

Old Age Care: The Swedish Way

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Abstract

Old age care will become an increasing task in all societies as population aging gives an increasing number of elderly that will need help with daily activities. In this article different means – and their costs – of old age care are discussed. There are three ways of organizing old age care, the family, the market and the state, each one with its pros and cons. Irrespective of form, old age care is expensive and due to aging costs will increase. Thus it is important to find forms that have both high quality and use resources efficiently. Population aging as well as migration, changing family patterns and changing economic structures pose challenges to old age care and will most probably induce changes in old types of care. There might be lessons to draw from other countries. The main focus of this article is on the Swedish way, with some minor references to German and Japanese ways. It is shown how the Swedish system has evolved from being mostly a responsibility of the family to today's responsibility of the local public sector. It is tax financed and need of care is judged by local authority. Recently, privatization of providing old age care has obtained a footing, not financing though. Dissatisfaction with the care provided has lately increased the care given by family members.

Key words: Sweden, old age care, history, recent trends

I. Introduction

Becoming old means that the probability of being able to care for oneself decreases. The need for help with daily activities such as getting dressed, cooking and so forth, increases. All societies take care of their elderly in one way or other. There are three main methods of organizing old age care: the family, the market and the state (public sector). Old age care organized by the market or the state may both be viewed as insurance; this is not the case with a family device as the family is too small to take advantage of the law of large numbers.

With ordinary utility functions, i.e. that utility increases with more goods, however at a decreasing rate, people have risk aversion. Risk aversion means that without insurance, people would save too much in order to avoid being old and needy without means to get care. Insurance builds on the law of large numbers, i.e. it suffices to save/pay premiums in accordance with the average risk of need of care in old age. Even if it turns out that you will not need care, either because of death or because you are still going strong when old, insurance gives utility by the fact that the risk of being out of means if needed is removed. There is a willingness to pay for insurance due to risk aversion. Thus, insurance is welfare enhancing as savings can be kept down and life time consumption can be increased, giving increased utility.

Long term care is expensive. It should be noted that this is true irrespective of care form. Assuming that market work is an alternative to home work and care of old relatives, family care means that someone, usually a daughter or daughter-in-law, has to refrain from market work, the wage being the alternative cost. Due to the high costs, out of pocket payments are not possible meaning that the market is not a viable solution without insurance. The figures in table 3 below give an illustration: assume that there will be a need of residential care the last two years of life. The cost exceeds 1 million SEK, which is far beyond what an old age pension can finance. Calculations show the premium needed to finance these two years amounts to approximately

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6000SEK a year if payments start at the age of 25, the double if starting at the age of 45 and as much as 39000SEK a year if at 65, with a rate of return assumed to be 2.5 per cent (Kruse & Ståhlberg, 2017). Provision by the public sector means tax financing with dead-weight losses and distortions. Thus, each way has its costs, costs that should be weighed against its benefits (Kruse & Ståhlberg, 2013).

An advantage with family care is the closeness between the tender and the elderly, reducing the information problem on desires and needs. The family model builds on an (implicit) contract between generations, on tradition that might foster altruism, sometimes felt as forced (Carmichael & Ercolani, 2016). Thus, closeness may be a good thing but it may also induce emotional blackmailing or difficulties in settling difference of opinion on need between the elderly and the tender. Furthermore, families are too small to take advantage of the law of large numbers. There will be an uneven distribution between families, some being fortunate enough to have long-living parents, which, however, increases the cost, and some families will have no parents to support. The family model has no means of evening out these differences (see also Kruse & Ståhlberg, 2017, for a fuller discussion).

If the family model is not used, a formal insurance is needed. There are advantages to make this insurance obligatory. One reason for this is that when young old age care seems very far away. However, to buy old age care insurance later in life means high premiums, prohibitively high as shown in the example above. Thus, due to myopia, the young ones have to be forced into insurance. Also, the possibility of free riders is often used as an argument in favor of obligatory insurance. Note, however, that compulsory systems also have disadvantages; it puts a restriction on the individual's choice of life cycle consumption pattern and may thus reduce utility. There are voluntary old age care insurances, for example in the United States of America. In this case, the insurance companies use large resources to screen potential buyers in order to avoid high risk persons, who will not be allowed to buy insurance. In a voluntary system this kind of so called cream skinning seems hard to avoid. Also, when an insured person applies for care, large resources are used in order to decide whether care is needed and if so, what kind of care (Olsén, 2004). Germany and Japan have both formal old age care insurance, encompassing the whole population. They are obligatory and tax financed (Ikegami, 2007; Rothgang, 2010). In Germany, the need of care is estimated with basic and instrumental ADLs (Activities of Daily Living) in three levels: light, medium and severe. The dependent may choose between home care with cash benefits or in-kind benefits, and nursing home care. The payments are paid out to the dependent who is to choose care form (Rothgang, 2010). In the Japanese insurance, it is explicitly noted that relatives (usually daughters and daughters-in-law) are not allowed as providers. The Nordic countries do not have formal insurances; however, as will be argued below, the systems in these countries may be viewed as social insurance.

