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Economics of elderly care - the state of knowledge in Sweden¹

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Abstract

Se inledning!

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Elderly care in Sweden is the responsibility of each local authority. It is largely financed by local taxes. The local authorities also have very much freedom in deciding how care is to be conducted and what fees the individual recipients are to pay.

Public care of the elderly during the first half of the 1900s consisted only of institutional care. The first efforts to provide care at home began around 1950 and developed rapidly, culminating in about 1978 (Szebehely, 1995). After that, the trend reversed, the number of elderly persons who received care at home declining rapidly. This was due to economic developments at the time and to those who received care at home needing increasing amounts of care.

Local authorities have adjusted to the situation by reducing the amount of service they provide, through assessing individual needs more strictly than earlier, and through raising the level of fees. How and due to what mechanisms this situation has developed and what effects it has had, are matters of research in Sweden at the moment (see e.g. Blomberg et al., 2000; Szebehely, 2000).

Developments in Sweden have led to resources for elderly care becoming increasingly limited in relation to existing needs. This has made research on costs and cost-effectiveness increasingly important. As an example of research on possibilities for increasing cost-effectiveness, I will refer to a study of group living units for persons suffering from senile dementia. The study in question (Svensson, Edebalk & Persson, 1996) concerned 106 units of this sort. Variations in costs from one unit to another were examined in relation to the characteristics of the various units and the persons living in them.

The results indicate variables relating to the individuals to have an influence on costs, e.g. these being higher if the persons are more limited in their physical functions. What is of greater interest, however, are those variables that the local authorities can more readily influence, especially the number of patients living in a unit and whether the unit is a completely independent one or is combined with some other form of institutional arrangement. There appear to be economy of scale advantages in group living units. And if a unit stands alone, its costs tend to be higher than for a unit combined with one or more other units. Research has shown that how a unit is organized can have a marked effect on the costs of running it.

One can also compare the costs of different forms of residence in which care is involved, such as comparing the costs for a person living and receiving care at home with those for a person living and receiving care in an institution. Only few, small, studies of this type have been carried out in Sweden (Szebehely, 2000). The costs of service and care for persons living in an institution vary rather little, at least on a short-term basis, in relation to how dependent the persons are on care. The costs for living in an institution consist mostly of fixed costs. There is a built-in insurance effect of living in an institution. This is connected with the fact that personnel able to come to a person's assistance if anything happens, are always available there. This makes institutional living rather expensive if the care recipient has no appreciable functional difficulties, whereas economies of scale play the predominant role in the case of persons whose functional abilities decline.

Costs for care at home are more variable and can increase markedly as the individual's need for care increases. For elderly persons with good functional abilities, the costs of care at home are rather low compared with those of persons living in an institution. As the need for help increases, however, help at home becomes more expensive, not simply because of the time required for care, but also because of the added personnel that is called for and the need of visits at night and on weekends. When extensive care is required, care at home can become very expensive, more expensive than the corresponding degree of help at an institution. In terms of cost-effectiveness, therefore, living in an institution is the best arrangement for those in need of extensive care.

Account needs, however, also to be taken of the fact that moving to an institution can be highly stressful and that this can result in an increase in the costs of care and in a lowered quality of life for the individual. Further research is needed here. We also have very limited knowledge of what preferences elderly persons who are in need of considerable care have concerning the choice between living and receiving care at home and living in an institution.

An important question for elderly care is whether preventive measures that result in present costs, can reduce costs in the long run. Denmark is often referred to as a pioneer in this respect (Anell m.fl., 1999, Szebehely, 2000). Each resident of that country who is 75 years of age or older is offered a visit by a district nurse twice a year, the aim of which is both to inform the person of the service and care available and to obtain information regarding the person's need of help. The Danish reform that led to this was based on positive results obtained in a project at the beginning of the 1980s. Thorough knowledge of the long-term

effects of such measures is lacking, however. It is uncertain whether the need of care is simply put off to a future date or whether the care needed later is reduced in this way. This too is a matter for further research.

Community care of the elderly in Sweden was characterized earlier by a monopoly of the local authorities regarding both the assessment of an elderly person's need of care and the providing of care. The person who assessed the care an elderly person needed was usually also in charge of the personnel who provided the service.

A new model that has developed is termed the purchaser-provider split. It involves keeping assessment of the elderly person's need of care separate from the providing of care. The aim is better targeting, which is important for using the available resources effectively and for keeping costs under control.

A few studies of those persons who assess the needs of the elderly have been carried out in Sweden. The knowledge we have, points to the value of using specialized officials who are better able to take into account the elderly person's needs in their entirety and to make consistent decisions (Socialstyrelsen, 1997). Such persons have been found to be more restrictive in the amount of care they decide upon, and to justify their decisions more thoroughly than those traditionally given the job of making such assessments.

