventions: "They have such strict rules, they have their routines, you can't change them."

At SALAR's Elderly Parliament in spring 2006, former EU parliamentarian and social commentator Marit Paulsen (Liberal Party) described her dread of the day she will need help and support to manage daily tasks, and stated in no uncertain terms that when that day comes she wants to be able to make decisions for herself – for example to keep going to the theatre, go elk hunting and fishing – and not allow the home help services to set her limits.

Are people really able to do what they want and live as freely and independently as possible throughout their lives? Do we demand greater adaptation of users and their families than we do of the care organisations? What quality do we want, and what can we afford?

Impressions and counter-impressions

Why does the gloom-and-doom image of care of the elderly prevail? Why do individual failures gain the status of system-wide shortcomings?

In the world of ageing, it is easy to depict in words and images the frailness of the body, the rage and crying out of the dementia patient, the grey boredom. It is harder to document and describe the warmth, the hugs, the tenderness – all the details that come into play as life heads towards its unjustly undignified end. The same individual event, the same individual human being's vulnerable situation, the same assisted living facility can be described in many different ways depending on the beholder's identity, perspective and time frame.

In summer, when staff has many temporary stand-ins, at times when supervisors are replaced or the organisation is being changed, the risk of mistakes and poor quality is likely to increase. Less often do people express the more common situation – the stable staff group that remains in place year after year, in a rewarding team effort where many feel that working with elderly people is the best possible job. Everyone who provides the backbone of the business, who has knowledge and experience, who knows what to do, where the keys are, which patients have dentures or need a little extra cream in their coffee, a schnapps with dinner or an extra hug before bed.

What is "typical" of care of the elderly today? Crises and scandals, or one of the world's best functioning systems for providing care to elderly people? A healthcare system where 75 percent of local authorities have implemented systems for handling complaints, and 25 percent have quality declarations based on their work with care of the elderly. Hundreds of thousands of employees in all local authorities participate in skills development regarding ethics, approach, leadership, dementia care, rehabilitation in everyday life, nutrition, terminal care and much more.

Greater knowledge allows open comparisons

We need a reasonable discussion of care of the elderly, highlighting both merits and flaws. We have a need for more collective knowledge on quality, results and value for money. Better collaboration between local authorities and regions can very likely contribute to enhanced efficiency in publicly financed medical and social care.

New, individual-based statistics will contribute to such a knowledge base. National quality indicators will gradually lead to the ability to make comparisons between quality, results and costs in different local authorities and for different activities. The Swedish Association of Local Authorities and Regions is participating in this joint project with the National Board of Health and Welfare, with the aim of allowing open comparisons in the field of care of the elderly as well.

The individual users' ranking of medical and social services is also a key element. A National User Survey will provide this information and fill out the picture provided by the local authorities' own surveys.

About the Elderly

Overall, we are living longer and are healthier for a larger part of our old age. For most people, retirement means many healthy years that can be filled with activities. Over 17 percent of the Swedish population is age 65 or older, about 1.6 million people.

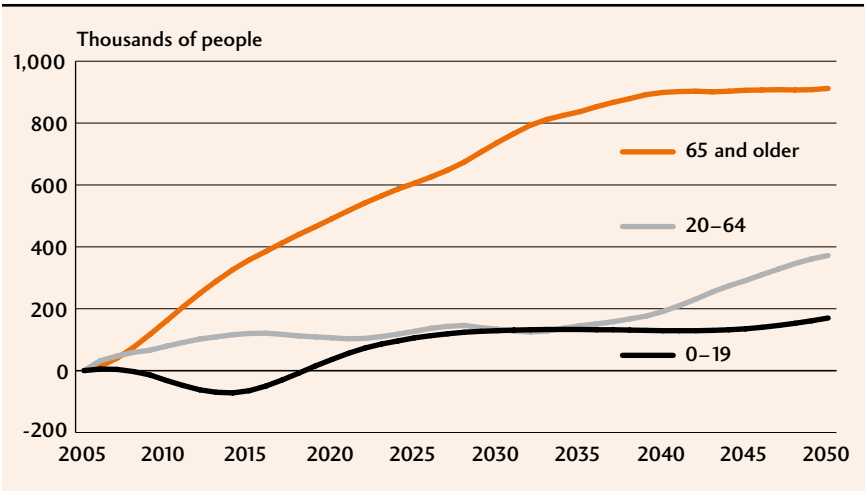
The demographic trend

The proportion of elderly people in the population is increasing, both in Sweden and in the EU. In the coming fifteen years, the group of younger elderly (aged 65–79) will increase the most, after which the people aged 80 and above will increase.

Demographic trends in Sweden

The population trend shows that in the next 30 years, the largest part of population growth will be in people aged 65 and older. By 2035, the majority of population growth will consist of people who are not of working age. This is illustrated in figure one, showing the population growth until 2050, starting in 2005.[1]

Figure 1 Population of Sweden, 2005–2050. Change in comparison with 2005, thousands of people

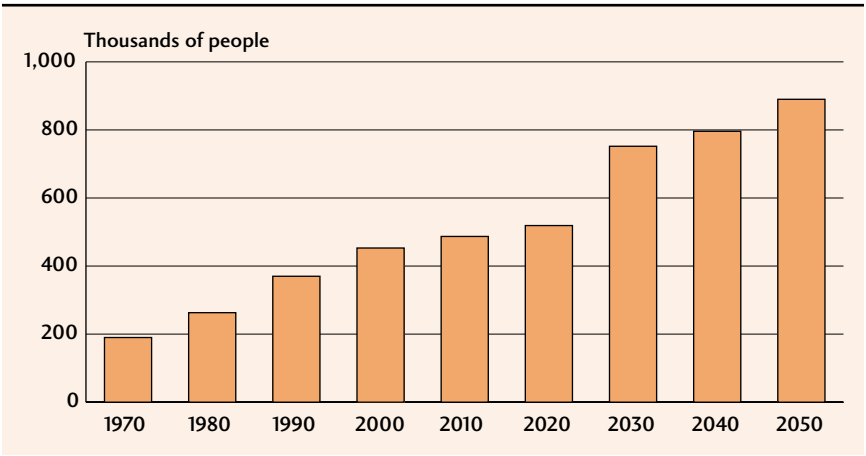


Source: Statistics Sweden 2006, *Population projections*

[1] Statistics Sweden 2006, *Population projections*

For the local authorities, the growth of the elderly population in the oldest age groups is most interesting, because it will have the greatest impact on the need for medical and social services. The very oldest part of the population has increased since the mid-20th century. In the coming 15 years, the largest proportion of the population growth will be in the 65–79 age range, but in the 2020s that figure will shift to the 80-and-older group. This means that we have several years to plan and prepare before the number of people aged 80 and older will increase dramatically. See also figure two.[2]

Figure 2 Number of people aged 80 and older, 1970 to 2050, thousands



Source: Statistics Sweden 2006, *Population projections*

When those born in the 1940s begin to show increasing care needs, around 2020–2030, those born in the 1960s will be reaching retirement age. This means that the cost of pensions will be increasing at the same time as the percentage of gainfully employed people decreases. Therefore it is crucial to take advantage of the resources we have in people over 65.

Table 1 Relative age distribution (percentual) of the population, 1905–2050

	1905			1955			2005			2050		
Age	Tot	W	M	Tot	W	M	Tot	W	M	Tot	W	M
0–9	22	21	23	16	15	16	11	10	11	11	11	11
10–19	19	19	20	14	14	15	13	13	14	11	11	11
20–64	50	51	49	59	59	59	59	57	60	54	54	55
65–74	6	6	5	7	8	7	8	9	8	10	10	10
75–	3	3	3	4	4	3	9	11	7	14	15	12
All	100	100	100	100	100	100	100	100	100	100	101	99

Source: Statistics Sweden 2006, *Population projections*

[2] Statistics Sweden 2006, *Population projections*

The average life expectancy of men is expected to increase more than that of women. This means that the percentage of women among the very oldest will gradually decrease. Today women are 64 percent of the very oldest; in 2040 they are expected to represent 57 percent.[3]

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

Year	Number aged 65+	Percentage aged 65+	Percentage women
2005	1,565,000	17.3	57
2020	2,056,000	21.2	54
2030	2,303,000	22.9	53
2040	2,464,000	23.9	53
2050	2,478,000	23.6	53

Source: Statistics Sweden 2006, *Population projections*

Table 3 Number and percentage of people in the population aged 80 and older

Year	Number aged 80+	Percentage aged 80+	Percentage women
2005	487,000	5.4	64
2020	525,000	5.4	60
2030	763,000	7.6	57
2040	812,000	7.9	57
2050	912,000	8.7	56

Source: Statistics Sweden 2006, *Population projections*

Demographic trends in the EU

In the EU, 17 percent of the population is above age 65, corresponding to about 75 million people. The population of the EU grew younger when the EU got ten new member states in 2004, but this is a short-term change. The population of the EU countries will grow increasingly older. The highest percentages of people aged 65 and over in 2005 were in Germany and Italy (19 percent) and Greece (18 percent). The lowest percentages were in Ireland (11 percent), Cyprus and Slovakia (12 percent). Sweden has the highest proportion over age 80 in the EU.[4]

The increasing elderly figures primarily affect the 15 "old" EU countries. For example, the proportion aged 80 and over will increase an average of 50 percent in the coming 15 years. Europeans are not only living longer, but are also experiencing reduced natality. In 2003, the natural population growth in Europe was 0.04 percent. In the new member states, with the exception of Cyprus and Malta, the population even decreased. Current nativity rates, averaging 1.4 children per woman, lie under replacement, which requires 2.1 children per woman. In many EU countries, immi-

[3] Statistics Sweden 2006

[4] Eurostat 2006 *New release 129/2006, EU25 population aged 65 and over expected to double between 1995 and 2050*

gration is vital for population growth. Yet despite continued immigration, the EU population is stagnating and even shrinking, in contrast, for example, to the USA. Japan is undergoing a similar trend to that of the EU, with low birth rates and low immigration.

Factors that affect demand for medical and social services

Many 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:

- personal finances
- health and lifestyle
- housing standard
- living arrangements – alone or as part of a couple
- family and/or social network

The elderly's finances

Elderly people's finances depend mainly on the income they had during their working lives, and how long they worked. Capital assets and investments also affect the person's finances. The biggest difference in personal finances is often between singles and couples. A national survey called Senior 2005 showed that of singles in the age range of 65–69, about 20 percent will have an income under what is considered a reasonable standard of living (according to the national norm for financial aid) for a long time in the future.[5] Women, to a greater extent than men, tend to have worked less years during their working years due to childbirth and part-time work when the children were small. This, and the fact that many women have had lower wages than men, leads to their pensions being lower.

Elderly people born abroad, who 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

Retirement

Retirement means a life change. The natural contact with colleagues decreases or disappears, and the social network changes. The person must adapt to a new life situation, create new contacts and new networks. Seniors who participate in social, cultural, physical or other activities are often more alert and healthy much later in life, and can get along without

[5] Senior 2005, SOU 2003:91, *Äldrepolitik för framtiden, bilagedel D (Elderly policy for the future, annex section D)*

care longer. The negative effects of changes in one's network and poorer health are often worse for men than for women, because men usually have less social contacts.

Average life expectancy

The average life expectancy in Sweden increased dramatically in the 20th century. In 2005 it was 78 years for men and 83 for women. A person who retires at age 65 hopefully has many good years to look forward to – on the average 17 years for men and 21 for women. One reason for the increase in life expectancy is that the elderly's health has improved significantly. When the first law on general pension insurance was introduced in 1913, the average retirement age was 67 and the average life expectancy (from birth) was just over 55 for men and 57 for women.[6]

Much of the increased life expectancy since 1913 is due to reduced infant mortality.

Table 4 Average life expectancy and average remaining life expectancy, broken down by sex

	Average life expectancy at birth		Average remaining life expectancy at age 65	
Year	Men	Women	Men	Women
1900	51	54	12	13
1925	61	63	13	14
1950	68	71	14	14
1975	72	78	14	17
2005	78	83	17	21

Source: Statistics Sweden 2006, *Medellivslängd och återstående medellivslängd (Average life expectancy and average remaining life expectancy)*

Lifestyles of the elderly

Lifestyle is also extremely significant for health, in particular exercise, eating, smoking and alcohol habits. Other key factors are living situation, social contacts and physical and social activity. Several studies show that a high activity level – physical, social and cultural – among seniors reduces the risk of premature mortality, illness and functional disabilities.[7]

Elderly health trends

According to the National Board of Health and Welfare report *Äldres levnadsförhållanden 1988–2002 (Living conditions of the elderly, 1988–2002)*, elderly people's subjective assessments of their own health changed little between 1988/89 and 2002, or improved slightly in 2002. Men consistently report improved health, and a health index shows a slight trend towards

[6] Swedish Association of Local Authorities 2001, *Vägval i kommunal äldrepolitik (Choice of direction in community elderly policy)* & Statistics Sweden 2006

[7] Ingemar Norling 2004: *Ett gott och friskare liv som äldre (A good, healthier life for the elderly)*

better health for men. In addition, the average age has increased. Perceived worry and anxiety have not become more common. Although the number of elderly people is on the rise, the number of elderly in the population needing assistance is unchanged, or even lower in 2002 than previously.[8]

Social contacts

The most important social contacts for many elderly are their partner and children. Over half of all elderly people have both a partner and children. More of the single elderly have children today than in the late 1980s. An unchanged proportion – 39 percent – have siblings. Fourteen percent are without partner or children, corresponding to about 220,000 people aged 65 or older.

Half of those interviewed in the National Board of Health and Welfare's report *Äldres levnadsförhållanden 1988–2002 (Living conditions of the elderly, 1988–2002)* have children living within a 10-km radius, and even more see their children at least once a week. In general, the elderly have a more "close-knit" social network today than before, and many of them help someone else outside their own home. Feelings of loneliness and a wish for more contacts occur, but are not general.

Loneliness among the elderly

Being old is not synonymous with being lonely, and loneliness does not only affect elderly people. These are some of the conclusions of a recently published research report from the Danish *Videnscenter på Ældreområdet*. Three percent in the 52–62 age range state that they often or occasionally feel lonely; the corresponding figure in the 77–82 age range is five percent. There is a correlation between loneliness, physical and mental disability and social alienation.

All of those interviewed experienced loneliness rooted in the lack of a spouse or the lack of a physical, social and emotional relationship. One necessary condition for avoiding loneliness is the existence of people one can, wants to, and actually does spend time with. Different kinds of housing for the elderly often have meeting places, but this is no guarantee that there are others there that the individual wants to spend time with.[9]

Elderly with other ethnic backgrounds

The concept of elderly people with a different ethnic background includes both elderly people belonging to one of the national minority groups and those born in other countries.

[8] National Board of Health and Welfare 2004, *Äldres levnadsförhållanden 1988–2002 (Living Conditions of the Elderly 1988–2002)*

[9] Videnscenter på Ældreområdet 2006, *Portretter av gamle ensomme – gör boligen en forskel? (Portraits of lonely elderly people – does housing make a difference?)*

National minorities

The national minorities in Sweden are the Sámi (Lapps), Sweden-Finns, Tornedal Finns, Roma and Jews. The national minority languages are Sámi, Finnish, Meänkieli (Tornedal Finnish), Romani Chib and Yiddish. Sweden's national policy for minorities grants Finnish-speaking elderly the right to care provided completely or partly in Finnish in the administrative region for Finnish, which includes Gällivare, Haparanda, Kiruna, Pajala and Övertorneå. The administrative region for Sámi includes Arjeplog, Gällivare, Jokkmokk and Kiruna. In addition, the needs of elderly people belonging to the official national minorities shall be considered nationwide.[10]

In the spring of 2006, SALAR conducted a survey including questions about whether the local authorities provide medical and social services in the national minority languages. Of the nation's 290 local authorities, 281 responded. Table 5 shows the responses to the question as to whether the local authorities offer medical and social services in the national minority languages.[11]

Table 5 Number of local authorities offering medical and social services in the national minority languages

Minority language	number responding yes	number responding no	number responding "not applicable"	number who did not respond
Romani	7	75	183	16
Meänkieli	7	74	184	16
Sámi	4	78	183	16
Yiddish	3	77	185	16
Finnish	70	78	123	10

Source: SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*

Most replied that the issue is not or has not been applicable.

