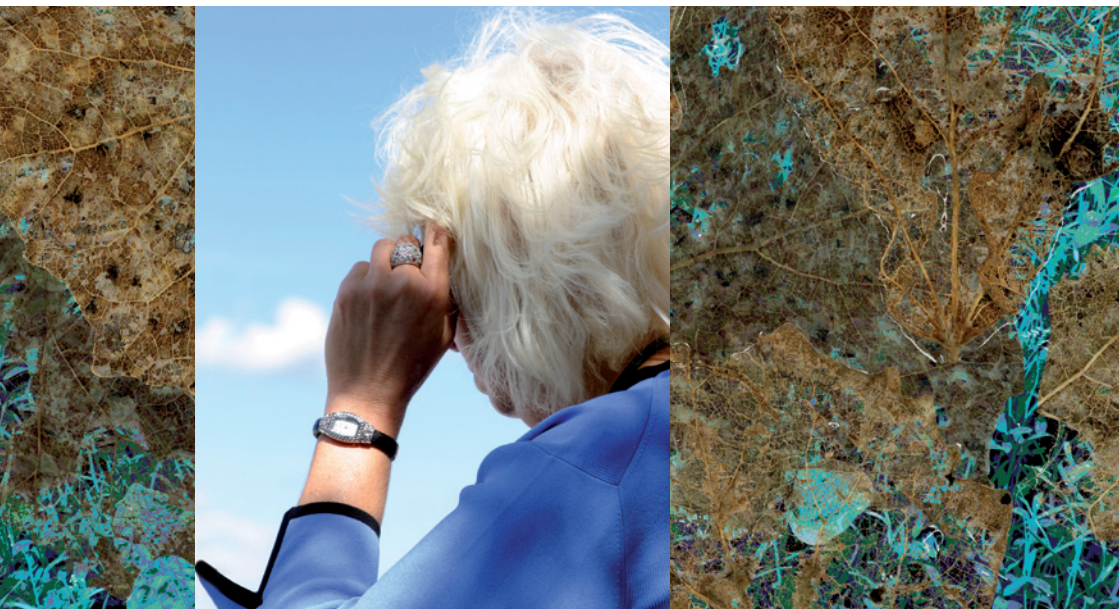

Towards healthy aging in Sweden



Helena Östlund



SWEDISH COUNCIL FOR WORKING LIFE
AND SOCIAL RESEARCH

*Towards healthy
aging in Sweden*

Helena Östlund

A series of popular scientific knowledge overviews from FAS, the Swedish Council for Working Life and Social Research.
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Preface

This paperback in the FAS popular scientific series aims to highlight current Swedish research on the new demographics in society and the impact of an aging population on health, wellbeing and economic development. The reported research is interdisciplinary in nature and looks at aging from a variety of perspectives.

This is an exciting field of research which ranges from the function and development of the brain throughout life to medical, psychological and physical aspects of aging and to building a society that provides quality of life and dignity from the cradle to the grave. Ongoing research suggests that the conditions for aging reflect the social stratification, gender structure and ethnic diversity of the population.

For most people in Sweden, the dream of a long and meaningful life is no longer utopian. Life expectancy has gradually increased in present-day Swedish society. When Parliament in 1913 decided to introduce a public pension at age 65, the mean life expectancy was 55. Many citizens would never reach retirement age, let alone have a few good years to look forward to in the autumn of life. Today many can count on a long and rewarding life, sometimes several decades, after retirement. Sweden is one of the countries which has to seriously tackle the challenges of the 85+ generation. According to Statistics Sweden, almost 1,500 citizens are centenarians, most of them

women. An interesting observation is that half of them confirmed their tax return by text message! However, good aging is not only about creating secure conditions and good quality of life for older individuals who have obvious difficulties coping with everyday chores for reasons such as serious comorbidity or functional disabilities.

It is just as much about half of Swedish citizens aged between 65 and 85 finding themselves in good or excellent health. Aging was formerly seen as a burden and cost to society. It's now time to turn the perspective around. The question is how we can better utilize and develop the new potential and force for development inherent in the growing generation of active seniors. In a study (2007), the Knowledge Foundation outlines what the new demographics and longer life expectancy mean for society and the economy. The new senior living industry offers major challenges in terms of leisure, culture and learning, nursing and social care. However, the time earned and liberated from paid work need not only result in consumption, culture, travel and personal development. Good aging also creates resources for volunteer work, social care and time for others.

