Swedish old-age care: traditions, challenges, and experiences

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Background: long roots

Modern welfare in Sweden has long roots. Organized parish support for sick, frail and older persons in medieval times formalized in 1571; after 1862 obligation of the secular municipality (*kommun*). Long tradition of local tax with routine, collective and transparent decisions on the allocation of poor-relief.
Historically, support was often institutional care and/or support (monetary or in-kind) of family carers. PHOTO ANCIENT POOR-HOUSE

Early mistakes

Traditions and stability are good in many ways, but may obstruct change.
Public policies favoured institutional care at the expense of community care: backlash in the 1940s from newly organized pensioners.
Critical reportages exposed the shortcomings of public policies. PHOTOS OLD-AGE HOMES SWEDEN Not only Sweden: ASILO IN TOLEDO, SPAIN 1935

Reorganization

After serious scandals a government commission (1952) established new guidelines we still live with: "home-care, not care-homes".
Public Home Help (Ayuda a Domicilio) the most rapidly expanding public service so far: from about zero in 1950 to 16 % of the 65+ in 1975, with the total older population doubling at the same time.
In 1950 older people had just one choice, in 1975 they had two, but still with little differentiation among users. PHOTO HOME HELP CLIENT IN 1960s.

Initial improvisations

Difficulties to recruit Home Helpers – mostly ex-housewives - and many impoverished (female) family carers lead to extensive employment of carers as pro forma Home Helper for the cared-for person and, when possible, also for others (in 1970 they made up a quarter of all staff, today 1 %).

Shifts in service use

Institutional care and Home Help were increasingly rationed as new ideas took off and municipalities began to be financially pinched. Users of both programs gradually became older and would use the services shorter time. This process accelerated after 1975 and especially for residents in institutions.

Age distribution of users of services for older people, Sweden 1975 and 2008. Per cent of users.

	1975	**2008**
Home Help		
65 – 79	58	28
80+	42	72
Institutional care*		
65 – 79	35	19
80+	65	81

*In 1950 12 % of residents were under 67, 49 % 67-79, and 39 % 80+. (In 1938 69 % were 65+.) In 1950 41 % of the residents were assessed as mentally and physically healthy.

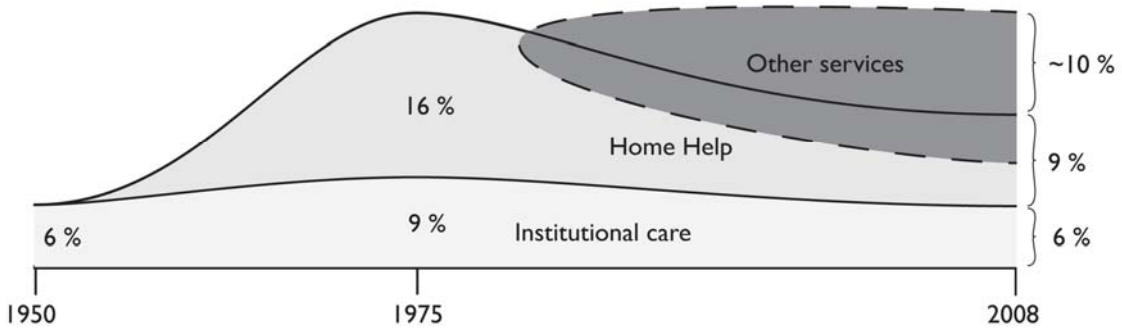
Coverage rates
Stricter needs assessments and demographic pressure led to lower coverage rates in both these programs.

Coverage rates of public services for older people, Sweden 1975 and 2008.
Per cent of older population.

1975	**Home Help**	**Institutional care**	**Sum total**
65+	16	9	25
80+	39	25	64
2008			
65+	9	6	15
80+	23	16	39

These are national averages: there were/are big local variations. Analysis of Home Help suggests variations respond to local differences in *need* defined as percentage of older persons who are frail AND live alone (both vary a good deal locally).
No individual *rights*, only municipal *obligations*, continuously renegotiated.

Panorama of services: cutbacks, diversification and total coverage
Step by step other, "minor" services emerged, all through the single-entry municipal administration: transportation services, meals-on-wheels, alarm systems, home adaptations, day care… They often precede and delay Home Help or institutional care: diversification.



Source: computations on statistics on services, government investigations and survey data.