Foreign-born elderly

In 2005, the number of people aged 65 and older born outside Sweden was about 170,800, or 11 percent of the population in this age range. As table 6 indicates, the number and proportion of the foreign-born population aged 65 and older is increasing. The proportion of foreign-born elderly is significantly larger in the younger age groups (55–74) than in the oldest. The number of countries of origin is also increasing.[12]

[10] Proposition 1998/1999:143 *Nationella minoriteter i Sverige (National Minorities in Sweden)*
[11] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*
[12] Statistics Sweden 2006, *Utrikes födda i riket efter födelseland, ålder och kön. 2000–2005 (People in Sweden born outside Sweden, by country of birth, age and sex).*

Table 6 Number and percentage of foreign-born individuals aged 65 and older, broken down by age category, and number of birth countries represented in 2005

2005	Age 55–64	Age 65–74	Age 75–84	Age 85–94	95–
Number of foreign-born people	150,200	101,200	56,400	12,300	835
Proportion of the population born elsewhere	12.5	13.2	9.9	5.8	5.7
Number of countries of origin	168	154	137	99	51

Source: Statistics Sweden 2006, *Utrikes födda i riket efter födelseland, ålder och kön. 2000–2005 (People in Sweden born outside Sweden, by country of birth, age and sex).*

Less than half of the foreign-born elderly in 2005 were born in a Nordic country; 90 percent were born in a European country. Only one of ten were born outside Europe.

Table 7 The ten largest groups of foreign-born residents aged 65 and older, 2005

Country of origin	Total	Country of origin	Total
Finland	53,300	Poland	5,900
Germany	15,900	Estonia	5,700
Norway	14,200	Bosnia-Herzegovina	5,400
Denmark	12,600	Hungary	4,300
Yugoslavia	9,400	Iran	3,300

Source: Statistics Sweden 2006, *Utrikes födda i riket efter födelseland, ålder och kön. 2000–2005 (People in Sweden born outside Sweden, by country of birth, age and sex).*

Care of elderly people with other ethnic backgrounds

SALAR regularly monitors trends in care of the elderly as regards those belonging to national minorities and those of foreign background. Most recently in spring 2006, SALAR and the National Board of Health and Welfare conducted a survey of interventions provided to these groups in care of the elderly. The survey was the fourth on the subject since 2000.

The preliminary survey results show that interventions in general have increased since 2000. Most of these interventions also saw an increase between 2004 and 2006. The information below is preliminary, based on the responses from 248 local authorities which had come in when this document was printed.

Of the 248 responding local authorities, about half responded that they have elderly care recipients with special needs due to ethnicity. Another 19 local authorities responded that the need will exist within 2–3

years. The number of communities with a need for staff with linguistic or cultural competence, or special activities for an ethnic minority group, is approximately the same as two years ago. However, the proportion of local authorities offering special food for all or a majority has increased significantly, for 27 percent in 2004 to 57 percent in 2006. We have not yet had the opportunity to analyse these results.[13]

Table 8 Percentage of local authorities that have special initiatives for elderly who belong to national minorities and elderly with foreign background in 2006*

	For all or a majority	For a smaller group	No at all
Staff who speak the users' mother tongue	32	62	5
Staff with cultural competence	25	60	12
Option to receive special food due to ethnicity	57	28	11
Activities adapted to ethnic minority group	7	30	56

* Percentage of those responding that they have, or will have within 2–3 years, users with special needs due to ethnicity

Source: National Board of Health and Welfare and SALAR 2006

Most of Sweden's local authorities have a small number of elderly people belonging to the national minorities and with a foreign background. However, the metropolitan regions, and regions bordering on neighbouring countries, have a larger proportion. The number of countries of origin represented in the elderly population also varies between local authorities, which has led to the development of different strategies to meet the needs. Some local authorities offer special housing, home help and/or day activities specially intended for or adapted to elderly people of a different ethnicity. Other local authorities have staff of a different ethnic background in their units, who can be matched with users with the same background. Family care providers are also common among these groups. Day activities for the elderly in special and regular housing are an example of how special needs can be met without special housing or home help groups.

Number of special housing facilities with an ethnic focus increasing

The number of special housing intended for or adapted to elderly people from a different ethnic minority group is increasing. In 2000, Sweden had a total of 20 such residences, and in 2002 that figure was 25. In 2004, the number of such facilities had increased to 30 residences or wards for elderly people from ethnic minority groups. The preliminary figure for

[13] National Board of Health and Welfare & SALAR 2006, *Care of the elderly belonging to national minorities and of foreign background*

2006 is 34 residences. This is an increase of 70 percent since 2000, and 13 percent since 2004.[14]

Table 9 Number of residences or wards for elderly people from ethnic minorities

Year	Number of residents	Number of local authorities with one or more residences
2000	20	14
2002	25	20
2004	30	23
2006	34	21

Source: National Board of Health and Welfare and SALAR 2006

Medical and social services in the EU

Medical and social services to the elderly vary widely within the EU. There is a difference between northern and southern countries, between Catholic and Lutheran countries, between insurance-financed and tax-financed systems, and between urban and rural areas within countries.

All EU countries offer residents a general or almost general right to medical and social services. This means that the majority of the EU population is covered by existing systems, although these vary from one country to another. One reason for these variations is whether the system is financed by taxes or insurance. The insurance systems are often based on participation in the labour market. Different professional groups – such as employees and entrepreneurs – are treated differently. Every system has its limitations as to the degree to which they cover costs of treatments or what types of treatments they cover.

The differences in care of the elderly are greater between EU countries than differences in healthcare. In some countries, the family is still responsible for providing care of the elderly, or financing it. Society only gets involved when the family can no longer provide care for their elderly relative.

Increasing numbers of countries are adopting a broader allocation of responsibility for care of the elderly. Often, the local authorities have the responsibility, as in Sweden. All EU countries have an infrastructure for professional care of the elderly, but its significance varies depending on factors such as the role of the family and the scope of the offering.[15]

[14] National Board of Health and Welfare & SALAR 2006, *Äldreomsorg till äldre som tillhör de nationella minoriteterna och äldre med utländsk bakgrund (Care of the elderly belonging to national minorities and of foreign background)*

[15] European Commission 2003, *Proposal for a Joint Commission-Council report on Healthcare and care for the elderly. Support for the national strategies for ensuring a high level of social security*

In Italy, volunteer organisations and co-operatives are key in care of the elderly. The Netherlands focus on community planning and availability. The UK carries out extensive preventive work in areas such as falling injuries and nutrition. Sweden is unique with its high proportion of the population receiving home help services, good access to assistive devices and short-term care.[16]

How does the EU work with medical and social services?

The demographic development in the EU places great strain on the social welfare systems as regards pensions, healthcare and care of the elderly. These common challenges for the EU member states have contributed to placing healthcare issues high on the European agenda in the 1990s.

As early as 1989, the EU established a European research centre for social, demographic and family issues,[17] in order to monitor trends in the member states. In the early 90s, a range of EU documents contained formulations describing a common challenge in the increasing proportion of elderly people. This challenge is often described from several dimensions: The relative decrease in the working-age population and the ageing workforce, the pressure on the pension systems and public finances, the growing need for medical and social services and the increased gap between the elderly as regards their family situation, accommodation, education and health.

Since social politics is a national concern, there is no opportunity for the EU to harmonise laws or regulations in healthcare and care of the elderly. However, a more in-depth collaboration has begun, in line with the open method of co-ordination. Under this model, the countries' social and healthcare ministers meet and decide on EU-wide goals and how to measure them. After that, each country finds its own path for achieving these goals. The process involves many reports, analyses, new reports, evaluations and so on. The goal is to support the member states in developing their own social policies. The common goals for medical and social services are: Access to medical and social services for everyone regardless of income or wealth, high-quality care and financially sustainable care. These three goals are broken down into several proposed measures that the member states can use. There is no sanction system if a country does not meet the goals or submit reports in time. However, they do feel a certain moral pressure.[18]

[16] European Commission 2003, *The Long-Term Care Expenditure in an Ageing Society*

[17] *European Observatory on the Social Situation, Demography and Family.* The centre was closed in the early 21st century.

[18] European Commission (2004), *Modernising social protection for the development of high-quality, accessible and sustainable healthcare and long-term care: support for the national strategies using the 'open method of coordination'* COM (2004) 304 final

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 being able to stay in their own homes as long as possible, as well as various forms of support, such as a personal safety alarm, meals on wheels, transportation service, medical and social care via home help services and home medical services.

For elderly individuals to continue living a normal, independent life, they need housing that is suitable and available for themselves and for the staff who will provide medical and social services to them. This means that flats, blocks of flats and residential areas should be designed so that people who have difficulty with stairs, need a walking frame or wheelchair, are visually or hearing impaired, or have memory problems, can get out and spend time in the neighbourhood on their own.

When the elderly need access to staff round the clock, many must move to special housing. These are primarily people with a dementia disease and people with extensive need of continuous minding and medical interventions. A move to special housing requires a formal decision from the local authorities' social services.

General measures

Community planning for the elderly

Active community and housing planning is a necessity in order to create environments that are attractive and available to everyone, including those with disabilities. Community planning should make it easier for elderly people to remain in their own homes and live normal lives. 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.

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, for example walks, also gives great physical and mental health benefits.[19] Proximity to commercial and public service and good transport makes it easier for elderly people to remain at home and manage on their own.

[19] Norling, 2004, *Ett gott och friskare liv som äldre (A good, healthier life for the elderly)*

Figure 3 Community care of the elderly in 2005

Home help in regular housing

Age group	Number	Percent
65–79	36,900	3.4
80–84	35,500	13.7
85–	62,600	27.5
Total 65–	**135,000**	**8.6**

Special housing

Age group	Number	Percent
65–79	20,000	1.8
80–84	23,000	8.9
85–	57,400	25.2
Total 65–	**100,400**	**6.4**

Elderly granted LSS

Age group	Number
65–79	3,500
80–	400
Total 65–	**3,900**

Day activities

	Number
In regular housing	11,100
In special housing	1,100
Total 65–	**12,200**

Community home medical services

Local authorities with home medical services: 146

Age group	Only home medical services	Home help & home medical services
65–79	5,550	8,950
80–84	3,900	8,450
85–	5,250	16,000
Total 65–	**14,700**	**33,400**

Meals on wheels

People aged 65–	Percent 65–
57,300	3.7%

Personal saftey alarms

People aged 65–	Percent 65–
157,200	10%

Home adaptations

Granted aid	64,700

Transportation services (2004)

Age group	Number	Percent
65–79	91,200	8.4
80–	209,600	41.2
Total 65–	**300,800**	**19.4**

Short-term care/housing

	Number
People aged 65–	8,700
Number of residential days	247,300

Source: Statistics Sweden 2006; National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005 (Elderly – Medical and Social Services 2005)*, National Board of Housing, Building and Planning 2006; SIKA 2005, *Färdtjänst och riksfärdtjänst 2004 (Transportation Service and National Transportation Service 2004)*, SALAR 2006

Several of Sweden's local authorities have invested in fixing up residential areas for the elderly. They have taken stock of existing housing to plan for improvements in those buildings suitable for the elderly to live in. By selecting particularly suitable neighbourhoods for renovation and accessibility adaptation, communities can better meet elderly people's demand for suitable housing.

Housing for the elderly

A good home is one of the most important requirements in order for elderly people to remain in regular housing. This means that the home should be suitable and adapted to the elderly, for example spacious, practical bathrooms and lifts to provide good accessibility.

In spring 2006, a special investigator was asked to head a delegation on housing for the elderly, Seniorboutredningen (directive 2006:63). The delegation will monitor and analyse the needs and development of housing issues for the elderly, both in the regular housing market and in special housing. The final report will be submitted on 31 December 2009.

Elderly people in regular housing

The majority of elderly people, 94 percent of those over 65, live in regular housing. The proportion of those living in special housing increases with age. Over 16 percent of people over age 80 live permanently in special housing.[20] The renovation of buildings into more practical, accessible housing will make it even easier in the future to remain in ordinary housing. There will also be new technical solutions that make daily activities in the home easier.

Some people may need to move to new residences when they grow older. Table 10 shows that 59 percent of people aged 65–74 and 37 percent of those over 75 live in detached and semi-detached houses. This can be a problem as people grow older – it becomes harder to manage mowing the lawn, taking care of the garden, clearing snow and cleaning. Many houses have stairs, and elderly people who develop problems with their hips, have a stroke and so on have trouble with stairs. Therefore, the demand for available flats is likely to increase, as well as the demand for housing with some common services or social activities, which some OAP flats have.

[20] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005 (Elderly – Medical and Social Services 2005)*

Table 10 Population, by age and type of housing in 2004[21] (as a percentage of the age group)

Type of housing	All	Of which in the age group: 50–64	65–74	75+
House, regardless of ownership	56.4	63.8	59.0	37.2
Tenant-owned flat	12.6	13.0	16.5	18.7
Rental flat	29.6	22.2	23.4	42.0
All	98.6	99	98.9	97.9

Source: Statistics Sweden 2006, *Hushållens ekonomi (Household Finances)*

Overall, more men live in houses, while more women live in rental flats. This difference becomes slightly sharper for people over age 65.[22]

OAP flats

What is an OAP flat?

Increasing numbers of elderly people who want to move to more accessible housing are requesting OAP flats. These are regular flats for people over a certain age, usually 55. The flats and buildings are designed to provide good accessibility. When the residents need medical and social services, they receive them on the same terms as elderly people in regular housing – through home help and home medical services. OAP flats sometimes offer added security through a superintendent. Some also have facilities for common activities, which the residents themselves arrange, and perhaps a kitchen and dining area for cooking and socialising in groups. The costs of such 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.

No formal decision on aid

Since OAP flats represent a part of the open housing market, no formal decision under the Social Services Act is required to obtain one. Those interested in an OAP flat place themselves in a queue with the housing companies or buy a tenant-owned flat. 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, in others individual flats in a residential area. In recent years, some local authorities have converted service flats to OAP flats, which has increased the supply of flats.

[21] Data on special housing has not been noted for people under age 65
[22] Statistics Sweden 2006, *Hushållens ekonomi (Household Finances)*

OAP flats can be an alternative for those who have trouble managing a house of their own, or who currently live in old, less accessible flats. The range of OAP flats is not very big, and the demand for such flats may increase when many elderly people who now live in houses want to move.

How many OAP flats are there?

According to a questionnaire survey SALAR conducted in 2005, there were 19,000–19,500 OAP flats in the country, an increase of 62 percent in comparison with a corresponding survey in 2000, when there were about 12,000.[23]

What property owners own OAP flats?

The allocation of property owners was:

Table 11 Percentage of OAP flats, per type of property owner

Property owners	Number in 2005	Percent in 2005	Percent in 2000
Tenant-owner associations	3,196	17	40
Private property owners, companies etc	1,692	9	9
Local authority-owned companies	10,971	60	24
Foundations	1,807	10	9
Other (incl. co-operatives)	762	4	3
Could not be determined			15
Total	18,428	100	100

Source: SALAR 2005, *Seniorbostäder, En kartläggning 2005 (OAP Flats, a Survey)*.

Activities to create services and security

To the question whether there is service staff, such as a receptionist, expanded caretaker staff, care staff etc at the OAP flat who are not employees of the local authority, 54 local authorities said yes.[24]

Planning of more OAP flats

99 local authorities, or 38 percent, responded to SALAR's questionnaire in 2005 that they had plans to build or establish new OAP flats. The total was 3,500 planned OAP flats nationwide.[25]

The National Housing Board's 2006 market survey confirms that increasing numbers of local authorities – a total of 147 – have built or are planning to build more OAP flats. About a hundred local authorities are planning new production of OAP flats and thirty or so are planning renovations. New production in 2004–2005 gave over 4,000 new OAP flats.

