Grant-in-Aid for Scientific Research (B)

Overseas Academic Research
No.24406037

Survey to understand current conditions for elderly people in Japan, Sweden and Thailand

Feb. 2013

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Survey to understand current conditions in Sweden  
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A. Basic information (SCB Statistics Sweden 2011)

1. Total population: 9,480,205 (November 2011)

2. Population trends and forecast

Sweden’s population is expected to rise for every year in the forecast period 2011-2060. At the beginning of the 2020s, the population is expected to pass 10 million and in 50 years, it will be close to 11 million. The population increase has been unusually large in recent years as a result of both more migration into Sweden and an increased birth rate. Last year, the population grew by 75 000. In the next few years, the population growth rate is expected to fall, mainly as a result of less migrants coming into the country. In 2010, 99 000 people migrated into Sweden, which is fewer than the three previous years. Migration will continue to decrease, according to the forecast. The number of close family migrants is also expected to fall, although more foreign workers are expected to come to Sweden.

The fact that more people are living longer is increasing Sweden’s elderly population (80+ years). Today there are 497 000 people over the age of 80. In 20 years time, this figure will have risen to nearly 800 000. The baby boom of the 1940s will also affect the number of people in this age group. In 50 years, every tenth Swedish person, or 1 million people, will be over 80. Today it is one in twenty. (The future population of Sweden 2011-2060” published in April 2011 by Statistics Sweden)

3. Birth rate

Sweden’s population has aged rapidly over the last 50 years. In 1950, Sweden’s population distribution reveals a classic pyramid shape, where each successively younger cohort represents a larger percentage of the population. Life expectancy at birth rose by 8 and 10 years for males and females, respectively over this period. As a result, Sweden’s population structure diverged from the classic pyramid shape and was replaced by a formation more closely representing a pillar, where the percentage of the population in each age cohort is more evenly distributed. By 2030, the anticipated mix of low birth rates with continued improvements in life expectancy will result in a much older society, where the population structure more closely depicts an inverted pyramid.
By 2030, Sweden will have an average age of 47 years, compared to an average age of 41 today (2011) (Figure 1·3).

The drop in fertility rates during the Depression and WWII created a slight indentation for several younger cohorts. Between 1950 and 2000, Sweden's fertility rate plummeted from 2.21 to 1.29. The birth rate is forecast to drop slightly. There were 115,600 births in 2010. In 2012, the fertility rate is estimated to 1.98 children per woman. It is assumed that this has now peaked and the birth rate is expected to decline slowly over the next few years. In 2011, the population growth rate was estimated to 0.168 percent, birth rate 10.24 births/1,000 population and death rate 10.21 deaths/1,000 population (UN Population Division, World Population Prospects, 2011).

Figure 1. Sweden 1995

Figure 2. Sweden 2010
B. Current state of ageing

1. Number of elderly people: 1,757,000 in 2011
   Proportion of elderly people 65+: 18.5 percent in 2011 and predicted to be 24.6 percent of the total population in 2050.

2. Aging trends and forecast
   Sweden's population is ageing, and at the same time our health is improving and life expectancy is increasing. The number of Swedes over the age of 85 is expected to increase by 50 percent over the next 20 years and double by 2050 (Table 1 and 2). Today's elderly people is active; some keep working after they reach retirement age while others become involved in community life in other ways (Government offices of Sweden, March 2011).
   The ratio of old to young people in the Nordic Region is increasing. In 2007, the number of people over the age of 80 was 450,000 (5 percent of the population). Forecasts suggest that no fewer than 8 percent of the Swedish population will be 80 or older in the year 2040. This increase in the ratio of old to young is due to people living longer and a fall in birth rates although the Nordic countries still enjoy high birth rates compared to almost every other country in Europe (The Nordic Counsel, 2011).
   Over 17 percent of the Swedish population is 65 years old or older, about 1,6 million people. 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. The very oldest part of the population has increased since the mid-20th century and people aged over 80 is projected to almost double between now and 2050. (Ministry of health Sweden, 2007)
Table 1. Number and percentage of people in the population aged 65 and older