With advancing age it is natural for various disorders and minor functional disabilities to increase. This can relate to vision, hearing or mobility. It is the goal of a welfare society to create a good and stimulating life for as many of its citizens as possible. This also constitutes a major challenge for society. Significant investments have already been made in terms of staff competence and on the job training.

However, not all citizens live equally long lives. Women live longer than men. The well-educated live longer than the poorly educated. People who have had arduous and stressful occupations with a high level of risk do not live as long as those with personal control and influence over their work situation. It is a concern that tomorrow's society will offer growing possibilities of predicting life expectancy based on a person's DNA code. Not everyone may want to know how much time they have left if they are carrying a poor health prognosis. Yet everything is not determined by our genetic heritage and working life. The research also shows that people's social capital and lifestyle

influence public health and life expectancy. The content and quality of life and various forms of mental and physical activity are of major importance.

Knowledge about aging and the elderly plays a major role in FAS's responsibility for research on working life, public health and welfare. This is also a highly prioritised knowledge field to which the government has allocated specific funding. The council also participates in a European network on aging research, ERA-AGE, www.era-age.group.shef.ac.uk.

FAS hopes that this publication, which is based on interviews carried out by science journalist Helena Östlund, may lead to a better understanding of the state of research in this field. We also hope that the publication will generate information, knowledge and reflection in all who wish to further their knowledge about how Sweden should deal with the new demographic situation and capitalise on the resource which people constitute throughout their lives, not only during their period at work.

Kenneth Abrahamsson

Programme Director

Swedish Council for Working Life and Social Research (FAS)

CHAPTER 1

Aging – a new phenomenon in human history

The dream of eternal life is a perennial theme in art and science. As early as 1546 the German artist Lucas Cranach painted the fountain of youth, where the old and sick descend into a pool and emerge on the other side young, healthy and reborn.

But why do we humans really age? Why don't we live for a thousand years? That is something the researchers still don't know much about. Aging is a new phenomenon in human history. In the past, people usually faced an early death from disease. Today increasing numbers die at an advanced age without really being ill – even though their bodies obviously function less well than in their earlier years.

Not only humans but all living organisms age. Much research is being devoted to exploring what processes make a disease-free body age. There are many hypotheses – which have yet to be confirmed. It could for instance be a matter of inflammatory mechanisms or oxidative stress; in other words changes in cell metabolism that cause damage to the cells.

And not only do humans age – we also age in different ways. Why we do is another thing the researchers do not understand. As they study elderly populations, they find increasing numbers of human variations in both mental and physical functions. But we do not know why there are such major individual variations.

Women live longer than men

Why for instance do women live longer than men? Why is there a difference in life expectancy between counties? For men the longest and shortest life expectancy varies by two years in different parts of Sweden. Why are poorly educated seniors more prone to illness than the well-educated? Here again there are many hypotheses.

“We know there is a genetic background which interacts with environmental factors, but that is just about all we know,” says Laura Fratiglioni.

Laura Fratiglioni is Professor of Geriatric Epidemiology and Director of the Aging Research Centre (ARC) in Stockholm. She points out that with geriatrics being a very young discipline, it is hardly surprising that we do not know more about aging.

Geriatrics became a separate discipline only in the 1970s and Bengt Winblad, the first professor of geriatrics at the Karolinska Institute, was appointed in 1984. The first major research projects started to appear in the early 1990s.

Both individuals and society would have much to gain if we could prevent morbidity and functional impairment among the elderly. Functional impairment can for instance be prevented through better adaptation of housing and the outdoor environment to the needs of seniors. Until now we have focused mainly on treating disease only when it has become manifest.

Many elderly people have comorbidity

Frailty and feebleness – words that describe what often afflicts people in their eighties in the form of various disorders. Many in this age group have comorbidity, meaning that they suffer from at least two diseases. Over half of people over the age of 75 have two or more diseases, the most common being dementia, hypertension and heart failure. Diseases that generally receive much attention, such as cancer and myocardial infarction, are on the other hand not very common among the elderly.

“If we could find a strategy for reducing frailty, we would achieve amazing results,” says Laura Fratiglioni. “It could be pharmaceuticals as well as other treatment modalities. Once we know the answer to

why we age, we will also know how to prevent frailty.”