An innovation within elderly care in Sweden during the 1990s was the use of contractors. This involves the local authorities' engaging an external agent for providing care-at-home services within a given district or for operating a home for the elderly, doing so on a contractual basis.

At the same time, the local authorities retain official responsibility for the measures decided upon, for ensuring that they are carried out, and for determining the fees the individual is to pay. Care of the elderly on a contractual basis expanded considerably during the 1990s and today some eight percent of those receiving elderly care receive it from private contractors.

Since contractual care of the elderly is rather new in Sweden, knowledge of its long-term effects is very limited. It has been noted that cost-consciousness and quality-consciousness within elderly care have increased and that the contracting-out of care appears to have contributed to this (Svensson & Edebalk, 1997).

Since the beginning of the 1990s, changes in contractual care have occurred. One such change is that the market has come to be increasingly dominated by a small number of large companies. The rather short contractual periods, as a rule for three years, have made it difficult for care-providing companies to plan long-range. This, in turn, has tended to have a negative effect on the investments these companies make and on their training of personnel. To counteract this, the companies have begun increasingly to reach agreements in principle or call-off agreements with various local authorities allowing the latter to purchase rooms in homes for the elderly at prices that are agreed to. In principle, the broader range of services the companies can offer in this way should make it possible to better meet the wishes of the care recipients.

Let us consider now the fees paid by care recipients. Such fees cover approximately five percent of the costs of elderly care in Sweden. The local authorities have considerable freedom in determining what fees to

take. However, fees are not permitted to exceed the local authorities' own costs in providing care. In addition, the care recipient is to be guaranteed sufficient funds for his/her own personal needs when fees have been paid.

How fees are determined and what elderly persons receive for the fees they pay vary considerably from one local authority to another. It is usual for fees to be related to the care recipient's income. A serious problem here, however, that various researchers have drawn attention to, is that such income-related fees accentuate marginal effects. These represent the summed effects of the higher taxation, lower housing benefits and higher fees that are linked with an increase in the care recipient's income. High marginal effects create various problems. They are thought of as being unjust and as giving the care recipient (and his/her relatives) motives for economic manipulations aimed at reducing the reported income of the recipient and thus the fees to be paid.

For elderly care to function effectively, account must be taken of the elderly persons wishes. It would be possible to introduce a voucher model into elderly care generally. At present, such a model is only employed by a few local authorities in Sweden in the form of use of service checks (Svenska kommunförbundet, 1999b).

The limited use of a voucher system thus far is partly due to the fact that, for it to function properly, all care at home in a given community would have to be covered by it. For this to be accomplished, thoroughgoing changes in the local authorities' organization and way of working would be necessary. Many Swedish researchers believe that in the future elderly persons will demand greater freedom of choice. There is a clear need of research to determine what model would be best for

achieving this. It would for instance be interesting to learn more about the emerging system of quasi-markets, that are emerging in Japan.

The economic and demographic challenges with which elderly care is faced can lead to the level of financing by fees increasing in the future. In view of the high costs for care of the individual, however, no more than a small part of the costs can be met by fees. Here we must also pay attention to the marginal effects.

Local taxes have been the major source of financing elderly care in Sweden. Continued financing in this way requires that elderly care be provided with funds from tax revenues at a rate that covers the increasing needs that can be expected. Raising taxes can be difficult for various reasons, however. One is that the income to which taxes apply is far more mobile than it was earlier, where persons, capital, commodities and services can move across national borders very easily today. This makes it difficult for the tax level in Sweden to deviate much from the tax levels in other countries.

Another financing alternative is that of insurance. Compulsory elderly care insurance was introduced in Germany in 1995 and in Japan last year. Questions of how such an insurance functions and of its positive or negative aspects are of considerable interest from a research standpoint.

The possibility of introducing compulsory elderly care insurance in Sweden has also been discussed (Edebalk & Svensson, 2000, Söderström et al., 1999, Grip & Örtendahl, 2000). According to some researchers an insurance system would have the advantage of being a more reliable form of financing elderly care. At present, it can be difficult for a care

recipient to move to a different community since this results in an increase in costs for the local authority in question. If insured, the insurance money would follow the care recipient to a new community. This would improve the position of the elderly and provide them greater freedom of choice.

There are different ways of constructing a system of insurance premiums. The German solution involves all employees and retired persons making payments. In Japan, in contrast, all persons over 40 years of age are to pay, and the premium is of a flat rate type. How a system of insurance premiums could and should be designed is an important matter for research.

Another question is how such an insurance should be organized. In Germany the health insurance system administers the insurance, whereas in Japan it is the local authorities. Still another area of research interest is that of assessment of needs of the elderly. Who should best make such assessments and how should they be carried out? Still another area for research concerns development of the market for public and private providers of care. The most important question we as researchers should ask, however, is how the welfare of care recipients and their next of kin is affected by an elderly care insurance.

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