<table>
<thead>
<tr>
<th>Year</th>
<th>Number aged 65+</th>
<th>Percentage aged 65+</th>
<th>Percentage women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>1,565,000</td>
<td>17.3</td>
<td>57</td>
</tr>
<tr>
<td>2020</td>
<td>2,056,000</td>
<td>21.2</td>
<td>54</td>
</tr>
<tr>
<td>2030</td>
<td>2,303,000</td>
<td>22.9</td>
<td>53</td>
</tr>
<tr>
<td>2040</td>
<td>2,464,000</td>
<td>23.9</td>
<td>53</td>
</tr>
<tr>
<td>2050</td>
<td>2,478,000</td>
<td>23.6</td>
<td>53</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2006, Population projections

Table 2. Number and percentage of people in the population aged 80 and older

<table>
<thead>
<tr>
<th>Year</th>
<th>Number aged 80+</th>
<th>Percentage aged 80+</th>
<th>Percentage women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>487,000</td>
<td>5.4</td>
<td>64</td>
</tr>
<tr>
<td>2020</td>
<td>525,000</td>
<td>5.4</td>
<td>60</td>
</tr>
<tr>
<td>2030</td>
<td>763,000</td>
<td>7.6</td>
<td>57</td>
</tr>
<tr>
<td>2040</td>
<td>812,000</td>
<td>7.9</td>
<td>57</td>
</tr>
<tr>
<td>2050</td>
<td>912,000</td>
<td>8.7</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2006, Population projections

3. Factors of ageing

For several decades the percentage of older people in the population has gradually increased in industrialized countries, a phenomenon that has started early in Scandinavian countries, especially Sweden. There are two main factors behind this development: the first, fertility rates are low and continuing to decline (the so called ‘bottom-up’ cause of population ageing); second, is increasing life expectancy (the so called ‘top-down’ ageing or population ‘greying’). Sweden does not have an especially low fertility rate compared to other European countries; however, life expectancy at birth in Sweden has been increasing considerably over the course of the last century.

(a) Increase in life expectancy due to a reduction in mortality

The increase in life expectancy in Sweden from an average age of about 35 in the mid-eighteenth century to about 80 years in the new millennium is a spectacular achievement. It is a story about the interplay between disease, medicine, and economic, social, cultural and political conditions. One of the trends in this story is the convergence of public health policies and outcomes in Europe but local contexts have
also had a considerable impact upon the conditions for a healthy life. Effective chemotherapy, initially developed during the 1930s, in the form of sulpha drugs, and antibiotics, in the form of penicillin, have contributed to the dramatic post-war decline in infection-related morbidity and mortality, for example from pneumonia and rheumatic heart disease. Effective drugs (in the form of streptomycin and paraaminosalicyclic acid) were introduced in the mid-1940s to combat tuberculosis, resulting in reduced mortality. Large-scale polio vaccinations were initiated in the late 1950s. The general decline in infectious diseases (including tuberculosis) began long before the introduction of effective drugs or vaccinations (Social change and health in Sweden, 250 years of politics and practice, by Jan Sundin and Sam Willner, 2007). Advances in medicine after 1850 (including vaccination against smallpox and antiseptic and hygienic conditions in hospitals) combined with improved sanitation and sewage systems to decrease the death rate precipitously. Increased life expectancy led to a population boom that aroused fears of overpopulation in Sweden because the rapid population growth placed tremendous pressure on the agrarian society, resulting in the emigration of 20 percent of the total population (mostly to the United States). Attitudes toward population increase had changed by 1930, and birth rates declined, while average life expectancy improved. Life was still difficult for many, with unsanitary and crowded housing and inadequate hygienic conditions for the poor. Contrasts between the wealthy and the poor were reflected in birth and death rates and life expectancy. Infant mortality rates ranged from 49/1000 per births in low-income families to only 14/1000 in high-income families. Sweden introduced some forms of government social security programs between 1930 and 1940 including national health insurance, employer medical insurance, maternity welfare, housing allowances, nursery schools, children's health services, free school meals, and information on nutrition and health. The population of Sweden grew to 6.4 million by 1940. (Cultural Geography by R.Jackson and L.Hudman, West Publishing Company, St. Paul, MN, 1990. p.145-6)

(b) Decrease in the youth population due to the declining birth rate

See the above section on birth rate.