Much research also needs to be done on how to provide better care for the elderly.

“We still don’t know very much about it; much of our medical knowledge comes from research on the middle-aged. Yet we use the same parameters, the same pharmaceuticals, the same treatment and the same ideas on the elderly. Most pharmaceutical research is for instance carried out in people who are at most 65 years of age,” comments Laura Fratiglioni.

What is for example the best way to care for seniors who need assistance, but can still cope at home? There is no research into this. How are people with dementia best cared for? Here there is a little more research, although not very much.

Prevention through a sensible lifestyle

Overall, health in old age is predicated on risks and protective factors that come into play in different phases of our lives: genetic vulnerability is there already at birth. In youth and adulthood both individual risk factors such as diseases, and environmental factors such as contamination can affect us. This is counterbalanced by protective factors, such as a sensible lifestyle, which enable us to influence the risks.

Laura Fratiglioni points out that you have to start preventing ill health late in life while you are still young. This means taking care of your body, being physically active, avoiding stress, eating healthy food with lots of vegetables and fruit but not too much fat, keeping your weight down and avoiding smoking. We have to take care of our soul; health is also about feeling well mentally and socially.

“We must not forget that at 65 we have a third of our life still ahead of us. Sometimes we regard life merely in terms of productivity, as if the time after work is of no significance,” stresses Laura Fratiglioni.

Laura Fratiglioni is Professor of Geriatric Epidemiology and Director of the Aging Research Centre (ARC) in Stockholm.

FACTS Aging Research Centre

The Aging Research Centre (ARC) is a national interdisciplinary centre for aging research. Founded in 2000, ARC is operated by the Karolinska Institute and Stockholm University. Its researchers include geriatricians, epidemiologists, social gerontologists and psychologists. In 2007 ARC was chosen as one of ten FAS centres, strong research environments that receive basic funding for a ten-year period. These are research environments that are either international leaders in their field of research, or that are expected to be capable of attaining a leading international position with the extra funding from FAS.

ARC and the Stockholm Gerontology Research Centre are two interdisciplinary centres which jointly form Äldreforskningens Hus. The Gerontology Research Centre was established in 1986 by Stockholm County Council and the City of Stockholm. The general aim of the Gerontology Research Centre is to capture and utilize experiences and research findings in this field that particularly impact the situation of seniors in society, as well as initiating and undertaking independent or collaborative research and development relating to the conditions for seniors.

FACTS The Swedish National Study on Aging and Care – SNAC

The purpose of the Swedish National Study on Aging and Care (SNAC) is to increase knowledge about the needs of the elderly. SNAC is a national epidemiological study initiated in 2000. A total of 8,000 sixty year-olds are examined at Kungsholmen in Stockholm and in the regions of Hälsingland, Blekinge and Skåne.

SNAC-K is the part of the study which concerns Kungsholmen and forms the core of the entire project. SNAC-K comprises 3,400 individuals who are examined by a nurse, a doctor and a psychologist every seven years. A new cohort of 60 year-olds is invited at each new round of examinations. The studies result from a government initiative in Sweden's National Action Plan for Policy for the Elderly presented in 1998. In addition to government funding they also receive matching grants from the municipalities and county councils participating in the study.

CHAPTER 2

An aging world population

In 2020 the large Swedish baby boomer generation will be approaching age 80 – “the fourth age” (see page 29) when the need of care increases. Many politicians and researchers are concerned about how we will cope with the added costs and personnel requirements of the elder boom. However, demographer Tommy Bengtsson isn’t that worried.

“I don’t think one should exaggerate the cyclical phenomena. Of course the load may increase periodically and we’ll see increased waiting times for healthcare and senior services. I heard a politician say “the baby boomers should not expect to get the same service as earlier generations”. No, why would we, I thought; we’ve always been a crowded generation and are used to competing.”

In the early 1900s only eight percent of Swedes were over 65 years of age. By 2025 they are expected to comprise no less than 22 percent of the population. Tommy Bengtsson, Professor of Demography and Economic History at the Department of Economic History, Lund University, points out that whether the elder boom becomes a problem depends not only on the demographics, but in equal measure on society’s resources and the health of the elderly.

Tommy Bengtsson notes that we do not entirely know how the health of seniors in their final years will develop, generally speaking. The research provides no clear picture. He outlines three different scenarios:

“We’ll have two or three years of decline at the end, more or less like today, but since we live longer, we’ll have more vigorous years as pensioners. In other words, morbidity will be compressed.