[23] SALAR 2005, Seniorbostäder, *En kartläggning 2005 (OAP Flats, a Survey)*
[24] SALAR 2005, Seniorbostäder, *En kartläggning 2005 (OAP Flats, a Survey)*
[25] SALAR 2005, Seniorbostäder, *En kartläggning 2005 (OAP Flats, a Survey)*

According to the housing market survey, a total of 7,165 new OAP flats are planned for 2006–2007, as follows:

New production	58 percent
Remodelling	14 percent
Conversion of services flats	28 percent

The housing market survey shows that more and more public utility housing companies are remodelling or adding on to meet the need. Nearly six of ten projects are owned by public utility housing companies.[26]

Support for the elderly in regular housing

The local authorities offer many kinds of support to elderly people who still live in regular housing. This includes meals on wheels, home adaptations, transportation service, security alarms, help with simple practical tasks, technical devices, home help and home medical services.

Meals on wheels

How many receive meals on wheels

Nearly all local authorities offer deliveries of cooked meals to the elderly and disabled in regular housing, according to a survey by SALAR in spring 2006. Of the 281 local authorities that responded to the survey, 276 offer meals on wheels. Only five local authorities said no. In spring 2006, 57,300 people received meals on wheels, a slight decrease compared with a survey in 2004. 97 percent of respondents make formal decisions about food distribution. A little less than half of the local authorities have established political guidelines for meals on wheels.[27]

Preparation, distribution and joint production

189 local authorities prepare 100 percent of the food in publicly owned kitchens, while 51 local authorities have contracts with private companies to prepare 100 percent of the food. The rest of the local authorities use a mix of both systems. About half of the local authorities state that they have joint production with schools, the child care system or other system. Just over half of the local authorities distribute meals via home help staff, while 43 use solely a specific distributor. The rest have variations of these two.[28]

[26] National Housing Administration 2006, *Bostadsmarknaden år 2006–2007 – Slutsatser av Bostadsmarknadsenkäten 2006 (The Housing Market in 2006–2007 – Conclusions of the Housing Market Survey 2006)*

[27] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*

[28] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*

Hot or cold food?
132 local authorities distribute only hot food to the elderly, while 99 only distribute food that must be heated. The rest have a combination of hot and cold food.[29]

How often is the food distributed?
More than half of the local authorities (167) distribute food daily and a total of 201 distribute food more often than once a week. In addition there are many variations and combinations.[30]

Common meals
Nearly half of the local authorities (143) arrange common meals in connection with day activities/day centres; however, only four organise/offer meals in smaller groups. Company at mealtimes is offered in just over 200 local authorities, but most state that such offers occur only after a special needs assessment. Thirty-eight replied that they offer this when staff is available, while three always offer company.[31]

Home adaptations
The local authorities provide grants for certain measures needed for the disabled to use their homes efficiently. 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.

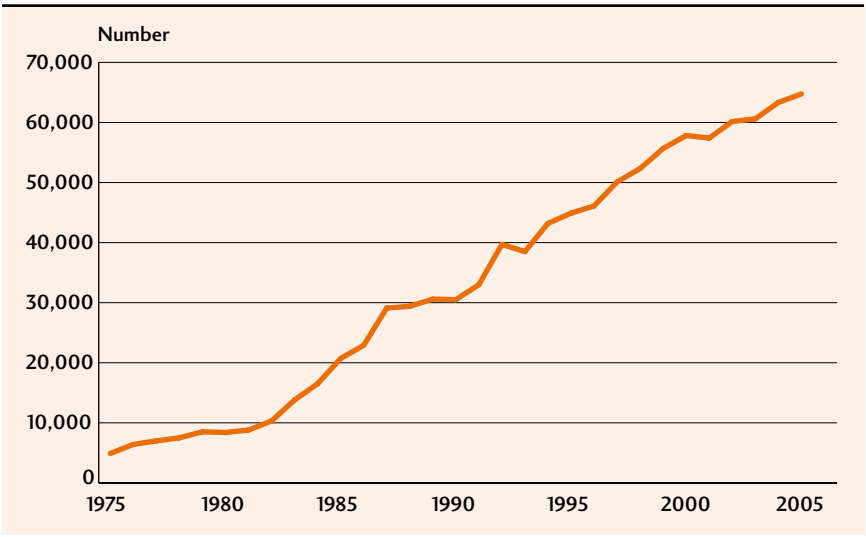
The number of approved grants increased from 63,300 in 2004 to 64,700 in 2005. The total cost to the local authorities has risen from SEK 835 million in 2004 to SEK 857 million in 2005.

In 2005, the local authorities granted an average of seven housing adaptation grants per thousand residents, the same figure as the previous year. The average cost per resident in each local authority averaged SEK 98, an increase from 2004, when the amount was SEK 96.

Most of the home-adaptation grants were small: about 61 percent are under SEK 5,000, and about 84 percent are under SEK 20,000. The average cost per case amounted to about SEK 13,200 in 2005. Adaptations to houses are more expensive than those in blocks of flats. The average for houses in 2005 was SEK 19,000 and for blocks of flats SEK 9,300.[32]

[29] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*
[30] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*
[31] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*
[32] National Housing Board 2006

Figure 4 Grants approved per year 1975–2005



Source: National Housing Board 2006

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 percent of the population. The number of people granted transportation services dropped from 1994–2004, from 50 to 41 per 1,000 people. One reason for this is that public transport has become more accessible and adapted to people with disabilities. Of those who are entitled to transportation services, 19 percent are under age 65, 25 percent are aged 65–79 and 56 percent are aged 80 and older. Of those who were entitled to transportation services in 2004, 67 percent were women.

A total of 12,328,600 one-way trips were made with transportation services in 2004. On average, each person entitled to transportation services makes 33 trips per year, which is slightly less than in 2003.[33]

Expenditures for transportation services in 2004 amounted to SEK 2.5 billion including the Stockholm County Council, which handles the transportation services for the entire county. In some counties, the county transport authority is also in charge of transportation service. Transportation service's income from individual fees amounts to SEK 178 million.[34]

Users who must travel outside the range of the local transportation services can be approved for national transportation assistance. The local

[33] SIKA (2005), *Färdtjänst och riksfärdtjänst 2004 (Transportation Service and National Transportation Assistance 2004)*
[34] Statistics Sweden 2005

authorities grant approval and provide funding for expenditures 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 percent were under age 65, 23 percent were aged 65–79 and 36 percent were over age 80.[35]

Personal safety alarms

Elderly and disabled people can obtain personal safety alarms. In the spring of 2006, a total of 157,169 people had personal safety alarms in the 274 local authorities that responded to this question in the SALAR survey of spring 2006. The corresponding question was asked in 2004, when the local authorities responded that 131,000 people had personal safety alarms. The response frequency was somewhat lower that time, so the figures are not completely comparable, but they do indicate an increase since 2004. Of the 276 local authorities that responded to the question, 249 make formal aid decisions for each alarm, while 26 state that they do not make such decisions.[36]

Home help

Elderly people who are unable to manage activities of daily living 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 such support and help in the home. 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, 135,000 people aged 65 and older had been granted home help as of 1 October 2005, or 8.6 percent of the population in this age range. Of these, 73 percent were aged 80 and older and 70 percent were women. The number of people aged 65 and older with home help services has increased by two percent since last year and by seven percent since 1998. The proportion of people granted home help has increased primarily among the oldest group, aged 80 and older, an increase of 16 percent since 1998. Among the younger elderly, the proportion has decreased.[37]

[35] SIKA (2005), *Färdtjänst och riksfärdtjänst 2004 (Transportation Service and National Transportation Assistance 2004)*

[36] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc)*

[37] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005, official Swedish statistics; National Board of Health and Welfare 2000, Äldre – vård och omsorg år 1999*, official Swedish statistics

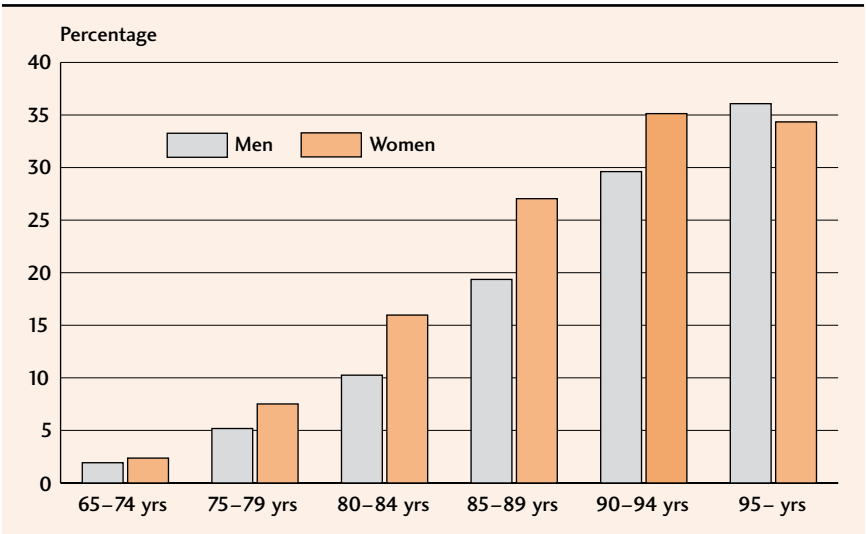
A greater proportion of women than men aged 65 and older received home help, 10.6 percent of women and 6 percent of men. The situation is the reverse in the oldest age group: of those aged 95 and older, 36 percent of the men and 34 percent of the women received home help.[38]

Table 12 Number and percentage with home help in regular housing

	1998		2004		2005	
Age	Number	Percent	Number	Percent	Number	Percent
65–74	18,500	2.4	16,800	2.2	16,600	2.2
75–79	23,300	6.7	20,200	6.4	20,300	6.5
80–84	33,100	14.1	36,300	13.7	35,500	13.7
85–	51,100	25.8	59,000	27.3	62,600	27.5
65–	126,000	8.2	132,300	8.5	135,000	8.6
65–79	41,800	3.8	37,000	3.5	36,900	3.4
80–	84,200	19.5	95,300	19.8	98,100	20.1

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

Figure 5 Percentage of the population in regular housing who had been granted home help as of 1 October 2005



Source: National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

The number of home help hours has increased successively since 2000. In 2005, a total of 4,130,600 home help hours were granted, an increase of three percent since the previous year and 15 percent since 2000. In the 21st

[38] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

century, the number of granted home help hours has increased more than the number of elderly people receiving home help services. This means that those receiving home help are receiving more hours per person than they were five years ago.[39]

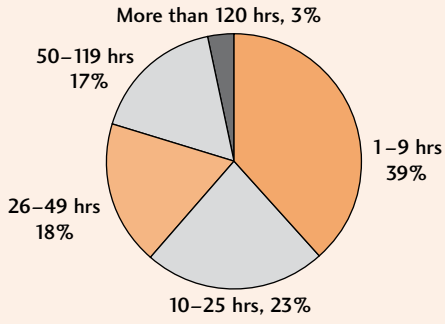
Table 13 Absolute and percentual change of the number of granted/ estimated home help hours in October 2000-2005. Rounded figures

Year	Number of approved home help hours in October
2000	3,592,200
2001	3,617,500
2002	3,818,400
2003	3,812,700
2004	4,019,700
2005	4,130,600
Change 2000–2005	+ 15 percent

Source: National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, page 18

In 2005, 38 percent of everyone aged 65 and older had been granted 1–9 hours of home help per month, 23 percent had been granted 10–25 hours and 3 percent had been granted more than 120 hours. This is approximately the same proportion as the previous year.[40]

Figure 6 People aged 65 and older with home help, per number of hours in 2005



Source: National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

[39] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics; National Board of Health and Welfare 2001, *Äldre – vård och omsorg år 2000*, official Swedish statistics

[40] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

Short-term housing

Short-term housing/short-term care is a complement to home help services, an intermediate stage between regular housing, special housing and medical care, which allows people to remain in their own homes longer. Short-term care and short-term housing are temporary accommodation, often in or connected to special housing. Short-term housing and short-term care are used for rehabilitation, nursing after a hospital stay, home-hospital care and relief of family members (usually a spouse who is an informal care provider).

In October 2005, 247,300 residential days in short-term care/short-term housing were registered, an increase of 19,600 days or nine percent since October 2004. The number of people in short-term care/housing on 1 October 2005 was 8,700 people aged 65 and older. This is a reduction of about 400 people compared with 2004.[41]

Table 14 Number of registered residential days in 1999, 2003, 2004 and 2005

	1999	2003	2004	2005
Bed-days	191,400	221,100	227,700	247,300

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

Day activities

Home help can also be complemented with day activities, which make it easy for elderly people to keep living in regular housing. Day activities can also be provided as a supplement to special housing, but this is less common. It is also common that daily activities are integrated into the other activities in special housing.

Day activities are primarily intended for elderly and disabled people with dementia disorders and mental impairment. They are also open to people who for other reasons need activation and rehabilitation. As of 1 October 2005, about 11,100 people aged 65 and older and living in regular housing had been granted day activities. At the same time, 1,100 people in special housing were entitled to day activities. About 64 percent 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.[42]

[41] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics; National Board of Health and Welfare 2005, *Äldre – vård och omsorg år 2004*, official Swedish statistics

[42] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics; National Board of Health and Welfare 2005, *Äldre – vård och omsorg år 2004*, official Swedish statistics

Table 15 Number of people aged 65 and older who were approved day activities as of 1 October between 1999 and 2005

Year	Elderly people in regular housing	Elderly people in special housing	Total
1999	10,500	3,000	13,500
2000	11,700	3,800	15,500
2001	10,200	4,100	14,300
2002	10,400	2,600	13,000
2003	10,600	2,100	12,700
2004	11,000	1,500	12,500
2005	11,100	1,100	12,200

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

Special housing

According to the Social Services Act, the local authorities must establish special types of housing for service and nursing of elderly people who need particular support. In special housing, most residents have their own rental contracts today. The local authority determines what housing constitutes special housing. These residences are allocated by the local authority according to the assessment of the need for aid. The local authorities are responsible for healthcare interventions up to the level of registered nurse, but not for doctor interventions. People living in special housing have staff available 24 hours a day.

The need for special housing depends in part on how much support home help and home medical services can provide in regular housing, how the home is designed and the availability of short-term care, short-term housing and day activities in the community.

Elderly people in special housing

On 1 October 2005, 100,400 people aged 65 and older lived permanently in special housing. That corresponds to 6.5 percent of all people aged 65 and older. In comparison with 2004, the number of people living in special housing has decreased by 4,400 people, or four percent. The decrease has occurred in all age groups.[43]

[43] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

Table 16 Number and percentage of elderly living in special housing

	1998		2004		2005	
Age	Number	Percent	Number	Percent	Number	Percent
65–74	10,900	1.4	8,700	1.2	8,300	1.1
75–79	17,000	4.9	12,800	4.1	11,700	3.7
80–84	27,900	11.9	24,900	9.4	23,000	8.9
85–	62,900	31.7	58,400	27.0	57,400	25.2
65–	118,700	7.7	104,800	6.7	100,400	6.4
65–79	27,900	2.5	21,500	2.0	20,000	1.8
80–	90,800	21.0	83,300	17.3	80,400	16.5

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

The number of elderly living in a room with no cooking facilities, toilet or shower/bath has decreased, as has the number who share their home with someone other than a spouse, partner or other close family member. The number of people living in 1–1.5 room with cooking facilities, toilet and shower/bath has increased.