Age structure (CIA, 2012):
0-14 years: 15.4 percent (male 722,558/female 680,933)
15-64 years: 64.8 percent (male 2,982,268/female 2,910,135)
65 years and over: 19.7 percent (male 800,169/female 992,665)

4. Expenses for the elderly as a proportion of national income
Elderly care is a challenge for Swedish economy. Elderly people represent a growing share of the Swedish population. Many are in good health and lead active lives, and most live in their own homes. Sweden invests more of its gross domestic product in its elderly than any other country in the world. As a proportion of GDP, Sweden’s allocation to elderly care is almost five times the EU average (Government offices of Sweden, March 2011). With a realistic projection which also includes costs of technological development, the share of GDP rises by just over 2 percent up to 2050. The improvement in health which prolongs the average life expectancy of 65-year-old by 2.6 years presupposes technological development, with more effective medicines and methods of treatment. The costs of health and elderly care, in relation to GDP, are expected to increase from the current level of around 13 percent to around 16 percent in 2050 (The future need for care, Results from the LEV project, Government offices of Sweden, 2010).

Most elderly care is funded by municipal taxes and government grants. In 2010, the total cost of elderly care in Sweden was SEK 95.9 billion, (USD 14.0 billion, EUR 10.7 billion) but only 3 percent of the cost was financed by patient charges. Health care costs paid by the elderly themselves are subsidized and based on specified rate schedules (Government offices of Sweden, March 2011).

However, rising healthcare costs, as well as the lack of availability of some services in the public sector, have led to the gradual expansion of private-sector providers. Many are publicly funded, mostly small treatment units or specialists, which currently account for around 10 percent of healthcare provision financed by county councils. The increased demand for private care provision has so far mainly been seen in out-patient health and medical care; in-patient services have shown a decreasing trend. In mid-2007 restrictions on activities at contracted-out hospitals were removed, with the result that county councils are now able to transfer all or part of the operation of hospitals to private for-profit companies. According to the government, this will contribute to more creative and efficient health and medical care. In fact, around 25 percent of health centers are now privately run by enterprises commissioned by county councils. (http://www.healthofnations.com/countries/profile/sweden)

5. How the elderly live

Very few elderly in Sweden live in the same household as their children or younger relatives. The trend changed gradually since the time of heavy industrialization of the country in the late 19th century with migration of the workforce to large cities.
One main goal, if for commercial and public services to be easily accessible, so that the elderly can continue to live at home and look after themselves. The accessibility requirement has been given greater prominence in legislation. For people with impaired mobility, the municipalities offer to adapt their homes to their needs. When older buildings are refurbished, some of the flats are adapted specifically to the needs and preferences of the elderly. Older people with disabilities can apply to their local municipality for home adaptation grants, the aim being to enable them to continue to live there. The municipality pays the entire cost if the grant is approved, regardless of the financial status of the applicant. (Elderly care: Ensuring quality of life, published by the Swedish Institute, March 2010)

**Senior housing popular**

A growing number of the elderly in Sweden want to live in senior housing, i.e. ordinary homes for people 55 and over. In such homes, accessibility is a priority. Some are newly built, while others are regular homes that have been made more accessible in conjunction with conversion or renovations work. (Elderly care: Ensuring quality of life, published by the Swedish Institute, March 2010)

**Special housing**

Just over 17 percent of the country’s inhabitants over 80 years of age live in special housing where staffs are on duty day and night. Such housing is needs-assessed and allocated by the municipalities. Most of those in need of care and support around the clock suffer from dementia. (Elderly care: Ensuring quality of life, published by the Swedish Institute, March 2010)

**6. Household’s income of elderly in Sweden**

Sweden is often included in international comparative studies on income and income inequality. In these Sweden is typically among countries with the lowest incidence of low income of the elderly. This is confirmed with the comparison of the percentage of persons over age 60 with low incomes in Sweden and 13 other OECD countries in 1981 and 1987. About 3 percent of persons above age 65 in Sweden falls under a poverty line of 50 percent of the median for equivalent disposable income in 1995. The Gini-coefficient of 19.6 percent for the retired population in Sweden was the lowest reported for 19 countries. “Sweden’s Pensioners: How They Have Fared in the Roller
7. Healthy life expectancy and average life expectancy

Three different scenarios based on a baseline situation of 2010 are referred to as expansion of morbidity, dynamic equilibrium and compression of morbidity (Table 3). All the scenarios entail an increase in life expectancy of 2.6 years for a 65-year-old, which is in agreement with the Statistics Sweden population forecast. The differences between them are the health of the population in the final stage of life. In expansion of morbidity people live longer but become ill at the same age as today. This is achieved in the model by providing people with mortality risks as if they were younger. In the dynamic equilibrium scenario, both morbidity and death are deferred equally much by giving the model individuals a health status as though they were younger. In the most positive scenario, compression of morbidity, the years of frailty at the end of life are reduced by a further improvement in health (The future need for care, Results from the LEV project, March 2010).