“As average life expectancy increases, the final period of decline will be prolonged as much as the healthy period. In other words, the proportion of sick years will stay the same.”

“The final period of ill health is prolonged more than the healthy period as average life expectancy increases. In other words, morbidity will expand.”

Chronic diseases will occur later

Researchers were formerly optimistic, believing that the care-intensive final years would be compressed or remain constant. However, because the very sickest have not been accessed in interview surveys, the results have been found to paint too positive a picture.

At the same time it is true that chronic diseases that formerly developed around age 45 now appear around age 55–60.

“I turned 60 last summer and am relatively fit, but in my parents’ generation many found it hard to keep working flat out and the last years before retirement were an ordeal. A 60 year-old today is incredibly more energetic than just 30 years ago. I personally believe that if there’s a trend for diseases to occur later in life, that should mean we’ll be fitter, even if we do require care in the final phase.”

From his window Tommy Bengtsson has a view over Ideon, Scandinavia’s first research village, for 25 years a meeting place for researchers from different disciplines, innovators, and entrepreneurs.

He started his own academic career as an economic historian, writing his dissertation on the textile industry during World War II. As a recent doctoral graduate he learned a method for analysing changes in a country’s economy and population over time and was attracted by a new project aimed at studying the demographic transition.

This means transition from a society with high fertility, many children and high mortality to our present society with small families and low mortality.

Mortality and fertility are declining

Tommy Bengtsson explains what the demographic transition entails: first mortality declines and the country experiences major population growth. This happened in Sweden in the 19th century and in the developing nations in the second half of the 20th. Fertility then declines, which in Sweden started in the late 1800s and ended in the 1930s.

Researchers formerly believed that the early decline in mortality during demographic transition occurred because society became modernised, the economy was developed and ways were found to treat diseases. But Tommy Bengtsson's research group showed that this was incorrect.

“It was a spontaneous decline. Historically there have been periods with more or less disease and this was a period of diminished morbidity. Only after 1850 is mortality influenced by the modernisation process.”

Before the transition started in Sweden, one-third of the population was under fifteen years of age and only 5-6 percent was over 65. At that time Swedish women on average had four children versus 1.8 today. Transition in the developing nations has gone twice as fast as in the Western world. When mortality started to decline in Western countries, it took 130 years for fertility to level out while the same process took half or one-third as long in the developing nations where annual population growth has been more than double that of Western nations.

“This is due primarily to external influences: they have gained access to antibiotics, better sanitation systems with sewers and potable water, and DDT to fight the malaria mosquito.”

Around 1950, a few years after the UN was formed, world leaders discovered that we were at risk of a huge population explosion. Population growth was found to be 2-3 percent, not one percent as previously thought. The world population was then expected to double within 25-35 years.

“They asked themselves, ‘if we can't manage to feed the population today, what are we going to do when there are twice as many of us?’”

Global focus on the population issue

The expected problems created strong interest in the population issue among politicians and researchers. Initiatives included contraception campaigns as well as lending money to the developing nations in order to accelerate development.

Today fertility has declined world-wide, even if some countries south of the Sahara lag behind because their demographic transition started later. But even there, a clear decline is seen.

Today the global problem therefore is not high fertility – on the contrary, it is a low birth rate.

“The growth rate was disrupted back in the early 1970s, so we didn’t get the population increase we feared. Population growth simply isn’t a problem today.”

Tommy Bengtsson explains that there are two camps within economic-demographic research, one pessimistic and one more optimistic. Researchers from the pessimistic camp warned that a population bomb was about to explode and predicted shortages of non-renewable resources such as copper and zinc. But this has not happened: technological development has allowed us to replace these substances with others.

“The pessimists consistently underestimate technological development and interchangeability.”

The optimistic camp – to which Tommy Bengtsson belongs – believes that humans do not multiply indiscriminately like rabbits; we are social beings and understand what is right and wrong. A pivotal book among the optimists is “The Ultimate Resource” by US economist Julian Simon.

“The Ultimate Resource – that’s the human being. In a chapter called ‘Standing Room Only?’ he asks the question, would we multiply until we could ultimately just stand together like a ribbon of flesh around the world? Obviously we would not. Firstly, we have the ability to recognise a problem and adapt ourselves accordingly; secondly, technological development enables us to replace one product with another.”