User rates of services for older people (65+), Sweden 1950-2008 (*percentages***)**

Coverage rate for institutional care and Home Help culminated at 25% of the 65+ around 1975. If the newer, "minor" services are included, we still have 25 % coverage rate.
Sometimes these other services overlap with Home Help, but often they do not.
Focus on cutbacks conceal that in 1950 15 % ended their life in institutional care, in 1975 30 % (+ 20 % with Home Help), today about 90 % use public services before they die.

Expanding family care and market
Stagnation of public services is (partly) balanced by expanding informal care (time-series measures of prevalences and hours of help), primarily from partners – equally often men and women – and daughters. Nearly a quarter of adults are carers, although most of them provide limited amounts of help (65+ 22 %). Increasing use of commercial domestic services (tax subsidized). Two per cent live in expanding private "senior residences".
In Sweden very few (1-2 %) older people live with children, but they are increasingly partnered and most have children living nearby. Perceived loneliness is lower than in Spain.

Limited support for carers
Carers are now publicly recognized, and municipalities are (2009) by law obliged to provide support to carers.
Public services in Sweden focus *individuals*: 9 out of 10 Home Help users live alone.
Little *direct* support to carers and few are remunerated.
Most carers don't want to attend support groups etc.: they want enough public services of good quality for the person they care for = *indirect* support to carers. Legal family obligations abolished in 1956. Carers and older people want *shared* responsibility, not family *or* state.

Do services target the "right" persons?: bigger needs, higher service-use
They did so not at all, or only partly, in the period 1950-1975. When few alternatives are available, administrations offer what they have and clients use what they can get.
Stricter needs assessments, raised co-payments (about 10 % of real cost) and more alternative services have improved the use of public services.
Only one type of institutional care (whereof a tenth for dementia sufferers). A new type of serviced residences suggested (2010).

Persons who use no public service often are in good health, persons who only use "minor" services mostly have small needs for help. Both groups rarely ask for more support.
The more services the users receive, the worse their ADL-status. (Home Help users get more hours of help, the worse their ADL-status: on average 32 hours/month, but distribution has very positive skew).

Older persons (75+) by service use and ADL-index*, Sweden 2000 (*percentage***)**

Type of public service used by older persons living in the community	*ADL-index, average**
No service use	8.3
Only transportation service	7.5
Only alarm system	7.5
Transportation service and alarm system	7.2
Home Help only	6.9
Home Help and transportation service	5.8
Home Help, transportation service and alarm system	5.5
Home Help, transportation service, alarm system and meals-on-wheels	3.8

* Here defined as number of activities of daily life (ADL) that a person can do without help for the following: shopping, cooking, cleaning, laundry, (un)dress, get into/out of bed, shower/bath, toileting, go outdoors without personal help. The index can thus vary from 0 to 9. Some 51 % managed all nine activities without problems.
Source: computations on the Hemma På Äldre Dar survey 2000. After Sundström et al.2011 in press.

Costs for services
In 1950 Sweden spent about 5 % of its GDP on older persons, including pensions and housing allowances, the big part of the expenses: 6 % in 1965, 7 % in 1970, and 10 % in 1975. It leveled off at about 14 % in the late 1980s: Small cost increases (fix prices) in municipal services for older people thereafter (ca. 2.9 % of GDP in 2009. All figures exclude acute health care for older people, now ca. 2.1 % of GDP.)
Few bed-blockers: municipalities have to pay the whole bill for them...
Higher spending not possible due to intolerable tax levels and budgetary constraints.
Rather high service levels can be attained at reasonable cost: diminishing marginal utility of continued expansions.

Privatization trend
To provide more choice, municipalities now have to invite private providers to compete in tax-paid services (so far ca. 15 % transferred):
Home Help
Institutional care
Primary health care
This shift has called for and also raised interest in quality measurements

Privatization results
Increased flexibility (also in public services)
Individualization, for example for specific ethnic groups and immigrants
Planning and monitoring now more difficult
Unclear organization
Reduced state involvement
Costs contained

Conclusions
State at road's end, expanding family care and growing market. Acceptable service levels can be attained at reasonable cost, but services take time to "mature".
It may be better to diversify services, rather than – for example – one-sided investments in institutional care. Variation in services seem to be more efficient and provides more choice to older people and their families.

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