Table 3. Remaining life expectancy at the age of 65 in 2010 and 2050 divided into health and unhealthy years according to three theories.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Healthy years</th>
<th>Unhealthy years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline situation 2010</td>
<td>14.7</td>
<td>5</td>
</tr>
<tr>
<td>Expansion of morbidity 2050</td>
<td>14.7</td>
<td>7.8</td>
</tr>
<tr>
<td>Dynamic equilibrium 2050</td>
<td>17.3</td>
<td>5</td>
</tr>
<tr>
<td>Compression of morbidity 2050</td>
<td>19.3</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Statistics Sweden 2010

C. Health of Elderly People

1. Rate of receiving medical care of people aged 65 years and over

Waiting times for preplanned care, such as cataract or hip-replacement surgery, have long been a cause of dissatisfaction. As a result, Sweden introduced a health care guarantee in 2005.

This means no patient in general or elderly patient should have to wait more than seven days for an appointment at a community health care center, 90 days for an appointment with a specialist and 90 days for an operation or treatment, once it has been determined
what care is needed. If the waiting time is exceeded, patients are offered care elsewhere; the cost, including any travel costs, is then paid by their county council (Figure 6.) Statistics from December 2010 indicate that about nine out of ten patients see a specialist within 90 days and receive treatment or are operated on within a further 90 days. Roughly 80 percent today feel they receive the care they need. In 2006, the figure was 74 percent.


2. Consumption of health and elderly care

In Sweden, most people in the population are healthy or have slight ill-health. Around 14 percent of the population has severe (5 percent) or moderate (9 percent) ill-health in 2010. The proportion is predicted to increase somewhat between 2010 and 2050 (from 14 percent to 15.9 percent) in the expansion of morbidity scenario. As it is more common for elderly people to have moderate or severe ill-health, and the number of elderly people is increasing, the number of people with severe ill health will probably increase by 45 percent between 2010 and 2050.

What effects does a change in health have on the needs of the ageing population for health care and elderly care and how is the trend in costs affected? The costs may increase as a consequence of different scenarios:

- The population grows (given the same average life expectancy)
- The population ages
- Health changes
- The level of ambition in health and elderly care rises.

The cost of health and elderly care will very probably increase with age. It is not just the number of young and elderly people per person in working age that affects the prospects of meeting future needs for health and elderly care. There is a clear age correlation between people's health and functional impairments and their need for health care and care for elderly as well as the costs of these services.

The per capita cost of elderly care increases steadily with age. However, as the number of people in the oldest age groups is lower, the total cost – the per capita cost in the age group multiplied by the number of people – is more evenly distributed across the ages. The total cost of health care increases up to the age of 65 and decreases from 75. The costs of care of the elderly rise quickly to reach their maximum value for the 85–89 age group. As expected, increased ill-health also results in greater consumption of health care.
a. In expansion of morbidity, age-standardized consumption per individual (i.e. when the effect of the age composition of the population differing between 2010 and 2050 is deducted) of both health care and care of the elderly increases.

b. Consumption decreases in the other two scenarios, most in compression of morbidity.

c. This produces a great effect in 2050, particularly for care of the elderly. The higher level of education in the population generally contributes to reducing consumption per individual in different age groups up to 2050.

Total costs increase when the number of elderly people rises. The number of elderly people will, however, increase with an ageing population. The future age distribution is shifted towards an ever larger proportion of very old people, which brings about increased consumption of health and elderly care in all scenarios. A simulation predicts that the consumption of health care by the ageing population is expected to rise by around 0.6–0.7 percent per year up to 2050. Expressed in current prices, this means an average increase in cost over the period of SEK 2–2.4 billion to 2030. The demographic pressure is greater. Around half the future increase in consumption of health care is due to the growth in population and half to an older population. The costs increase most for inpatient care and medication, which have a more pronounced age profile than outpatient care and primary care.