All over the world, both in developing countries as well as in so called welfare states the major part of old age care is performed by kin: spouses, children and sons and daughters-in-law. The extent of informal or family care differs; it differs between countries and over time. In Sweden, there has been a transition from a mainly family model to a model where the responsibility lies within the (local) public sector, is taxed financed with small out of pocket fees. These fees are income related, but within a rather narrow span. Care is given in accordance with need (determined by the local authority). Lately, there has been a critique that the public care is too scarce and parsimonious resulting in an increased care by kin and use of the market (Ullmanen & Szebehely, 2015).

II. History of Swedish old age care

In 19th century, Sweden was a rural society with more than 90 percent of the population living out of farming. When a peasant became old and was to transfer the farm to his heir, the contract contained conditions of old age support: a cottage to live in, a specified amount of food, a small piece of land where to cultivate for example cereals and potatoes. This was called *öto* be set

aside and it was understood that the son and daughter-in-law should give care when the elderly could not manage daily activities any more.

For an old person without relatives, or very poor ones, the municipality had the obligation to care for the old and needy. Either it could be in a poor house where old, disabled, mentally ill persons and orphans were mixed, or placed by an auction process where the old was to live by the one who demanded lowest payment. Instead of auction, some municipalities used a rotation principle, where the elderly was moved around among the households in the municipality. Needless to say, all these modes were unpleasant and dreadful.

At that time there were more than 2000 municipalities sparsely populated. The great emigration during the second half of the 19th century consisted mostly by young people, leaving the elderly behind. The result was a demographic structure with an unprecedented support burden. The burden fell heavily on the local public sector and forms a background to the political effort to introduce an old age pension system, thereby lessening the poverty among the elderly. In 1884 the liberal Member of Parliament, Adolf Hedin, proposed an old age pension system and in 1913 it was introduced. This was the first general old age pension system including the whole population and not only the working part as in Germany. It consisted of two parts, a defined contribution one that was supposed to become the major part, and a defined benefit part that paid out benefits although very small immediately (see Kruse, 2010).

In 1918 a poor law was passed, making the municipalities responsible of providing special care for the elderly. The municipalities were obligated to provide housing in old people's homes where the elderly were not to live together with disabled, mentally ill and so forth.

Thus, already in the first two decades in the 20th century, what might be said to characterize the Swedish model was in place: obligatory social insurance encompassing all inhabitants and public provision of in-kind goods and services. In those days, no one called it the Swedish model (see Carlsson & Hatti, 2016) but the first steps were taken on the path.

By the end of the Second World War, the old people's homes were small, old and miserable at the same time as the number of elderly and the demand for care increased. Old people's homes were heavily criticized by one of the most famous Swedish authors at the time, Ivar Lo-Johansson. He published a great number of critical articles in the newspapers, articles that brought the misery on to the political agenda. However, to build new homes took time and was expensive. To meet the demand, the Red Cross started home service in one municipality. It was a much appreciated service and considerably cheaper. Others were soon to follow (Edebalk, 2010; 2016).

Home help service was cheap in the beginning, as it used housewives' spare time with a low pay. However, gradually housewives disappeared as female labour force participation increased. The providers of home help service were professionalized and, thus, became more expensive. At the same time there emerged a strong ideology in favour of letting the elderly live in their home instead of old people's homes. The result was that for many years the municipalities' costs for home help service were subsidized by state grants while old people's homes did not receive any subsidy. A number of beds in residential care homes were consequently closed down. The subsidy to home help service distorted the perception of real cost of the different forms of care. Such distortions cause inefficiencies in the use of scarce resources. It has been shown that when a person needs a lot of care, care in an old people's home is cheaper (Edebalk, 2016). Also, there was no freedom of choice: long queues to old people's homes forced the elderly to remain in their homes, often lead a lonely life when the spouse had died and the children live far away.