Of those who lived in special types of housing on 1 October 2005, 80 percent were aged 80 and older and 70 percent were women. A greater proportion of women aged 65 and older lived in special housing – eight percent, while the figure for men was four percent. However, in the youngest age group, the proportion of men living in special types of housing was somewhat higher than the proportion of women.[44]

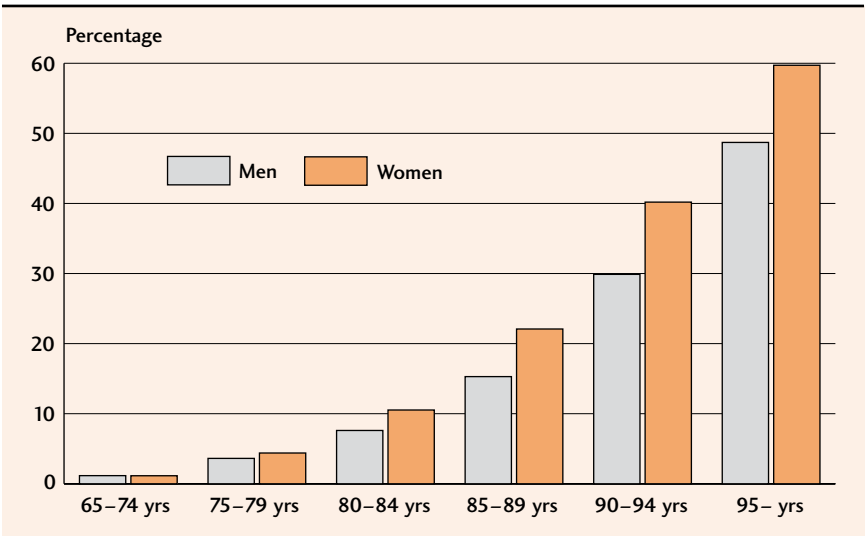
Table 17 Number of people living in special housing on 1 October 2003, 2004 and 2005, by type of housing

		Of which in						
	Total number of residents aged 65 and older	Multiple-bed room	1 room, no cooking, toilet or shower/bath	1 room, no cooking, with toilet, shower/bath	1–1.5 room, with cooking, toilet, shower/bath	2 rooms, with cooking, toilet, shower/bath	3 rooms or more, with cooking, toilet, shower/bath	Other type of housing
2003	110,900	3,300	6,900	19,200	53,900	21,500	1,400	4,800
2004	104,800	2,700	5,600	18,700	53,100	19,100	1,100	3,000
2005	100,400	1,800	5,000	18,000	54,200	17,200	1,000	3,200

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

[44] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

Figure 7 Percentage of the population permanently living in special housing as of 1 October 2005



Source: National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*, official Swedish statistics

New regulations and special delegation on housing for elderly

As of 1 July 2006, the local authorities are required to report to the county administrative board, local authority auditors and the city council all grant decisions under the Social Services Act that are not carried out within three months after the decision. The first time such decisions must be reported to the county administrative board is 1 October. On 1 July, new regulations were introduced for fines under the Social Services Act for grants that are not carried out within a reasonable time.

On 1 June 2006, a change was made in the Social Services Ordinance (2001:937) that spouses, cohabitants and registered partners who both need special housing shall be offered spaces in the same facility if they wish.

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 be treated and 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.

The Ädel reform in 1992 gave the local authorities responsibility for healthcare in special housing and day centres, but not for doctor interventions, which remain under the county councils. In addition, the county councils are responsible for providing home medical services, but can transfer this responsibility to the local authorities if this is agreed on. In 2005, half of Sweden's 290 local authorities (145) were responsible for home health services in regular housing.

Incentives for developing care of elderly people with extensive, complex needs for care

The spring 2006 financial proposition set aside SEK 600 million to local authorities and county councils to improve medical and social services to elderly people with extensive, complex needs for care. The funds have been applied for and allocated to the local authorities (70 percent) and the county councils (30 percent) to improve rehabilitation, food and nutrition and drug assessments, and reinforce doctor participation in both home health services and in special housing.

Scope and costs of the local authorities' home medical services

As a step towards improving the ability to monitor trends in community healthcare, SALAR, in collaboration with the Association of Local Authorities in the County of Jämtland and eight communities in Jämtland and Värmland provinces, has pursued a project on the scope and costs of community health and medical services.

The goal of the project was to develop a method of measuring the scope and costs of home medical services in the local authorities, with the idea that it could be used by other local authorities. The project did not deal with the results and quality of home medical services. The definition that the project used is that home health services are healthcare interventions provided to individuals under the Act on Health Services in their homes or a place where the patient is staying. For information on method and calculations, please refer to the project report, *Vad kostar hemsjukvården i kommunerna? (What do home medical services cost the local authorities?)*.[45]

The results show that home medical services are a major element of short-term care/housing, where 28 percent of working hours consist of home medical services. These measurements also show that a much larger proportion of working hours is spent on home medical services in regular housing – 26 percent – than in special housing, where the corresponding figure was 18 percent.

[45] SALAR 2006, *Vad kostar hemsjukvården i kommunerna? (What do home medical services cost the local authorities?)*

Table 18 The scope and costs of home medical services in the local authorities on average for Jämtland and Värmland in 2002

Activity	Percentage of FTE	Cost per resident, SEK	Cost per user, SEK
Regular housing	26	1,080	59,800
Special housing	18	1,010	67,900
LSS housing	7	120	40,700
Short-term care/housing	28	190	152,500[46]
Day activities	6	25	-
Total	19	2,400	-

Source: SALAR 2006, *Vad kostar hemsjukvården i kommunerna? (What do home medical services cost the local authorities?)* Page 6

The total cost of home medical services in regular housing is higher, SEK 1,080 per resident; in special housing the figure is SEK 1,010 per resident. However, the cost of home medical services per user is higher in special housing than in regular housing, SEK 67,900 compared to SEK 59,800. The staff uses more of its time on home medical services in regular housing and provides home medical services to more users. The cost for each user receiving home medical services in regular housing is therefore lower than in special housing, which has a high staff–user ratio and where each user receives more home medical services. These calculations show that 22 percent of expenditures for care of the elderly consists of costs for home medical services.

There are relatively large differences between the local authorities' expenditures for home medical services, with a variation between SEK 7,000 at the lowest to SEK 17,300 at the highest for residents aged 65 and older.[47]

Dementia care

Most people needing round-the-clock support have some kind of dementia disorder. The number of people with dementia was calculated by the Dementia Inquiry in 2003:

Table 19 The number of dementia patients in Sweden in 2003 and 2010 (forecast)

	2003	2010
People with dementia	139,000	150,000
aged under 65	8,700	9,700
mild dementia	41,000	44,000
moderate dementia	66,000	72,000
severe dementia	32,000	34,000

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

[46] Cost per bed
[47] SALAR 2006, *Vad kostar hemsjukvården i kommunerna? (What do home medical services cost the local authorities?)*

Age is the single most important cause of dementia disorders, according to the Swedish Council on Technology Assessment in Healthcare, SBU, in its 2006 report on Dementia Disorders. To put it simply, about eight percent of people aged 65 and older, and over 50 percent at age 90 and older, suffer from a dementia disorder. The report points out that about half of the people with a diagnosed dementia disorder are believed to live in special housing.

Expenditures for dementia care in Sweden are estimated to amount to about SEK 40 billion, including nursing interventions performed by the family members. The local authorities provide over 80 percent of this funding.[48]

In 2005, a national breakthrough project called Better Dementia Care was initiated by the Swedish Ministry of Health and Social Affairs, the Federation of Swedish County Councils and the Swedish Association of Local Authorities. Since then, several local and regional projects have been under way. The Ministry of Health and Social Affairs is now working to create national guidelines for dementia care, expected to be completed in 2007/2008.

Assistive devices

The responsible authorities for healthcare – 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 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 the 145 communities where the local authority has taken over home medical services. The responsible authorities for healthcare determine what constitutes an assistive device, so the range varies. Many local authorities and county councils do not provide simple assistive devices – mainly household aids – which must be bought from the county councils' technological aid centres or commercially.

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:

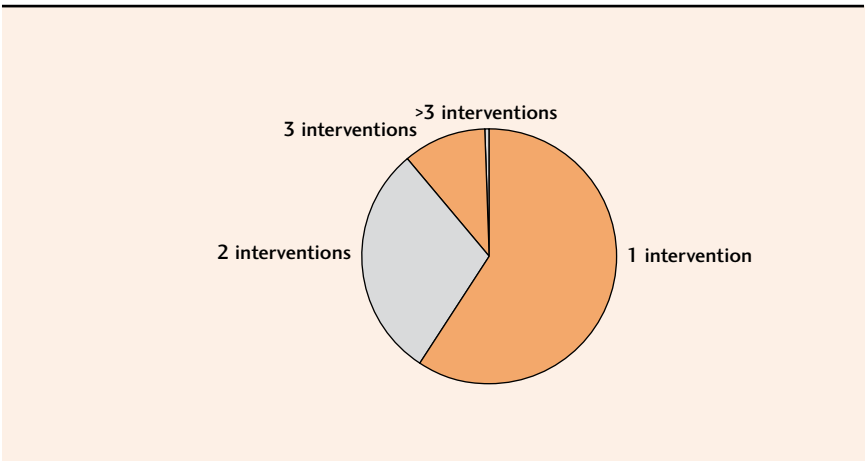
- People with learning disabilities, people with autism or autism-like conditions (group 1).

[48] SBU 2006, *Demenssjukdomar (Dementia Disorders)*

- People with significant, permanent intellectual impairments or brain damage caused by physical trauma or disease in adulthood (group 2).
- 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 2005, about 3,900 people aged 65 and older had been granted aid under the LSS act, or 0.25 percent of the population in this age group. The number of elderly people granted aid under LSS has increased by about 3 percent since last year. Support under LSS is somewhat more common among men than women. Of all elderly men, 0.28 percent received aid under LSS in 2005, compared with 0.22 percent of women. In total some 6,700 interventions were recorded for people aged 65 and older, about 6 percent of all recorded interventions. Of those who were aged 65 and older, 60 percent received only one intervention under LSS.[49]

Figure 8 People aged 65 and older grouped by the number of interventions as of 1 October 2005



Source: National Board of Health and Welfare 2006, *Funktionshindrade personer – insatser enligt LSS år 2005 (Functionally Impaired People – Interventions under LSS in 2004)*, page 18

The most common interventions among people aged 65 and over in 2005 were a home with special service, contact person, daily activities and escort service.

[49] National Board of Health and Welfare 2006, *Funktionshindrade personer – insatser enligt LSS år 2005*, Official Swedish statistics

Table 20 Number of people aged 65 and older with decisions on LSS interventions in 1999, 2004 and 2005*

LSS intervention	1999	2004	2005
Personal assistant	49	236	286
Escort service	741	918	924
Contact person	1,016	1,296	1,373
Relief service	54	59	52
Short-term stay	63	64	54
Housing, adults	1,853	2,238	2,256
Day activities	944	914	930

* Note that the same person can be granted multiple interventions

Source: National Board of Health and Welfare 2006, *Funktionshindrade personer – insatser enligt LSS* for the years 2005 and 2004; 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)*.

Community support for family and loved ones

Support to family members

Since the end of the 1990s, a large amount of the national development funds have regularly gone to helping family members of elderly people with dementia. In 1999–2001, SEK 300 million were allocated to stimulate the development of support to family members, called the Anhörig300 intervention. The National Development Plan for healthcare (2001–2004) also highlighted family members, and in 2005 the government decided to contribute another SEK 25 million over three years (2005–2007). At the end of 2005, the government took another initiative for family members by deciding to allocate another SEK 100 million. This new support also covers means for organisations for family members and OAPs and for a national centre for excellence regarding problems faced by family members of dementia patients.

Since 2005, the county administrative board annually allocates development funds for family members, to be monitored by the National Board of Health and Welfare. In its report *Kommunernas anhörigstöd, Utvecklingsläget 2005 (Local authority support to family members, Development Status 2005)*, the National Board of Health and Welfare provides a national picture of support to family members in 2005. Seventy-eight percent of the nation's local authorities pursued development work, an increase in comparison with 2004. All local authorities offered short-term care/housing as relief to the family members, and over 90 percent also offered relief in the home or day care/day activity as relief. The number of family support centres

– meeting places for family members – had increased since 2004 and were available in 40 percent of the local authorities. Family support circles/groups were offered in 76 percent of local authorities. Nearly 90 percent had family support meetings in special housing and over 90 percent offered family members the opportunity to participate in planning/follow-up meetings on their family member. The most common partners are OAP organisations, the Red Cross and religious associations. Collaboration with the county councils' healthcare also occurs.[50]

In 2005, the county administrative boards received 212 applications and paid out SEK 22.5 million, which means that one in four local authorities/districts did not receive this support. The application procedure was considered far too complicated in relation to the amount that could be sought.[51] The last application day for the SEK 114 million that can be sought for 2007 was 1 September 2006. More or less all local authorities have applied for development funds to expand their collaboration with volunteer organisations and the county councils' healthcare, and to further develop methods for relieving family members, such as temporary rest homes, respite care, relief teams, telephone hotlines, IT-based family support, meeting places for family members, preventive care offers, training of staff and family members, visits, improved information and more.

Community care or informal care in the EU

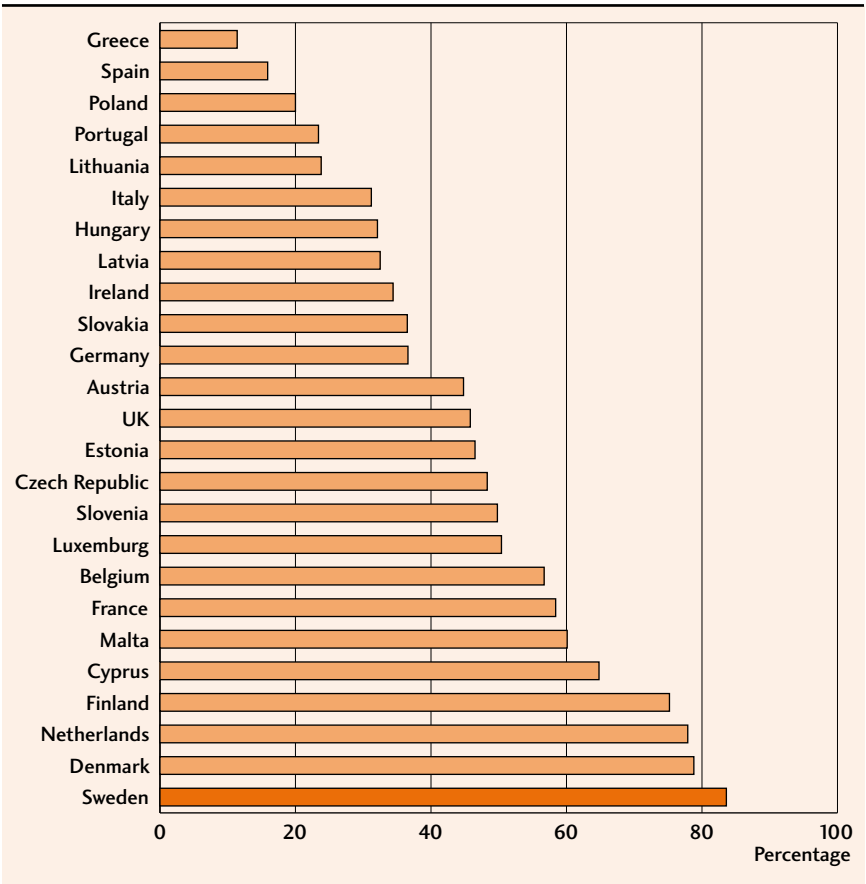
Most EU citizens agree that home help services are a better alternative for elderly citizens than special housing; however, opinions differ widely as to who should be responsible for the nursing needs of elderly people. The degree of publicly funded medical and social services differs widely within the EU. Over 80 percent of Swedes feel that society should be responsible for the elderly population, through home help and special housing. In Poland, Spain and Greece, the reverse is true: 80 percent or more prefer informal care. In general informal care is most popular in southern Europe and in Catholic countries, while northern Europe prefers community solutions.[52]

A greater proportion of elderly people live in single households in northern Europe than in southern Europe. In Denmark and Sweden, over 60 percent of people aged 80 and older live alone, compared with just 30 percent in Spain and Portugal. In Spain, 30 percent of people aged 65 and

[50] National Board of Health and Welfare 2006, *Kommunernas anhörigstöd, Utvecklingsläget 2005* (Local authority support to family members, Development Status 2005)
[51] National Board of Health and Welfare 2006, *Kommunernas anhörigstöd, Utvecklingsläget 2005* (Local authority support to family members, Development Status 2005)
[52] European foundation for the improvement of living and working conditions 2004, *Health and care in an enlarged Europe*

older live in households with more than two family members, while the corresponding figure in Sweden is less than five percent.[53]

Figure 9 Percentage who prefer community solutions to informal care for their own parents



Source: European foundation for the improvement of living and working conditions 2004, *Health and care in an enlarged Europe*

[53] Eurostat 2005 *The social situation in the European Union*

Medical care for the elderly

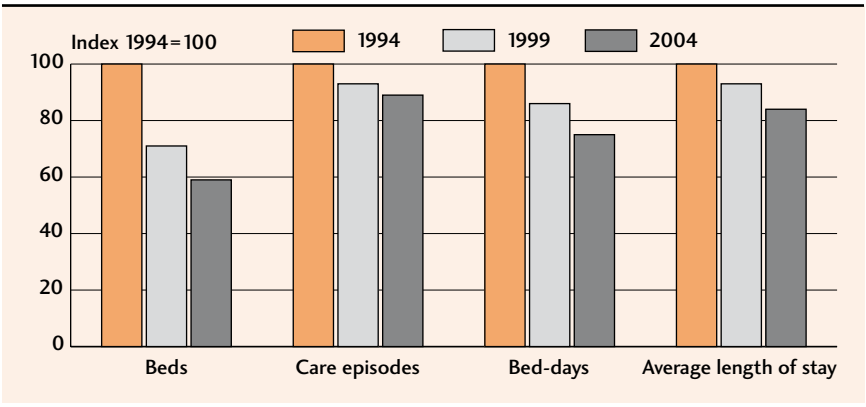
Medical advances and length of stay in inpatient care

Medical advances have improved the possibilities of treating various diseases and injuries even in older patients, which in turn entails increasing demands on and expectations of the healthcare system. To meet these increased demands the county councils have accelerated the flow in inpatient care, at the same time as a growing portion of medical care is provided outside hospitals. Rapid advances in medicine and the growing number of specialists have made these changes possible.