The number of households receiving elderly care will increase sharply in the future, by 40 percent up to 2030 and by 60 percent up to 2050. The need for care of the elderly, in particular for special housing, will therefore increase more than the need for health care in all the scenarios, assuming the same pattern of care as today. Another simulation shows that the consumption of elderly care increases on average by around 1.3–1.4 percent per year up to 2050, depending on health scenario. Expressed in current prices, this means an average increase in costs over the period of SEK 1.7–1.9 billion per year. Up to 2030 the demographic pressure is greater. The increase in costs is greater than the increase in population in all the scenarios since there will be an increase among the oldest.

Total consumption of care is increasing as the costs of health care and care for the elderly are expected to change per year in percentage terms and in billions of SEK up to 2030 and 2050. The percentage increases in costs are compared with the increase in the number of people in the total population and the number aged 65+. As expected, the costs increase more than the growth in population. This assumes, however, that the level of ambition is unchanged, which is regarded as less realistic.
To summarise, the ageing of the population brings about an increased need for health and elderly care. Health-care costs increase from 2010 to 2050 by a total of 26–30 percent and costs of care of the elderly by around 65–73 percent, i.e. more than twice as much as health care. The increase is greatest up to 2030. Costs of health care increase most around 2020 and the costs of care of the elderly most around 2025. (The future need for care. Results from the LEV project, 2010)

3. Mortality rate of elderly people by cause of death
Of those who die in a given year, 86 percent are 65 or over (82 percent of men and 90 percent of women). The difference can be explained by an increase in the life expectancy of the very old. The percentages have, however, remained constant for the last three years. The mortality in the last 10 years has dropped at the same rate among both young and older people.
Cardio-vascular disease is the dominant cause of death among both men and women. Tumors are, however, a common cause of death among women aged 65–74. The number of women dying from a tumor decreases dramatically after they reach the age of 75. Mental illness (especially Alzheimer's disease) is the third biggest cause of death among women in the 75+ age group. The frequency ratios are higher since many more women die in the 75+ age group than between the ages of 65 and 74. Nearly 11 times as many women and 4.1 times as many men in the 75+ age group die of cardio-vascular disease compared to the 65–74 age group.
A recent trend shows reduced mortality from cardiovascular diseases among both men and women. The number of deaths related to influenza has also dropped, probably because of an increase in vaccinations. Fewer women have also died of breast cancer, whilst lung cancer has claimed more lives. (A healthier elderly population in Sweden! 2011)

4. Recipients proportion at formal and informal care.
In the fifties, 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. (Swedish old-age care: traditions, challenges, and experiences, 2010)

The increased attention on voluntary and informal care is also driven by the current cutback in public old-age care expenditure in almost all European countries. In Sweden
there has been a reduction in service to elderly persons in the last 15 years with the most dramatic change occurring for persons 80 years and older who experienced a decrease in home care from 37 percent in 1988/89 to 21 percent in 2002/03. The 1990s, in particular, have been described as a period in which relations between public and voluntary sectors changed as economic conditions hardened. Moreover, a partly new ideological climate has implied a shift towards private and voluntary alternatives. (Informal care and voluntary assistance, 2010).

According to the National Board of Health and Welfare, approximately 15 percent of the population 65 years or older receive formal elderly care, home care, or assistance through a health care institution. The majority (37 percent) of the recipients of old-age care are 80 years and older (Socialstyrelsen, 2009).

The number of places in health care institutions, or särskilda boenden, has decreased significantly. According to the National Board of Health and Welfare, approximately 24,000 places in health care institutions have disappeared since 2000, which corresponds to a 20 percent decrease. Instead it has become more common for old people to receive assistance from informal sources such as family and relatives (Socialstyrelsen, 2009).

5. Main cause for needing long-term care or support

The difficulty for different individuals to fund their own health care and care for the elderly is due to the fact that the consumption of care is very unevenly distributed in the population. A small group needs a lot of care. Around half the cost of health care relates to the 3-4 percent of the population who have the highest cost of care. Nine disease groups account for 40 percent of care costs and dementia accounts for the disease with the highest prevalence of need. The distribution becomes less uneven if not just a particular year is studied but the costs of care of an individual during his or her life are added together. The aggregate costs of the health and elderly care up to 2050 have therefore been simulated using the model. Half the cost of health care relates to 22 percent of the elderly population, while half the cost of elderly care relates to 15 percent of the elderly. Viewed in a life-time perspective, the distribution of consumption of elderly care is thus more skewed than the consumption of health care. (The future need for care, 2010)