In the beginning of the 1960s, the Swedish public sector and its expenditures were at par with the rest of Europe. In 1960, public expenditure was around 30 per cent of GDP, the same as for example in Germany and only slightly above the figure in the USA (see for example Carlson & Hatti, 2016). However, during the 1960s and 1970s a rapid expansion took place. The expansion

occurred in social insurance and transfers, as well as in publicly provided goods and services. The expansion of transfers was both in amounts and in areas. A supplementary old age pension system was introduced; so were increases in sickness and disability insurance, parental leave, etc. Expansion in goods and services took place in health care, child day care, the education system and old age care to mention the biggest sectors. It was all financed by taxes, mostly income taxes and pay-roll taxes. The income tax was highly progressive, giving marginal effects as high as 90 per cent. In those days the production was within the public sector, and the consumption was decided by the authorities.

By the end of the 1970s the Swedish economy had considerable problems; both the public budget and the balance of current account showed large deficits. The expansion of the public sector had squeezed the manufacturing sector, by high taxes and by competing for both capital and labour. The public sector had to be reformed, according to all economic experts as well as all political parties in Sweden. Increased taxes were thought to be out of question. Instead efficiency had to be increased. The Social Democratic Party advocated freedom of choice within the public sector and fiercely opposed privatization which they felt would destroy the 'Swedish welfare state'. The right wing parties advocated privatization and market competition. In the election to the Parliament in 1985, called an 'election between systems', the Social Democrats won and the privatization debate faded away for the time being (Edebalk, 2016).

Due to economic problems and efficiency problems within the public sector, the privatization debate soon re-emerged. It is evident that separation between consumption, production and financing is not only possible but may also result in efficiency gains as well as increases in consumers' utility. The old (social democratic) model without consumer choice meant that the public authority determined what to consume. Public production without competition meant a lack of incentives to introduce more efficient methods. With the financing remaining public it is possible to introduce both more of consumer choice and competition in production and still keep the aims of equality and distribution according to need and with the care not being means-tested (for a fuller discussion, see Kruse & Ståhlberg, 2013).

In the early 1990s, a new law determining the municipalities' right of self-determination concerning among other things how to organize elderly care was launched. Privatization became more common. It started with a low share and increased gradually. In 2007 approximately 15 per cent of those living in special housing had a private manager, which increased to 20 per cent in 2014. Of those having home help service, 12.5 per cent had private managers in 2007; in 2014 this figure was approximately 18 per cent (NBHW, 2016).

Even with privatization, the responsibility as well as financing rests with the local public sector, the municipality. Procurement is a difficult task; to specify easily measurable items in the contract is easy. However, as it is intrinsically difficult to contract on non-observable outcomes, such qualities are likely to be treated in disadvantage. An early article showed that contracts focusing on observable qualities will give incentives for the producers (be it teachers or care tenders) to concentrate on these and score high on these items (Holmstrom & Milgrom, 1991). Thus, the contract has to handle a trade-off between efficiency/cost reduction and quality. However, it has also been shown that with repeated transactions quality may be promoted as reputation then becomes important.

Thus, results from theory show that effects may go in either direction. Empirical results show no large quality differences between public and private tenders. NBHW carries out yearly surveys on the elderly's view on the care. Questions are asked about care-givers' behaviour, for example if the care-giver has enough time, shows respect in connection with toilets' visits or showers, if the care takers' wishes have been ignored, and so forth. The result shows a slightly higher share for those being content with private tenders. The interpretation of surveys may be difficult as the answers not always reflect the true opinion. In search for an objective and unbiased indicator, Bergman et al. (2016) use mortality rates as a quality indicator. They investigated all

municipalities about their method of old age care, whether in-house production, privatization by procurement, voucher system or a combination of these. They use data for the time period 1990 to 2009 and conclude that when private providers are allowed to compete for contracts, mortality rates decrease by 1.6 per cent, so do costs per care taker.

Even so the privatization has been criticized. Especially in the early days of Swedish privatization of old age care, mistakes were made while awarding contracts focusing more on price than on non-measurable aspects such as quality. Newspapers were focusing on scandals, especially when they occurred within privatized care.