Over the past ten years the average length of stay for inpatient care has decreased, at the same time as more care is provided on an outpatient basis – through hospital-based clinics, primary care and home care, as well as within municipal medical and social services.

The number of inpatient care episodes for all age groups has declined by 10 percent and length of stay has decreased from an average of 7.0 days in 1994 to 5.9 days in 2004. Over the past ten years the number of beds has decreased by 40 percent and the number of bed-days by 25 percent, resulting in a 25 percent increase in utilisation. A summary of developments in inpatient care from 1994 to 2004 is presented below.[54]

Figure 10 Trend for number of beds, care episodes, bed-days and average length of stay, 1994–2004. Index 1994=100

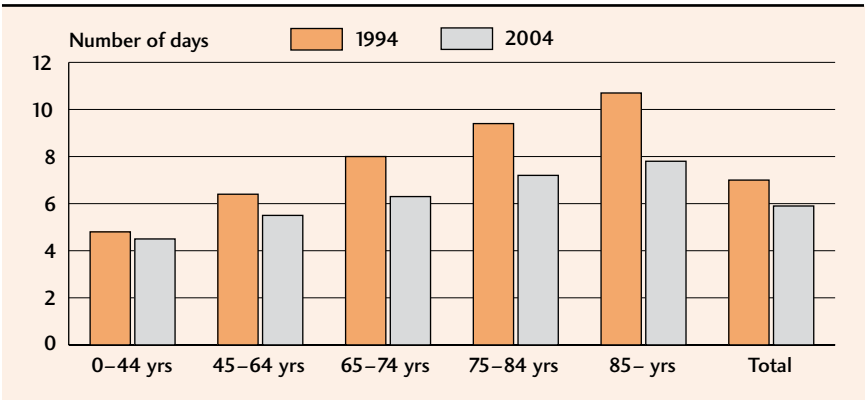


Source: The Swedish Association of Local Authorities and Regions (SALAR) 2006

[54] SALAR 2006

In the oldest age group (85 and up) hospitalisation decreased from 10.7 days in 1994 to 7.9 days in 2004, or by over 25 percent. The trend between 1994 and 2004 for various age groups can be seen in the following figure.

Figure 11 Average length of stay in different age groups 1994–2004



Source: SALAR 2006

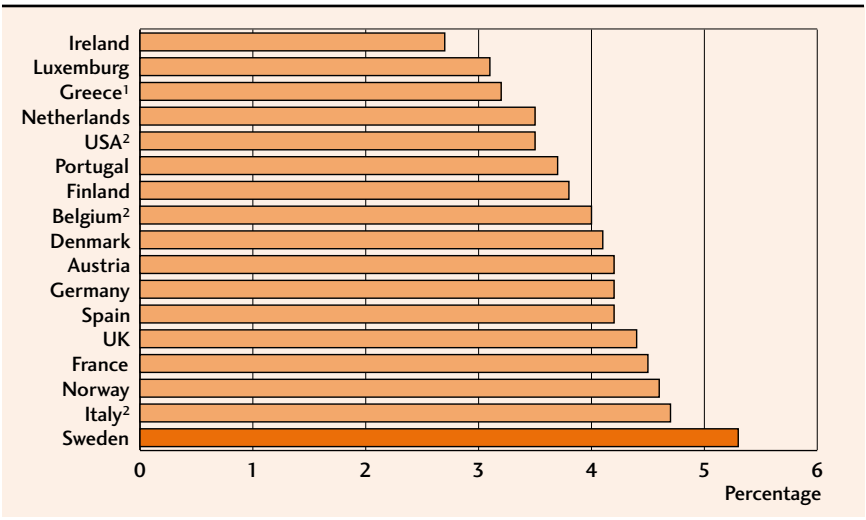
Structural changes have made it possible to provide care to increasingly older individuals. The demographic trend is important since care needs increase with rising age.

Sweden has the oldest population in the EU, with 5.3 percent of the population age 80 and older, as can be seen in figure 12. With rising age as an indicator of care needs, Swedish medical care has had to handle the largest care needs in the EU.

Medical and technological developments which make it possible to carry out procedures at higher ages amplify care needs, which are therefore increasing more than what the demographics indicate. This trend can clearly be seen in the statistics for hip replacement procedures in Sweden. Between 1994 and 2004, the number of people older than 85 increased by 24 percent at the same time as the number of hip replacement operations for this age group increased from 900 per year to 2,700 – in other words, by 200 percent. Compared with other EU countries, Sweden is in fourth place, as can be seen in figure 13.[55]

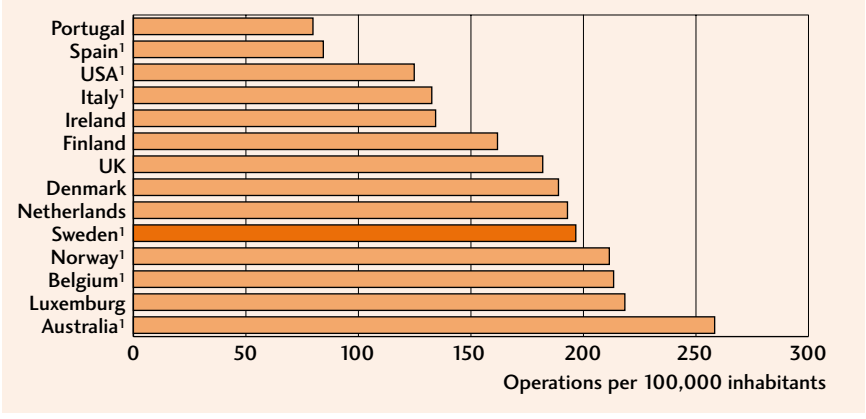
[55] OECD & SALAR 2006

Figure 12 Population age 80 and older as a percentage of total population in 2004



Source: OECD. [1]2002 [2]2003

Figure 13 Number of hip replacement operations per 100,000 inhabitants 2004



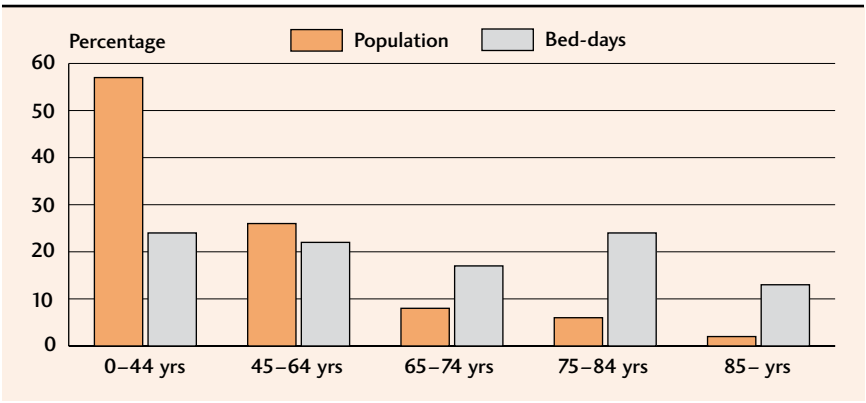
Source: OECD. [1]2003

Medical care utilisation by the elderly in inpatient care

Of all care episodes in 2004, 10 percent involve people over the age of 85 and 20 percent involve the 75 to 85 age group.

People over the age of 85 comprised 2.4 percent of the population and accounted for 13 percent of bed-days. The 75–84 age group comprised 6.4 percent of the population and used 25 percent of bed-days. The figure below shows the percentage of the population and care days in 2004 for various age groups.

Figure 14 Percentage of population and bed-days in 2004 for various age groups



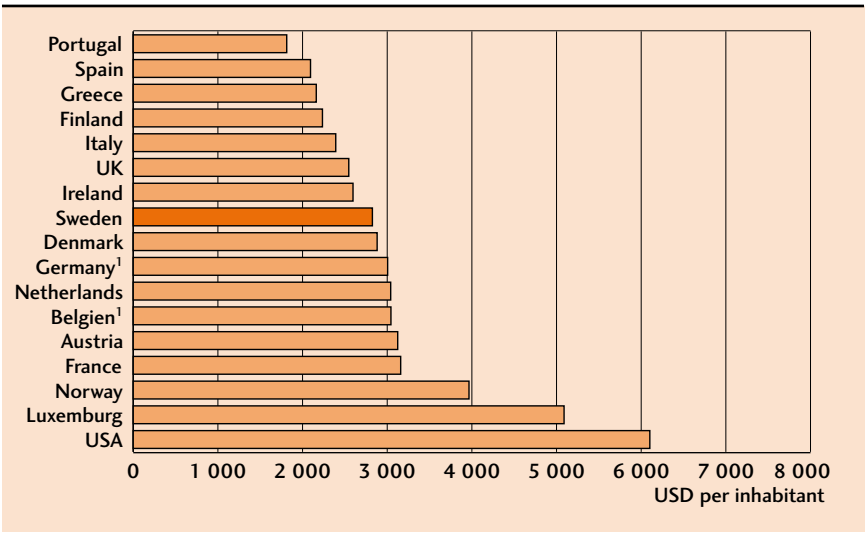
Source: SALAR 2006

Health care expenditures

The most common way to compare costs in international comparisons is to start with per capita expenditure and year, expressed in US dollars, while taking into account the purchasing power in each country. In this case the cost for 2004 in Sweden was USD 2,825. Healthcare costs were three times higher in the United States than in Spain and Portugal. Sweden is in the middle of the seventeen countries in this comparison of costs.

Among the Nordic countries, healthcare expenditures per inhabitant were highest in Norway (USD 3,966), followed by Denmark (USD 2,881) and then Sweden (USD 2,825). Expenditures in Finland were considerably lower (USD 2,235).

Figure 15 Healthcare expenditures per inhabitant, 2004. Purchasing power is taken into account. USD PPP



Source: OECD. [1]2003

Financing

County council taxes cover 70 percent of healthcare costs. Central government grants cover about 20 percent of the costs. Medical care for the elderly and people with disabilities provided in private or special housing is mainly financed by local authority taxes. Patient fees cover about 3 percent of the total cost of health care. Private insurance policies cover expenditures for less than 1 percent of the population and account for an estimated two per thousand of financing.[56]

Care guarantee

On 1 November 2005 the care guarantee in Sweden was expanded to include planned medical procedures. As a result, the care guarantee now covers all steps in the care chain as follows:

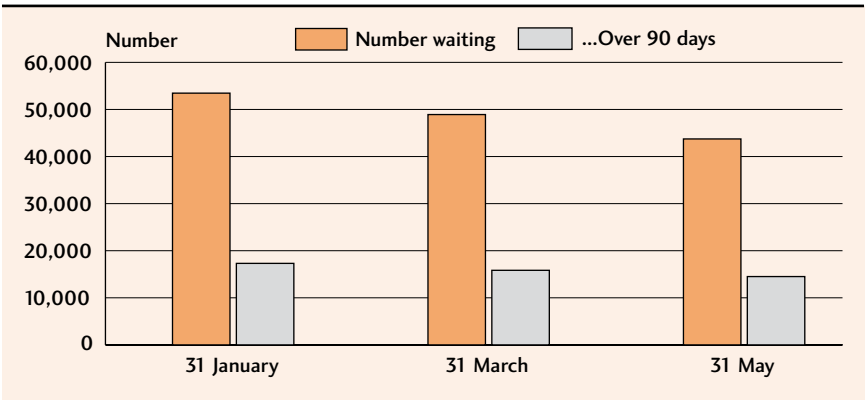
- Primary care offers same-day contact by telephone or in person.
- If a primary care doctor visit is needed, it should be possible to schedule this service within a maximum of seven days.
- After a decision to refer the patient to a specialist, it should be possible to schedule this visit in a maximum of 90 days.
- After a decision about treatment, it should be possible to schedule this treatment within a maximum of 90 days.

[56] SALAR 2006

- Visits and treatment may be scheduled beyond the limits of the guarantee time, provided that patient and doctor agree on this point.
- Work-ups and lab work, etc., are not covered by the guarantee.
- If a visit or treatment cannot be scheduled within the time limit, the patient shall be offered care within the guarantee period with another care provider. The home county council shall help the patient to arrange such care, at no extra cost to the patient.

Implementation of the expanded care guarantee has reduced waiting times for planned healthcare services, as can be seen in the following diagram:

Figure 16 Total patients waiting for treatment, as well as total who waited longer than 90 days as at 31 Jan, 31 March and 31 May 2006 (all county councils/regions)



Source: SALAR 2006, Care guarantee 05

The waiting time varies among clinics and among county councils/regions – and therefore also for the individual patient.[57]

Development of community care system

Currently there is a need to develop new strategies and solutions for medical care in local authorities and county councils. The increasing number of older people is one reason, along with the continued advances in medicine and technology. Other reasons include the changed expectations and values in the population and current problems in the form of inadequacies in accessibility to medical care and inadequate coordination of interventions for the elderly who are most ill. In order for the local health care system to work for the entire population and for different groups and individual citizens, collaboration between primary care, care of the elderly and hospital care needs to be developed and improved.

[57] SALAR 2006, Care guarantee 05

The entire country is in the process of developing community health services and community care services. Community care involves collaboration between county council and local authority activities. Local developments vary, depending on local conditions. Community care is mainly a function and an approach, in which care is based on the needs of the population and the individual. Priority will be given to care for the neediest groups, such as children, elderly who are most ill, terminal care and individuals with mental impairments and chronic illness.

In practice Community Care involves creating meeting places on various levels. New solutions can be found for problems through development and change processes. Shared activities are also being initiated in fields such as rehabilitation and interim care housing (such as in psychiatry and rehabilitation for the elderly). New entry points are being added to the healthcare system, making it easier to get in touch, along with activities aimed at promoting health and preventing illness.

Various forms of community health services are now available in 80 percent of the country. This long-term initiative should be viewed as an ongoing development process.[58]

Use of medications by the elderly

Incorrect use of medications leads to ill health in the individual and increased costs for society, as can be seen in a SALAR project description for a drug project. It is also well known that the elderly are more sensitive to drugs and that they suffer from side effects more often than younger individuals. Medical drug side effects cause up to 20 percent of all hospital admissions involving the elderly.