6. Family relationship between the main caregiver and the care receiver

In Sweden, care of elderly people is a public responsibility. There are comprehensive public policies and programs providing health care, social services, pensions, and other
forms of social insurance. Even so, families are still the major providers of care for older people. In the 1990s, the family was "rediscovered" regarding eldercare in Sweden. New policies and legislative changes were promoted to support family caregivers. The development of services and support for caregivers at the municipal level has been stimulated through the use of national grants. As a result, family caregivers have received more recognition and are now more visible. However, the "Swedish model" of publicly financed services and universal care has difficulty addressing caregivers. Reductions in institutional care and cutbacks in public services have had negative repercussions for caregivers and may explain why research shows that family caregiving is expanding. At the same time, a growing "caregivers movement" is lobbying local and national governments to provide more easily accessible, flexible, and tailored support. In 2009, the Swedish Parliament passed a new law that states: "Municipalities are obliged to offer support to persons caring for people with chronic illnesses, elderly people, or people with functional disabilities. (Informal caregiving for elders in Sweden: an analysis of current policy developments, 2011)

D. Sweden – Welfare State

The Social Services Act states that elderly people must be able to live and lead independent lives in safe conditions and have an active and meaningful existence in the company of others. Municipalities are required to establish special forms of housing for service and care of elderly people in need of special support.

1. Care managers assess need for help and support
Municipalities are entitled to design health and social care services that are adapted to local conditions. This means that the support offered to elderly people may vary. The municipalities have care managers who inform people about elderly care and assess what help people may receive. Examples of the most common services include home help for tasks such as shopping, laundry and cleaning, but also personal care, meals and emergency alarms. People may also apply to move to special housing accommodation. The county council or the municipality may approve special transport services and technical aids. Elderly people may also apply to the municipality to have their homes adapted to be able to continue living there.

2. Elderly people entitled to age with dignity under the Social Services Act
The Social Services Act, the Health and Medical Services Act and the Act concerning Support and Service for Persons with Certain Functional Impairments guide the municipalities' work on health and social care for elderly people. The municipalities are
responsible for certain health and medical care for elderly people under the Health and Medical Services Act.

Since 1 January 2011, the provision on national core values has applied in the Social Services Act. According to these core values, care of the elderly must focus on enabling elderly people to live in dignity and enabling them to feel a sense of well-being. This provision applies to both publicly and privately run operations. It covers both case management and the implementation of measures. It must guide elderly care operations and staff conduct and treatment of elderly people.

Under the Social Services Act, elderly people must be able to choose, to the extent that is possible, when and how they receive support and help in the home and other services.

The municipalities are responsible for the financing, content and most of the actual delivery of care services. Since 2009, the municipalities have been able to expose municipal care operations to competition.

3. The National Board of Health and Welfare reviews the quality of health and social care services

The National Board of Health and Welfare (Socialstyrelsen) is the expert and supervisory agency for social service activities. It also issues permits to private actors to run special service homes for the elderly, for example (Figure 4).

http://www.government.se/sb/d/15473/a/183501;
http://fall09hpm101sweden.providence.wikispaces.net/The+Organization+and+Delivery+of+Care

4. The Health Delivery System and Process

The principles for co-operation between counties and municipalities as providers of care according to the Elderly Reform are presented in the picture below. Note that family practitioners in primary health centers are employed by the counties and are responsible for medical care in nursing homes operated by the communities. The municipalities employ nursing staff (Figure 5).

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1534007/
While Sweden generally invests more resources in health care than other OECD countries, much of the technology is available only at Sweden’s eight regional hospitals. In an effort to limit costs, Sweden reserves admission to the regional care centers for those who require the most advanced diagnostic tools and the most experienced specialists. Indeed, there are several levels of care through which a patient must proceed before being referred to a regional center (Figure 6). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1534007/
When a patient is ready to be discharged from a hospital—whether from a county or regional hospital—a team comprised of the patient, his hospitalist, representatives from social care and the outpatient staff develop a care plan, outlining the medications, rehabilitative services and support the patient will require following his discharge from the hospital. Upon discharge, primary care providers (general practitioners or nurses) at the municipality level resume responsibility for the patient's care. The patient will receive necessary medical services through outpatient or home-based care as outlined in the care plan until he is medically cleared by the municipality (Figure 6).

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1534007/
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