Some of the care organizations that have won the purchasing of home help care or residential care are international for-profit financial equity firms. The (left-wing) critique has been that these firms take advantage of Swedish taxpayers' money in a profit-seeking way. However, most private care tenders are small firms owned by former public employees in the care sector.

III. Recent trends and expected development

Approximately 3 per cent of GDP is used for publicly financed old age care in Sweden. A comparison between European countries shows that Sweden is by far the country spending most public resources on old age care together with Denmark and Norway. Austria, the Netherlands and United Kingdom are spending less than half of this, and the rest of the countries are spending a quarter of this or less (Eurostat, 2012). As mentioned earlier, this does not mean that these other countries are spending less on old age care, only that they are not using the public sector.

The aging of the population has been going on for a long time, meaning that Sweden has one of the most aged populations in the world. Even so, the aging will continue, see table 1.

Table 1: Forecasted aging of the Swedish population (percent of total population)

Elderly population	2015	2040	Change (%)
65+	21	24	+39
85+	2.8	4.5	+97
85+ of those being 65+	13.2	18.8	--

Source: Statistics Sweden

The number of persons receiving old age care has risen. However, the increase is less than the increase in the old age population; thus the percentage of the elderly getting publicly financed care has decreased from 18.5 per cent in 2007 to 16 per cent in 2015 (NBHW, 2016). The ideology maintaining that staying in your own home with home help service still dominates. And the number of beds in residential care decreases, as is shown in table 2. It is also evident that this trend is at odds with the development in other countries. According to a survey conducted by NBHW (2017) the municipalities estimate the need for beds in residential homes to be met within two years. However, the waiting time to be admitted into a special home is increasing, and amounted to 57 days in 2015 (NBHW, 2017).

Table 2: Beds in residential long term care facilities (per 1000 population)

Country	2000	2010	2014
Denmark	8.6	8.5	..
France	7.4	9	9.7
Italy	2.2	3.6	..
Japan	4.2	5.5	6.2
Sweden	17	14.2	12.8

Source: OECD (2017)

A glance at table 3 shows that it is not only ideology that induces the preferences for home help service. The cost difference is huge, but the figures are averages and hide the fact that the dispersion is large, especially in the category home help service. Half of the elderly with home help service receives less than 26 hours a month, but 20 per cent has 60 hours a month or more, and 10 per cent 80 hours or more (NBHW, 2017). And at some point there is a break-even in costs where residential care becomes cheaper. As the number of oldest old increases, the reduction in the number of residential homes may cause inefficiencies.

Table 3: Number of persons in old age care and yearly cost per care taker, 2015

Home help service	
Share of people 65+ with home help service	12 per cent
Share of people 80+ with home help service	23 per cent
Cost per care taker: 1000SEK	143*
Residential care	
Share of people 65+ with nursing home care	5 per cent
Share of people 80+ with nursing home care	14 per cent
Cost per care taker: 1000SEK	560*

* 9.5SEK~ 1Euro; Source: SKL (2015)

Old age care is a public responsibility in Sweden. Neither children nor spouses have an obligation or legal responsibility to provide personal care in old age. However, as the trend has been a reduction in the provision of publicly financed old age care, informal care has increased (Ullmanen & Szebehely, 2015); according to this article, this change is to the detriment of the care takers who prefer not to burden their kin. However, due to the ageing of population we can expect further changes in the pattern of care.

Ageing and increased longevity mean increasing costs for old age care, irrespective whether it is financed within the family or by taxes. As said earlier, increasing taxes means increased distortions, thus increasing dead-weight losses. An alternative discussed is a formal old age care insurance to replace today's insurance, tax financed and provided by the Swedish municipalities. A tax may then be viewed as substituted by insurance premiums, assuming that such an ear-marked tax does not give rise to as much distortion as a pure tax. So far, a full-fledged proposal has not been worked out, but in the discussion of this issue it is emphasized that the judgement of need and the gate-keeping function have to remain within the municipalities in order to guarantee that need is the guiding principle. Also, it has been argued that even with an ear-marked tax/premium, it is hard to make promises about a specific amount or form of care as it would take place far into the future. And even so, there will of course be a debate dealing with the trade-offs between old age care and other responsibilities by the local public sector, such as schools, health care etc. Scarce resources, in relation to wishes/needs, will always cause debates on the best distribution as well as demands on efficiency.

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