Number of medications taken by the elderly

The new drug database at the Centre for Epidemiology (EpC) of the National Board of Health and Welfare shows drugs released by the pharmacy at the individual level. During the second half of 2005, 10 percent of men and 13.5 percent of women in the 65–74 age group picked up over 10 different medications each. In the 75-and-up age group, at least 20 percent of men and 25 percent of women picked up more than 10 medications per person. The highest use is in Uppsala and Västerbotten and the lowest in Dalarna and Örebro. Over 25 percent of Sweden's elderly population take hypnotics or sedatives.[59]

A survey that the National Board of Health and Welfare conducted in 2004 on the use of medications by the elderly showed an even more ex-

[58] SALAR 2006
[59] National Board of Health and Welfare 2006, *drug database, Centre for Epidemiology (EpC)*

tensive use of medications. The survey included 3,705 people aged< 65 and up *in special housing* in Jönköping. Healthcare consumers used *an average of 10 different medications per person.*

There were no major differences between people who lived in housing for patients with dementia and other senior housing. Of those who used the medications, 2.1 drugs were prescribed to be taken when needed. On average, men and women took the same number of medications. Four of five people used psychotropics and almost every third person took several such medications concurrently.[60]

Göteborg surveyed medication use among *the elderly in regular housing*. The survey included 4,823 people aged 65 and older. Those seniors used *an average of ten drugs per person*, in other words medication use proved to be equally as extensive among the elderly in regular housing in Göteborg as in special housing in Jönköping. However, the use of psychotropics was somewhat lower in regular housing, while the use of certain cardiovascular medications was somewhat higher.[61]

Medication costs

The following tables show medication costs. The reported costs refer to total costs (benefit + out of pocket) of prescribed medications.

Table 21 Cost per 1,000 inhabitants and day, 2005, SEK

	All	Men	Women
Age 65–74	14,600	14,700	14,300
75 and up	18,500	20,000	18,500
All ages	7,000	6,450	7,440

Source: Apoteket AB

Table 22 Total cost for 12 months, 2005, SEK

Age 65–74	4.1 billion
75 and up	5.4 billion
All ages	23 billion

Source: Apoteket AB

Project for improved use of medications

In 2006, SALAR carried out a project called "Improved use of medications for the elderly with extensive care needs". The goal of the project is to offer elders who need extensive care a good health-related quality of life and to achieve more cost-effective drug use. The project consists of several

[60] National Board of Health and Welfare 2005, *Medical and social services for the elderly, status report 2004*

[61] National Board of Health and Welfare 2005, *Medical and social services for the elderly, status report 2004*

activities, including a number of conferences aimed at county councils and local authorities for collaboration with respect to drug use by the elderly and a breakthrough project.

As part of this project, the Swedish Association of Local Authorities and Regions (SALAR) sent a survey to charge nurses (122) in a selection of Sweden's local authorities.

Preliminary survey results show that an estimated 50 percent of local authorities who received the questionnaire are conducting pharmaceutical reviews of special housing residents. The health care consumer participated in 15 percent of the reviews and relatives participated in eight percent. Thus, many local authorities are addressing issues related to seniors' medications. An extensive improvement project in this field is in progress throughout the country. Increased activity can be expected in 2007 because of the Government's focus on this field.[62]

Physical activity by prescription

In recent years the healthcare system has been using exercise as a preventive measure and as treatment. Physical activity by prescription is not just a recommendation to the patient to exercise, but a prescription for a special physical activity on a prescription form. A doctor subsequently follows up treatment outcome. Physical activity by prescription can be used for both prevention and treatment, as a sole treatment, or in combination with medication. Doctors prescribe physical activity to people of all ages. The national athletics organisations and the Swedish National Institute of Public Health collaborate extensively on education and skills requirements for adapting activities to the needs of the individual. Just about all county councils are working on the Physical Activity by Prescription project.

Terminal care

Medical care of the elderly and where they die has changed since implementation of the ÄDEL reform. For example, the number of people ready for discharge in hospital has decreased. At the same time the number of beds in hospitals has decreased by 40 percent over the past ten years. The change in medical care has entailed increased pressure on municipal care of the elderly, with increased demand for trained medical personnel. This can be seen in a recent study that the National Board of Health and Welfare conducted on where the elderly die – in hospital, in special housing or at home.

[62] SALAR 2006, *Preliminary results of charge nurse survey in a selection of Sweden's local authorities*

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". An estimated 45,000 more patients received home care in the late 1990s compared with what was common prior to the Ädel reform.

The report also shows that over half (about 63 percent) of people aged 65 and older have died outside the hospital since implementation of the Ädel reform in 1992, 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 percent) than women (34–38 percent) died in hospital. It is more common for the "younger elderly" to die in hospital, while the "older elderly" die at home.[63]

[63] National Board of Health and Welfare 2005, *Where do the elderly die – in hospital, special housing or at home?*

Individual providers of medical and social services

No major changes have occurred with respect to individual providers of medical and social services in care of the elderly over the past three years. From the late 1990s until 2003, 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 significantly between 2003 and 2005.

Table 23 shows trends in home help, special housing and short-term housing under the aegis of the local authorities and individual providers between 2000 and 2005. In 2005, the local authorities ran about 90 percent of care services for the elderly. About 13 percent of special housing was run privately in 2005 and 10 percent of the elderly received home help from individual providers. Corresponding figures for 2004 were 11 percent of special housing and 7 percent of home help.[64]

Table 23 Number of people aged 65 and older receiving care from local authorities and individual providers in 2000 and 2005

Operation	Local authorities		Indiv. providers		Total	
	2000	2005	2000	2005	2000	2005
Home help	112,400	121,800	8,600	13,200	121,000	135,000
Special housing	105,000	87,000	12,900	13,200	117,900	100,400 [65]
Short-term housing	7,500	8,000	900	600	8,400	8,700 [66]
Total	224,900	216,800	22,400	27,000	247,300	244,100

Source: National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2005*; National Board of Health and Welfare 2001, *Äldre – vård och omsorg år 2000*

[64] National Board of Health and Welfare 64, *Äldre – vård och omsorg år 2006*; National Board of Health and Welfare 2005, *Äldre – vård och omsorg år 2004*

[65] In special housing, another 199 people are provided beds in housing run by another local authority or county council. Rounded figures

[66] In short-term housing, another 86 people receive short-term housing in another local authority or county council. Rounded figures

Different forms of privately-run medical and social services

Contractors

The activity is most commonly carried out by an individual care provider in the form of a public limited company or foundation. Co-operative or non-profit associations also provide care. In 1994, 90 local authorities had individual providers of care of the elderly.[67] In late 2006 the SALAR will publish a draft for bid documents for procurement of care of the elderly.

Customer's choice

Several local authorities have 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. Customer's choice is available in care of the elderly both for home help and for special housing in certain local authorities.

SALAR conducted a survey of local authorities in spring 2006 in which we inquired how many local authorities had implemented customer's choice. Of the 281 local authorities that responded to the questionnaire, 24 local authorities *implemented* customer's choice for home help and eight local authorities for special housing. About half of the local authorities that implemented customer's choice are in Stockholm county. A total of 29 local authorities have responded that they *plan* to implement customer's choice in home help and eight local authorities plan to implement customer's choice in special housing.[68]

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.

Employee or user co-operatives are most common in care of the elderly. A number of non-profit associations also provide home help as a complement to the services provided by the local authorities. User co-operatives are mainly found in sparsely populated areas, while employee co-operatives are found nationwide and are usually small units. In 2002 Sweden had about 30 co-operative housing facilities for the elderly.[69] No major changes

[67] SALAR 2004, *Äldreomsorgens styrning (Management of care of the elderly 2004)*
[68] SALAR 2006, *Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc.)*
[69] SALA 2002, *Kooperativ äldreomsorg – en del i mångfalden (Co-operative care of the elderly – one of many alternatives)*

have occurred since then; a few have stopped and a few have been added. Currently there are between 30 and 40 co-operative housing facilities for the elderly.[70]

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 care of the elderly recipient.

In 2005, the local authorities purchased 199 beds in special housing and 67 cases of short-term care from other local authorities or county councils nationwide.[71]

[70] The Swedish Co-operative Institute 2006
[71] National Board of Health and Welfare 2006, *Äldre – vård och omsorg år 2006, official Swedish statistics*

Staff and Training

Number of employees

In November 2005[72] a total of 254,800 people (with a monthly salary) were employed in medical and social services in the local authorities, an increase of 500 from the previous year. However, compared with 1995, the number of employees has only increased by 33,000 or about 15 percent, a significantly greater increase than the total increase in employees in the local authorities, which is just over 5 percent. This calculation takes into account transfers between local authorities and county councils.

In the personnel statistics *employed* and *working* are two different concepts. The number of people *employed* also includes those who are on leave or on sick leave. The data on people who are *working* do not include these people. Of the total number of people *employed* in 2005, 35,400 were on some kind of leave – parental leave, sick leave or on a leave of absence to pursue studies – leaving 219,400 people who were *working*. In addition, 66,500 *hourly paid employees* worked in the sector.

Table 24 Number of people employed by the local authorities in different occupations. People with monthly salary, incl. those on leave. Rounded figures

Social services for the elderly and disabled	2005
Supervisors incl. home help inspectors	10,100
Assistant nurses, nurse's aides, medical attendants and mental health support workers	185,800
Nurses	12,200
Occupational therapists	2,700
Physiotherapists	1,400
Other nursing staff, incl. personal assistants	30,900
Other staff	11,700
Total	254,800

Source: SALAR 2006

The number of people *working* increased by 2,800 between 2004 and 2005. Compared with 1995, the number of people working increased by 23,000. Throughout the period 1995 to 2005, the number of people working in-

[72] SALAR's staff and payroll statistics are always measured on 1 November each year. For staff employed at an hourly rate, the figure shown is the number of people who receive pay in November

creased less than the number of employees, in part because absence due to sickness rose substantially between 1998 and 2000. In recent years the trend has reversed; the number of people working has increased more than the number of people employed because absence due to sickness has decreased over the past few years.[73]

Table 25 Number of people working for local authorities in various professional categories and staff turnover from 1995 to 2005. People with monthly salary, excluding those on leave. Rounded figures

		Change	
Social services for the elderly and disabled	2005	1995–2005	2004–2005
Supervisors incl. home help inspectors	9,300	*	400
Assistant nurses, nurse's aides etc	158,800	-600	900
Nurses	10,800	1,900	100
Occupational therapists	2,400	*	70
Physiotherapists	1,200	*	50
Other nursing staff, incl. personal assistants	26,400	18,500	1,400
Other staff	10,500	2,400	-200
Total	219,400	23,000	2,800

Source: SALAR 2006

* It is not possible to estimate the change for these groups since 1995.

Hiring

In 2005, the local authorities hired 19,200 new employees for medical and social services, about the same level as the 2004, but a sharp decline compared with the 1997 to 2003 period when between 25,000 and 30,000 employees were hired annually. The decrease in absence due to sickness is the most important explanation for this trend.

Of the assistant nurses and nurse's aides hired in 2005, 56 percent had nursing training and 34 percent had a different upper-secondary school background.[74]

Six of ten have nursing training

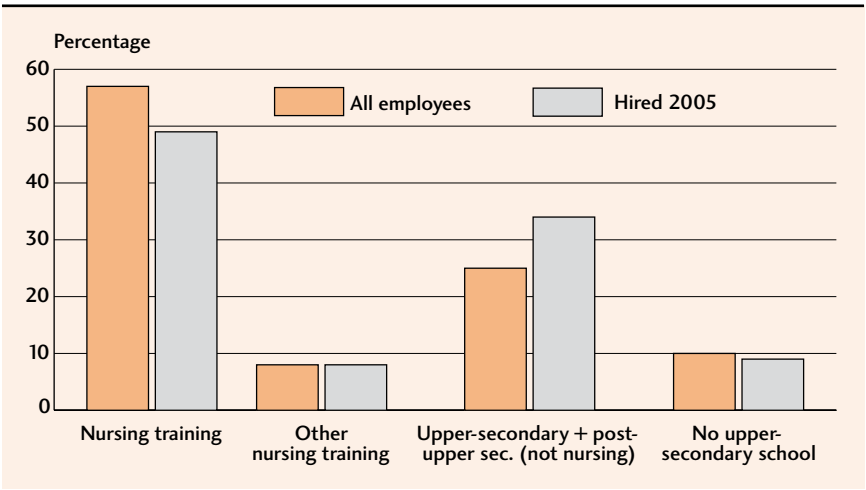
The staff have a good basic education on which they can build. Nine of ten assistant nurses and nurse's aides have upper-secondary education, and more than six of ten have nursing training.

Of the 12,600 assistant nurses and nurse's aides hired in 2005, 56 percent had nursing training, 29 percent had studied nursing subjects in adult education, 19 percent in upper-secondary school, and 8 percent had some

[73] SALAR 2006
[74] SALAR 2006

other nursing training. Of those who had no nursing training, 34 percent had other upper-secondary schooling and 9 percent had not attended upper-secondary school.

Figure 17 Educational focus of staff (salaried and on leave) and hired assistant nurses, nurse's aides and others in 2005



Source: SALAR and Statistics Sweden 2006

Many new hires are foreign-born

Over 20 percent of the approximately 19,000 new employees hired for community medical and welfare services in 2005 were born outside of Sweden. This percentage has doubled since 1995, when only 10 percent of new hires were born abroad. The increase has mainly consisted of staff born outside the Nordic countries and the EU. In 2005 15 percent of new hires belonged to this group. In 1995 that figure was just 5 percent.

Among the total number of employees in care of the elderly and disabled, the percentage of foreign-born people increased from just over 9 percent in 1995 to 13 percent in 2005. This growth mainly consisted of those born outside the Nordic countries and the EU, from just under 4 percent in 1995 to over 7 percent in 2005.[75]

Predominantly female professions

Over 90 percent of those working with care of the elderly and disabled are women, although the percentage of men has grown from 6 to 9 percent since 1995. Among permanent staff, the number of men doubled between 1995 and 2004 from 9,600 to 20,300.

[75] SALAR 2006

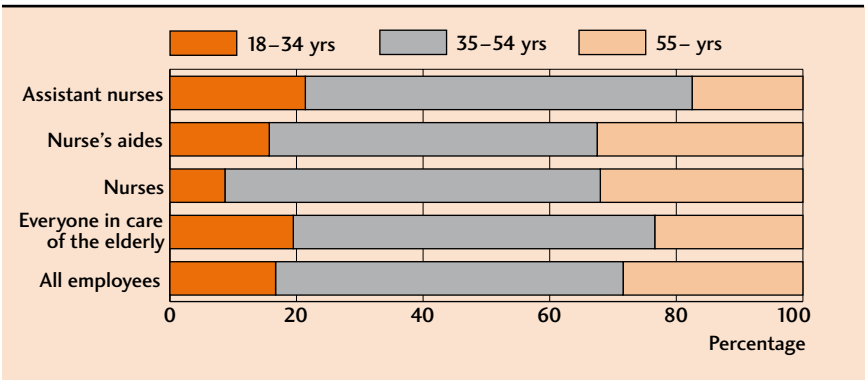
The percentage of men was higher among temporary fill-ins, 15 percent, than permanent employees, 9 percent. The largest concentration of men is among physiotherapists, personal assistants and supervisors.[76]

Age structure affects the need for hiring

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, 24 percent are aged 55 and older, which is lower than the figure for all local authority employees.

There are great variations among different professions. For example, 17 percent of assistant nurses are 55 and older, but this figure is 32 percent for nurse's aides. The percentage aged 55 and older is also high among nurses, 30 percent.

