Sick or just old ? - patterns of functional limitations and care consumption among older persons in Sweden

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Introduction

The Swedish national government launched a few years ago a large initiative with the aim of improving the coordination of acute health care and long-term care among the most sick older persons. It turned out that the knowledge about the target group was rather vague and a special sub-project was started to order to define the group in terms of numbers, health status and care consumption.

This resulted in defining four care-groups according to the criteria "extensive consumption of acute health care or not" and "extensive consumption of aged care and services or not" . The following criteria were used:

Extensive consumption of acute health care:
Acute hospital care due to multiple chronic diseases according to definition by National Board of Health and Welfare or last year
19 beddays or more in acute hospital care or
3 or more admissions to acute hospital care or
7 or more visits to specialist in out-patient care

Extensive consumption of aged care and services (LTC)
25 hours or more of home-help per month in ordinary housing or around-the-clock LTC in special accommodations

The aim of the analysis was to describe these care-groups with regard to numbers, functional limitations and care consumption.

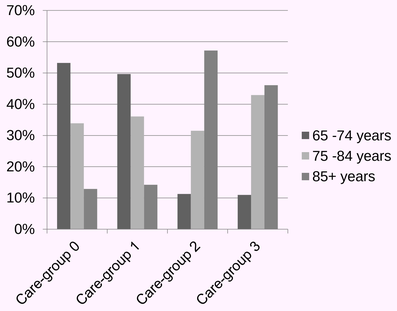
Material

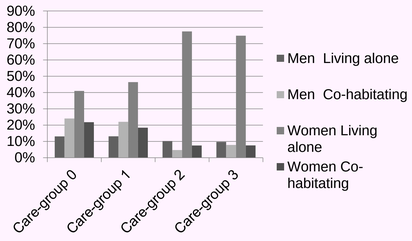
The care-groups were described using data from the SNAC-K project – the Swedish National study on Aging and Care, Kungsholmen. From the SNAC-K data were chosen two datasets:
Population part: Longitudinal sample of all citizens in the area, age-groups 60,66,72,78,81,84,87,90,93,96 years – in total 2 614 persons.
Care system part: All persons in the area, 65 years and above, who receive public LTC **-** in total 6937 persons.

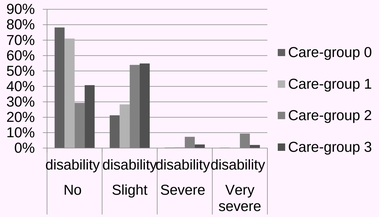
The description was made using both datasets with minor differences in results

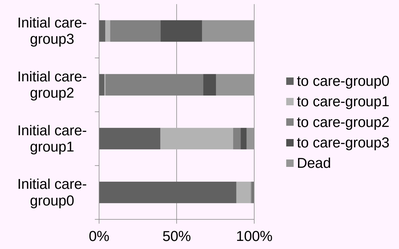
Proportion of older population by care group

			Percentage of tot. pop.
Group 0	Not extensive health care	Not LTC	72%
		LTC, but not extensive	5%
	Total	Care-group 0	77%
Group 1	Extensive health care	Not LTC	12%
		LTC, but not extensive	2%
	Total	Care-group 1	13%
Group 2	Not extensive health care	Extensive LTC, ordinary housing	3%
		Extensive LTC, special accommodations	5%
	Total	Care-group 2	8%
Group 3	Extensive health care	Extensive LTC, ordinary housing	1%
		Extensive LTC, special accommodations.	0%
	Total	Care.group 3	2%
			100%









Results

Around a quarter of the Swedish elderly population have either extensive health care or extensive LTC according to the definitions put forward by the National Board of Health and Welfare. Only 2%, however, have both. The "Sick" and the "Old" are to a large extent separate populations!

Care-groups 0 and 1 differ very much from care-groups 2 and 3 in terms of age and gender distribution as well as in disability according to different measures. The differences *within* these subtotals are much smaller, i.e. persons without extensive LTC do not differ very much in these respects whether they have extensive health care or not. The same goes for those with extensive LTC, whether they have extensive health care or not.

The analysis also shows that extensive LTC is much more stable than extensive health care. Around half of those with extensive health care one year do not belong to this group a year later. For extensive LTC the corresponding figure is 69% and the death rate is 26%. Among the survivors 95% stay on.

Discussion

The results are based on data collected in the district of Kungsholmen in Stockholm, the capital of Sweden. This inner-city district is rather affluent and thus somewhat atypical. However, comparisons with total Sweden with regard to total numbers and age and gender distribution showed very good agreement and thus the results should be at least fairly representative for Sweden.

The analysis presented here showed that the target group of the Governments intervention was smaller than expected, but pointed out other questions. One of these is the low acute health care consumption among persons in special accommodations. Does this reflect lesser needs or neglect? Aggravating is the fact more disabled persons receive less health care and this goes especially for cognitive disability.

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