Figure 18 Age distribution of permanent staff in certain medical and social services in November 2005. Percentage



Source: SALAR 2006

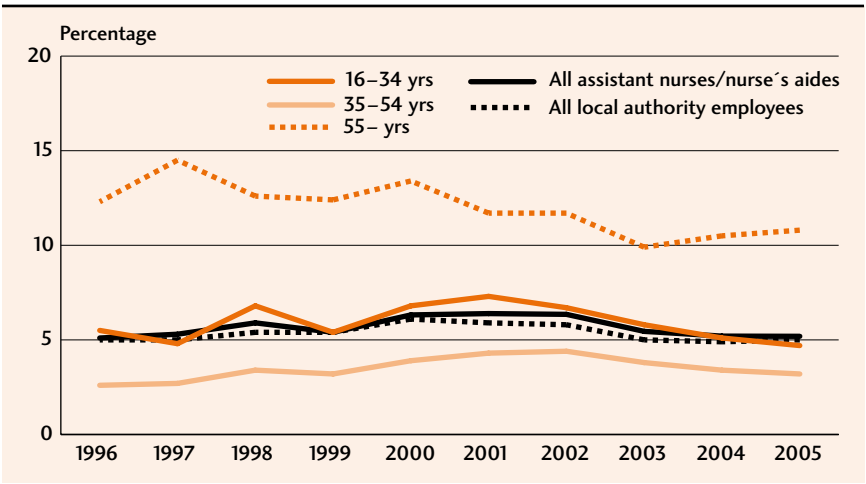
Staff turnover decreasing

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 5 percent. The corresponding figure for healthcare employees is 5.5 percent.

The percentage of *assistant nurses/nurse's aides* who leave their positions has stabilised at the 2004 level, which after the peak between 2000 and 2002 is a return to the situation in 1996 to 1997. The trend for both younger and middle-aged staff to leave is on the decline, while the leaving rate for the oldest is rising.

[76] SALAR 2006

Figure 19 Percentage of permanently employed assistant nurses/nurse's aides who left their positions between 1996 and 2005, by age

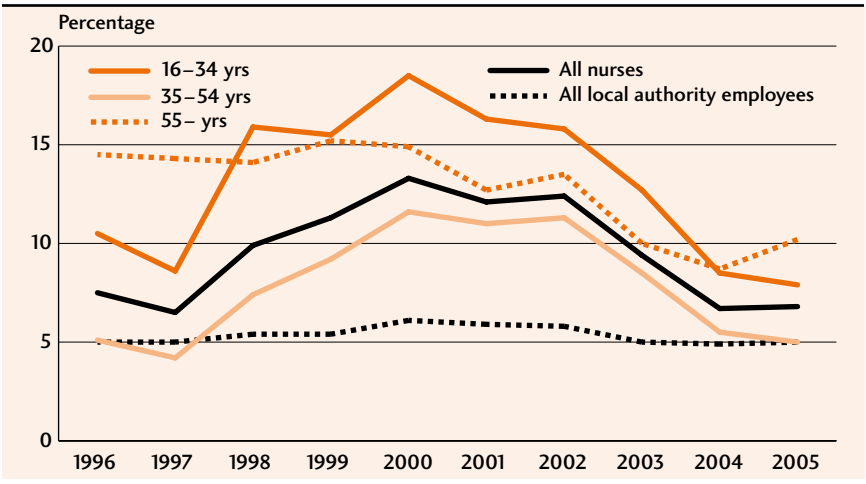


Source: SALAR 2006

Greatly reduced mobility among nurses

The job market for nurses has been good for several years. This favourable trend is reflected in the mobility figures, which have been far above average for local authority professions, especially between 1998 and 2002, though it has decreased substantially since then. A total of 6.8 percent of permanently employed nurses left their positions in 2005.

Figure 20 Percentage of permanently employed nurses who left their positions between 1996 and 2005, by age



Source: SALAR 2006

Leave and sick leave

Absenteeism continues to decrease

The percentage of employees who were completely absent – on parental leave, study leave or sick leave – decreased for the fourth year in a row in 2005. 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.

Absenteeism is higher in care of the elderly and disabled than in schools, childcare and other areas. In November 2005, 15 percent of permanently employed staff in medical and social services in the local authorities were completely absent for at least one month. The corresponding percentage in schools and childcare was 11.1 percent. Of all local authority employees, 11.8 percent were absent. This means that absenteeism varies per department, profession and age.

The percentage of *absent assistant nurses and nurse's aides* in 2005 was 15.5 percent, 1.2 percentage points lower than in 2004. Absence is particularly high among younger staff, which can be explained in part by parental leave, as well as by various forms of continuing education. In November 2005, just over 25 percent of all permanently employed assistant nurses and nurse's aides under age 35 were absent from their jobs for at least one month. Absence is significantly lower among older employees in this category at 12 percent. Sickness is the main reason for absence among older employees.

Variations can be found between men and women. Among all local authority employees, the absence rate for women in 2005 was 13.2 percent, while it was only 6.3 percent for men. One explanation for this trend 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, total absenteeism was 15.4 percent among women and 9.9 percent among men.[77]

Sick leave decreasing

Sick leave began increasing throughout the Swedish labour market in 1997, though more among women than men, and more among women working in local authorities than women in other sectors. National data from Statistics Sweden's labour market surveys show that sick leave among women began to decline in 2004 and the trend continued in 2005. Sick leave also declined for men, though the fluctuations are not as large.

[77] SALAR 2006

Statistics from SALAR for November[78] in different years also show that the percentage of local authority employees who were *completely on sick leave* for at least 30 consecutive days has declined since 2002 for all employees, as well as for personnel 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 the personnel 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 both 2004 and 2005, both among all employees in the local authorities and among employees in care of the elderly and disabled.

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.

Table 26 Percentage of permanent employees on full sick leave in November

Age	All local authority employees	All employees in welfare	Assistant nurses/ nurse's aides	Nurses
16–34	2.8	3.9	4.0	2.5
35–54	5.2	7.0	7.4	5.5
55–	6.3	8.5	8.8	8.8
All	5.1	6.7	7.1	6.3

Source: SALAR 2006

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 27 Percentage of permanent employees on partial sick leave in November 2005

Age	All local authority employees	All employees in welfare	Assistant nurses/ nurse's aides	Nurses
16–34	1.5	1.6	1.7	2.1
35–54	4.0	4.1	4.2	4.0
55–	5.5	5.4	5.4	6.0
All	4.0	3.9	4.0	4.4

Source: SALAR 2006

[78] These statistics are not comparable with Statistics Sweden's labour market surveys.

Working hours

The percentage of *full-time employees* in care of the elderly and disabled has gradually risen to an estimated 45 percent in 2005. The figure among all local authority employees is close to 68 percent.

Table 28 Number and percentage of full-time employees in health and social services

Year	Number	Share of total number of employees
2000	92,500	38.0
2001	101,300	40.3
2002	108,700	42.5
2003	112,200	43.4
2004	112,200	44.1
2005	114,400	44.9

Source: SALAR

In practice, 37.5 percent of people working in the medical and social services work full time, mainly 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 2005, this figure was 84 percent, calculated on the total number of people working in community medical and social services. For part-time employees in these fields, the corresponding figure is 73 percent. Two-thirds of part-time nurse's aides and assistant nurses work at least 75 percent of full time. The average activity level for hourly employees is about 40 percent of full time.

When the average activity level increases as more part-time employees expand their working hours, hiring needs decrease.

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 helped to reduce part-time unemployment.[79]

Payroll

Table 29 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

[79] SALAR 2006

percent of assistant nurses receive an average of SEK 1,772 a month extra in additions for unsocial working hours.

Table 29 Salary levels for full-time employees in certain health and social services professions in November 2005, plus additions for unsocial working hours (U.hrs)

	Monthly pay for full time, minus floating additions				
Profession	10th percentile	Median pay	90th percentile	% w/ U.hrs	Avg U.hrs/ month SEK
Assistant nurse	16,700	18,100	19,300	91	1,772
Nurse's aide	15,600	17,400	18,700	88	1,667
Nurse	21,000	23,200	26,800	75	1,476
Physiotherapist	20,000	22,400	25,000	1	311
Occupational therapist	19,800	21,800	24,200	2	433
Supervisor	22,400	26,400	30,700	3	801

Source: SALAR 2006

Median pay means that 50 percent of the individuals in the group have equal or lower pay. In the 10th and 90th percentiles, 10 percent or 90 percent of the individuals in the group have the same or lower pay, respectively.

Staff and skills supply in medical and social services

The need for new employees in care of the elderly will increase around 2020, when many of those born in the 1940s reach the age of 80. A projection of the current trend shows that job markets in urban regions are growing, while smaller job markets in rural areas are shrinking. In addition, an increasing percentage of young people are moving from small local authorities to larger ones with more job opportunities. If the forecasts in the projection of current trends prove correct, certain parts of Sweden can count on a considerable decline in population, while the percentage of elderly grows both overall and particularly in small local authorities in certain parts of the country. As a result, care of the elderly will need to utilise a larger share of the working population in the depopulated local authorities. Staffing needs in care of the elderly will vary substantially in certain parts of Sweden with the trends in the working age population.

Currently the number of new hires essentially meets the staffing needs for care of the elderly. In other words, there is time until 2020 to prepare for the increase in the number of people aged 80 and older.

The problem right now is not hiring personnel for medical and social services, but rather hiring people with adequate skills and updating skills

of existing staff (an estimated 40 percent) who lack these skills (nursing training or equivalent). It is essential to find new pathways for staff and skills supply that attract both men and women, as well as boys and girls. This nascent focus on medical and social service colleges found regionally is a good basis for hiring and training.

College is a co-operative format for training programs in medical and social services that creates a structure for learning in cooperation with the workplace on the regional level. This initiative tears down the barriers separating employers, schools, education coordinators and others. Many areas for collaboration can be placed within the college framework, such as links between college, upper secondary school, advanced vocational education, research, validation and practical activities. College benefits regional developments, while counteracting unemployment among young people and adults.[80]

The Government has launched a multi-year national initiative to support local authorities' long-term quality and skills development work in medical and social services for the elderly. Between 2005 and 2007 the central government allocated more than SEK 1 billion to this field. Most local authorities have applied for and received funds. The most common priority areas are developing training adapted to the future and changing needs of care of the elderly, methods of highlighting career paths, leadership development, training for supervisors, validation, logistics and team-building.

Staffing in the EU

The average pension age in the EU is 60. The average pension age in Ireland is 63, while it is 62 in Sweden and 57 in Belgium. The elderly dependency ratio, or the relation between the number of people age 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 who are age 65 and older. In 2010, the elderly dependency ratio in Sweden, Germany, Italy and Greece will be 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.[81]

The working age population will begin to decrease after 2010 and the labour market must rely on the older workforce to a greater degree. This is a problem, especially for the medical and social services sector, which already has a high average age in the workforce. Many countries are ad-

[80] SALAR 2006
[81] Eurostat 2005, *The social situation in the European Union 2002*

dressing staffing issues for medical and social services; today 10 percent of the EU's total workforce is employed in this sector.[82]

Table 30 Elderly dependency ratio within the European Union

Country	Elderly dependency ratio 2003	Elderly dependency ratio 2010
Italy	26.9	31.3
Sweden	26.6	28.1
Greece	26.0	29.2
Belgium	26.0	26.7
Germany	25.9	30.3
Spain	25.1	26.8
France	25.1	25.5
Portugal	24.7	24.5
UK	23.7	24.2
Estonia	23.5	-
Latvia	23.3	-
Finland	22.9	24.9
Austria	22.8	26.3
Hungary	22.4	-
Denmark	22.3	24.6
Lithuania	22.0	-
Slovenia	21.0	-
Luxemburg	20.9	23.6
Netherlands	20.3	22.3
Czech Republic	19.7	-
Poland	18.4	-
Malta	18.2	-
Cyprus	17.6	-
Slovenia	16.5	-
Ireland	16.4	17.3
EU-15 (old EU countries)	25.0	27.3
EU-25 (all EU countries)	24.1	-

Source: Eurostat 2005, The social situation in the European Union 2004

[82] European commission 2005, *Green paper "Confronting demographic change: a new solidarity between the generations"*

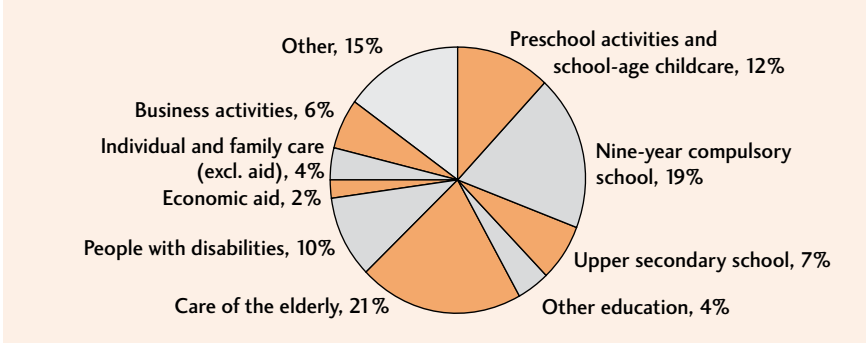
The Local Authorities' Finances

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' expenses

Between 2004 and 2005 costs increased by 3.4 percent in gross amounts, which corresponds to 1.1 percent in fixed prices. The net cost for care of the elderly and individual and family care increased at a much slower pace than the average, while costs for upper secondary schools, preschool and care of the disabled increased significantly more. Figure 21 shows how the local authorities' expenses, which totaled SEK 411 billion,[83] were allocated among various activities in 2005. The local authorities' resources mainly go to providing welfare services such as childcare and education, as well as medical and social services. These services make up 79 percent of total expenses. Care of the elderly has amounted to about 20 percent of the local authorities' total costs since 1999, when costs for the elderly were separated from costs for the disabled.

Figure 21 Distribution of local authority costs for operations in 2005 (SEK 411 billion). Percentage



Source: Statistics Sweden 2006, *Accounting summary for 2005*, SALAR 2006.

The cost trend over the past decade shows that local authorities have increasingly concentrated resources on activities that provide individual

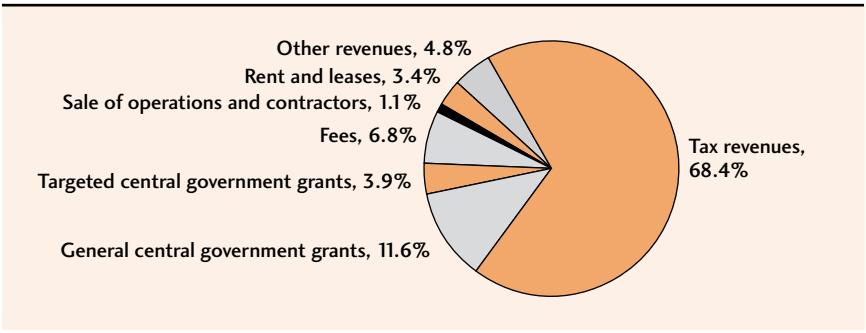
[83] Costs refer to gross costs minus internal revenue and sales to other local authorities and county councils; *Kommunernas räkenskapssammandrag år 2005 (The Local Authorities' Accounts Summary 2005)*, Statistics Sweden

services and are aimed at special groups (students, care recipients, etc.). In addition, several of the larger areas of operation have shifted towards using more resources for those with particularly large resource needs. At the same time, resources for activities which do not have target groups that are as specific, such as infrastructure or culture and leisure activities, have shown a more modest trend, further confirming the image of an increased focus of local authority resources.

Financing of local authorities' activities

Local authority revenues amounted to SEK 430 billion in 2005. Between 2004 and 2005 revenues rose 4.8 percent. A 4-öre increase in the average tax rate resulted in SEK 600 million in increased tax revenue. Local government taxes and central government grants account for 68 percent of local authority revenues for operations; see figure 22. Fees, which account for 7 percent, are mainly attributable to business operations. Fees finance only a relatively negligible portion of welfare services.

Figure 22 Distribution of local authority revenues for operations in 2005. Percentage



Source: Statistics Sweden 2006, *Räkenskapssammandrag år 2005 (Accounting summary for 2005)*, SALAR 2006.

Financial performance of local authorities

The financial performance of the local authorities improved in 2005 compared with 2004. Net income totaled SEK 8.5 billion,[84] an improvement of SEK 6.1 billion and the best performance of this decade. Profitability improved because revenues increased SEK 19.5 billion at the same time as costs only increased SEK 13.4 billion. This is the first time since 2000 that the increase in revenue sharply exceeds the increase in expenditures. Profit-

[84] Profit/loss before extraordinary items

ability was also affected by non-recurring expenses and revenues. Capital gains and losses as well as extraordinary revenues and expenses resulted in an unusually large positive net income in 2005.

The tax base is expected to grow until 2009 at an annual rate of over 4 percent,[85] at the same time as general central government grants increase, in part due to approved additional resources. On the expenditure side, in our opinion — despite relatively favourable conditions — the local authorities will act conservatively over the next few years in order to avoid jeopardising the margins they have now succeeded in achieving. Many local authorities also have old deficits to make up in order to live up to the Local Government Act's rules for restoration of deficits from previous years. In our assessment, net income in 2006 will be a positive SEK 8.5 billion, though we expect profitability in subsequent years to be somewhat weaker. All factors considered, from 2007 to 2009 we expect net income to be close to 2 percent of taxes and general central government grants.

The activities are more important than money; isn't it enough to break even? No, a surplus is desirable for several reasons. One common argument is that a long-term stable economy requires each generation to cover its own costs. For example, provisions for future pensions are required if the local authorities are to live up to welfare obligations over the long term. In addition, assets must be made inflation-proof (since amortisation does not cover price and quality increases for new purchases). The budget should also have a buffer for unforeseen events. As a result the scope and aspirations of activities overall must not cost more than the available resources.

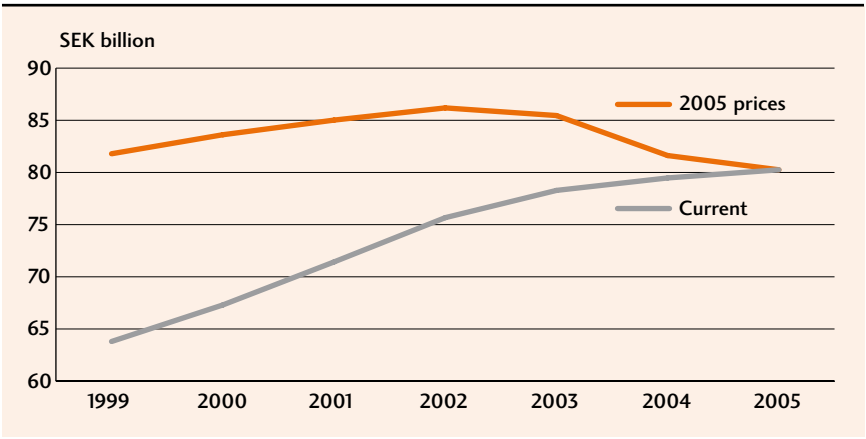
[85] SALAR, *Financial Report May 2006*

Costs and financing for care of the elderly

Costs for care of the elderly

The total costs for care of the elderly in 2005 amounted to SEK 80.3 billion,[86] an increase in gross amounts of 1.0 percent. Fixed costs[87] have fallen 1.7 percent due to a decrease in volume between 2004 and 2005. Figure 23 shows the development of costs for care of the elderly between 1999 and 2005.

Figure 23 Costs for care of the elderly, 1999–2005, Current prices and 2005 prices



Source: Statistics Sweden 2006, *Accounting summary for 2005*, SALAR 2006

Figure 24 shows the allocation of costs for care of the elderly in 2005. Most of the costs, 64 percent, went to medical and social services in special housing, 34 percent to medical and social services in regular housing, and 2 percent to preventive activities.[88] In 2000 the costs for medical and social services in special housing accounted for 70 percent, while costs for care

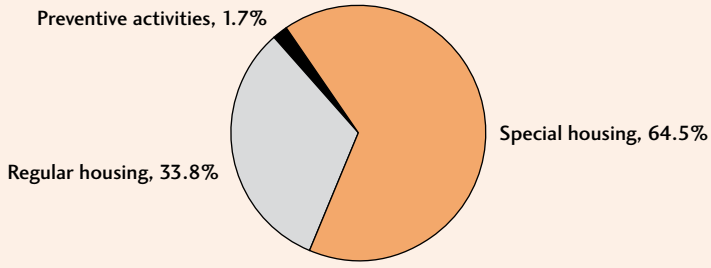
[86] This figure does not include transportation service, which cost the local authorities nearly SEK 1.7 billion. Transportation services cannot be divided up between the elderly and disabled

[87] Fixed costs were calculated using an index of the percentage of costs of care of the elderly that account for wages and wage trends, as well as percentages of other costs and the CPI trends

[88] Preventive activities were previously called preventive measures

in regular housing accounted for 27 percent. Thus the trend shows a shift of resources from special to regular housing over the years.

Figure 24 Allocation of costs for care of the elderly in 2005



Source: Statistics Sweden 2006, *Accounting summary for 2005*, SALAR 2006

The costs for regular housing cover resources for many types of interventions which the elderly can receive as support in order to be able to remain in their own homes. Services include home help, home medical services, short-term care/housing, day centres and home adaptations, as well as minor interventions such as alarms and meals on wheels. The overall resources for these interventions are increasing, while resources for special housing are decreasing.

Cost per care recipient

The average cost per care recipient in regular housing increased in gross amounts by SEK 3,200 (1.5 percent) between 2004 and 2005. In special housing, the average cost in gross amounts increased by SEK 14,700 (3.3 percent).

Table 31 Cost per care recipient in regular and special housing between 2000 and 2005, gross amounts[89]

Year	Regular housing	Special housing
2000	169,100	335,100
2001	183,700	363,500
2002	198,900	389,800
2003	208,500	421,400
2004	214,800	439,600
2005	218,000	454,300

Source: SALAR's key indicators, online at www.webor.se

[89] Unweighted mean, exclusive of facility costs

As table 31 shows, the cost per care recipient is approximately twice as much in special housing as in regular housing. The rate of increase in cost per care recipient has declined in both regular and special housing.

Differences between local authorities

Table 32 shows the median value[90] of the costs per care recipient living in regular housing and special housing, and the distribution of costs among local authorities.

Table 31 Distribution of costs per care recipient among local authorities, 2001–2005, in SEK, gross amounts[91]

Year	10th percentile	Median	90th percentile
Regular housing			
2001	111,000	178,000	260,000
2002	126,500	189,000	279,000
2003	139,100	200,700	285,000
2004	140,300	209,000	301,500
2005	149,500	212,000	295,500
Special housing			
2001	288,000	363,000	447,000
2002	313,500	388,000	476,000
2003	330,700	421,000	504,300
2004	348,000	441,000	529,000
2005	357,800	454,000	547,500

Source: Statistics Sweden, Accounts Summaries, for the stated years; National Board of Health and Welfare, *Äldre – vård och omsorg*, for the stated years.

In 2005, 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 149,500 or less (10th percentile) and 10 percent had costs of SEK 295,500 or more (90th percentile) for a 98 percent difference among local authorities. The corresponding difference in special housing was 53 percent.

The distribution of costs per user in special housing has been stable at about 50 percent since 2002. At the same time, the difference between the 10th and 90th percentile In regular housing decreased from 134 percent to 98 percent. One explanation for the diminishing difference between local authorities' costs per user in regular housing is that the local authorities with the highest costs (90th percentile) have cut their costs.

[90] The median value is the cost level at which an equal number of local authorities lie under and over

[91] 10th percentile means that 10 percent of the local authorities are below a specific value
90th percentile means that 10 percent of the local authorities are above a specific value

Some key explanations are 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 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.

Financing of care of the elderly

Taxes and general allowances financed the majority of total costs, SEK 80.3 billion, for care of the elderly, while fees financed only 4 percent of costs. This breakdown 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.[92]

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 1,588 per month in 2006.

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 percent in May 2002 to 30 percent in 2005.

[92] SALAR 2006

Health-promoting and preventive initiatives for the elderly

Many local authorities conduct health-promoting and preventive initiatives for the elderly such as injury prevention activities and work with public health in general. These tasks are voluntary for the local authorities, but interventions which can have great significance for the elderly, who can remain healthier longer as they grow older.

Public health

Interest in public health aimed at elderly individuals is growing as more studies show the positive effects of wellness interventions for the elderly. Several studies show that the elderly are healthier at higher ages.

Public health action plans

According to a survey that the Swedish Institute of Public Health conducted in 2004, 65 percent of the local authorities had a public health plan and the majority were adopted by the municipal executive board and/or the local government council. A total of 34 local authorities had adopted an action plan in 2004 and 50 local authorities were in the process of formulating a plan. Sixty-nine percent of the local authorities had public health coordinators.

The top priority target group in the local authorities is children and young people (74 percent). Sixty-one percent of local authorities give priority to one or more of the national target areas in the public health policy. The local authorities have assigned special priority to target nine, Physical activity, and target three, Secure and healthy conditions for growing up.[93]

About 40 local authorities provide local welfare annual accounts. The purpose of these annual accounts is to formulate a useful policy and follow-up document for the local authorities, which are naturally linked to the local authorities' budget and accounting processes. The welfare annual accounts are based on the comprehensive public health objective, the eleven target areas and nationwide work with indicators.

The local welfare annual accounts include about 30 health factors which are measured and monitored.

[93] Swedish Institute of Public Health

Public Health Forum and Healthy Cities

A total of 148 of Sweden's 290 local authorities and 19 of 21 county councils also belong to the Public Health Forum, a national forum for local and regional public health with the purpose of facilitating the exchange and distribution of knowledge. SALAR and the Swedish Institute of Public Health are responsible for the Public Health Forum.

The World Health Organisation (WHO) has an international network of cities designated as Healthy Cities in accordance with WHO criteria. Sweden has also had a national Healthy Cities network since 2004, to which ten local authorities belong. Healthy ageing is currently one of four areas of priority in the Healthy Cities project.

Injury prevention measures

Elderly patients are overrepresented in almost all types of accidents, resulting in extensive personal suffering and major costs for society. Men are more vulnerable to injuries than women. However, more women than men are hospitalised as a result of falls. Moreover, injuries are more common in rural areas than in areas such as suburbs.

Fall injuries

Fall injuries are the leading cause of injuries among the elderly. They account for 45 percent of total hospitalisations due to accidents. The mortality rate for fall accidents is almost three times as high as for traffic accidents. In 2003 almost 1,300 elderly patients died due to fall injuries and over 40,000 were hospitalised. In addition, fall injuries also result in A&E or primary care visits. More than five times as many individuals require hospitalisation as a result of fall accidents than traffic accidents. Fall injuries sustained by the elderly account for six percent of all bed-days in Swedish hospitals. The Swedish Rescue Services Agency estimated that fall injuries among the elderly cost society over SEK 5 billion annually.[94]

Many communities provide information to the elderly on the risks of injury in the home and outdoors.

As can be seen in a survey jointly conducted in 2004 by SALAR and the Swedish Rescue Services Agency, 71 percent of local authorities address safety issues for elderly patients in courses held for home services staff. In addition, the local authorities had 500 accident prevention projects. These examples are listed in an online database[95] at *www.raddningsverket.se/aldre*. Initiatives for "A safe and secure community" have had a positive effect on

[94] SIKA, *Accidents reported to the police*

[95] SALAR and Swedish Rescue Services Agency 2005, *Säkerhetsarbete för äldre personer 2005:9 – Enkät till kommuner och landsting 2004 (Safety for elderly people 2005:9 – Questionnaire to local authorities and county councils 2004)*

those local authorities that have adopted them and in other local authorities that have focused on similar activities. Two-thirds of county councils had similar initiatives in 2003. Certain local authorities have also employed a separate person whom the elderly and people with disabilities can contact to receive help with tasks not included in home help, called handyman services (see below, page 76).

Traffic injuries

Elderly patients are also overrepresented with respect to traffic injuries. There are many explanations for this situation; for example, vision and hearing both begin to fail with age. It becomes more difficult to understand what is happening in traffic and reaction time decreases as people age. In addition, elderly individuals are slower when crossing streets, for example, than younger individuals.

Another explanation for the large number of accidents may also be that the elderly who ride bicycles in traffic are less inclined to wear a helmet than younger people. The elderly who are injured in traffic often sustain more serious injuries than other age groups because of the fragility that accompanies ageing.

In 2005, 104 people[96] aged 65 and older died in road accidents. A few thousand were also hospitalised[97] and another large number needed to visit A&E or a primary care doctor.

Fire-related accidents

The elderly also often suffer more frequently than younger people from injuries and death in conjunction with fires. For men age 65 and up, the incidence is eight times greater than for men younger than age 20.[98]

International focus on injury prevention activities

The OECD is conducting a project about Emerging Risks in which it particularly pays attention to the vulnerability of the elderly to accidents. All affluent countries face the growing problem of injuries sustained by the elderly.

Activities for the elderly

Social contacts and activity level are highly significant for the health of elderly individuals. The local authorities extensively support clubs and associations, which arrange many activities in which the elderly also can

[96] SIKA, Accidents reported to the police
[97] National Board of Health and Welfare, Patient database
[98] Swedish Rescue Services Agency and Karlstad University: *Säkerhetens bestämningsfaktorer (Safety determinants)*

take part, and some activities that are particularly adapted for the elderly. In addition, the local authorities have their own selection of both exercise facilities such as indoor pools, exercise trails and groomed ski trails, which are used by the elderly – in many cases special times are set aside at indoor pools and other facilities for the elderly. Moreover, the local authority has its own activities, such as libraries and museums, where many elderly individuals are active. Some local authorities have focused on coordinating their own range of activities with those of clubs and associations and notifying the elderly about what is available. Such programmes can be found in communities such as Umeå and Norrtälje. As a result, the selection of activities for the elderly has substantially increased – as has their activity level.[99]

Passion for life

Passion for life is a collaborative project between the SALAR and Qulturum, the county council in Jönköping county. The aim is to provide seniors with the knowledge and tools needed to create a healthy lifestyle. The purpose also includes encourageing seniors to take active responsibility for their ageing. The areas on which the project has focused are food and drink, safety, social networking and physical activity. The working method can be compared with that of a study circle.

Meeting places are created in the form of "life cafés", where participants find inspiration to try changes at home, follow up on results, and gain new insights and increased understanding of how to implement lasting lifestyle changes. The idea is to go from word to action. Participants are recruited from the pensioners' organisations, PRO and SPF, in Jönköping and Göteborg. An important principle in the project is that seniors possess knowledge and that they pursue ideas. Advisors are being trained from the pensioner organisations, which receive support for running study circles. The pilot project is over and new circles are starting in collaboration with PRO and SPF, as well as the study associations ABF and SV.

[99] SALAR 2006, *Ett aktivt liv som senior (An active life for seniors)*

Help at home without an assessment of the need for aid

As of 1 July 2006, legislation went into force enabling local authorities to offer the elderly facility services without an individual needs assessment. Examples include service in the home and handyman services.

Services

This Act applies to *services to prevent injuries, accidents or ill-health.* Services may include changing light bulbs, hanging up curtains and heavy lifting such as moving furniture, cleaning, window cleaning, and various forms of shopping. The facility services in question for the elderly are essentially the same tasks that may be included in home help and that are service-oriented.

The local authority decides whether it wants to provide the service and which age groups should be offered these services. Among those local authorities that offer such services the age limit varies from 65 and up.

Even if the local authority chooses to offer services, it is still obligated to provide home help in accordance with section 4 of the Swedish Social Services Act. The local authority that chooses to provide services to the elderly must observe the equivalence principle, according to which all residents of the local authority over a certain age must be able to receive such services on the same terms.[100]

Handyman services

Handyman services are covered by the new legislation. One purpose of the handyman services is to prevent fall accidents and associated injuries such as hip fractures.

Making home visits to the elderly and people with disabilities and helping with practical chores not provided by home services has become increasingly common. The first handyman services were implemented in 2001 in Höganäs with "Malte the Handyman". According to a survey that SALAR conducted in spring 2006, 82 local authorities in Sweden now offer handyman services.

[100] Bill 2005/06:115, SALAR 2006, Circular 2006:37

The effect of Malte the Handyman in Höganäs has been evaluated in a national economics thesis at Karlstad University and a thesis at the Stockholm School of Economics. The theses include a cost-benefit analysis which ascertained that handyman services are a highly cost effective method for preventing fall injuries and keeping down medical and social services costs.[101]

[101] Karlstad University, Department of Economics 2004, *Att förebygga fallolyckor och höftfrakturer bland äldre (Preventing fall accidents and hip fractures among the elderly)*, Stockholm School of Economics 2005, *Malte the Handyman*

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