Investigations made by Tommy Bengtsson and his colleague Kirk Scott show that when the birth rate declines, the proportion of seniors

increases. During the 20th century, the proportion over the age of 65 rose from 8 to 18 percent in Sweden, almost exclusively as a result of fewer children being born. This gives a more rounded shape to the classical population pyramid with its broad base and narrow peak.

Immigration does not influence the decline in population

By contrast, the rising average life expectancy has yet to have a major effect on the population pyramid.

“Immigration has likewise had no major impact, nor will it be able to in the future,” notes Tommy Bengtsson. “Immigrants also become pensioners and stop having large families. For immigration to have an effect, it must keep rising to compensate for the death rate.”

Demographers formerly hoped that the birth rate after a period of decline would gradually rise again to 2.1 children per woman – the number necessary to keep the population constant. However, since many countries have long been at 1.3–1.4 children per woman, researchers are starting to doubt whether we will ever return to the higher level. Some of the lowest birth rates are seen in China, Germany, Italy, Japan and many Eastern European countries.

“The greatest obstacle to having more children is the difficulty of combining family and work,” emphasises Tommy Bengtsson.

Researchers speak of a country receiving a “demographic gift” at a certain stage. When fertility declines, the proportion of elderly people increases while there are fewer children to provide for. Overall this is a gain for society since a larger percentage of the population is of working age.

China for instance is now enjoying such a demographic gift and Tommy Bengtsson estimates that between one-third and one-quarter of its strong growth is due to this “gift”. However, this advantage eventually disappears. The proportion of elderly people then rises not because of a declining birth rate, but because of diminished death risks among seniors.

“Then we can expect not only an aging population, but also a drop in the percentage who are of working age. A continuing low birth rate not only prevents the workforce from growing, but over time also results in population decline.”

This means that labour shortages will create major problems in the world. Some countries such as Japan are already experiencing population loss of about one million annually. The UN expects about fifty countries to see population loss before 2050.

Most European countries will be affected, although not Sweden. This is partly because we have had fairly significant immigration and partly because our birth rate is slightly higher than in our neighbouring countries. For this we have to thank our family policy which allows women both to work and have a family.

“We are in reasonable shape. But since our welfare system is based on income tax, the tax rate will still have to rise unless total wages increase. The fundamental discussion carried by both the present and past government is that we must get more people into jobs. We have a major potential; there are large groups who enter the workforce late or leave it early on disability pensions.”

Only 65 percent working

A mere 65 percent of the working age population are working; the rest are studying, on disability pension or living off benefits, capital or family money. If you divide working time over the entire population between 20 and 64 years of age, we work on average 21 hours per week. Hence working hours could potentially even be reduced – at least if everyone between 20 and 60 years of age were working, but that is not currently the case.

Tommy Bengtsson believes that our economy would do best if we could get young people working earlier or get disability pensioners back to work. This would give the national economy more tax years than if pensioners stay on a few extra years.

There is also a major potential among immigrants. Today their workforce participation is 20 percent below that of the native-born. In the 1960s, as many male immigrants as native-born were working while even more immigrant women than native-born had jobs.

“We think it’s because the labour market has changed, making it harder to find a job today. It is easier for the well-educated, but many jobs suitable for the poorly educated have disappeared.”

Some researchers optimistically claim that there is a “second

demographic gift”. They believe that as the proportion of seniors increases in society, many will be saving more because they do not trust society to provide for them in old age. These savings are invested in the market, providing capital to corporations which results in more rapid technological development and increased growth.

However, Tommy Bengtsson urges caution before we start counting on this effect, since not enough is known. While empirical studies support the hypothesis, it could also be the result of parallel development. Gradual change is difficult to study because other changes take place concurrently and it is hard to distinguish between cause and effect. We won’t have the answer for several decades.

“I’m not that worried about the future. We economic historians are fairly optimistic because we see how society changes and organises itself to solve problems. We see its inherent strength. That doesn’t mean we can rest on our laurels; it will be a challenge to manage elder care as the proportion of seniors increases.”

Average life expectancy steadily increasing

So how old can we become? Throughout the 20th century, average life expectancy has continued to rise at a high and stable rate of about three months per year in the west, and slightly more for women than for men.

“When I give an afternoon lecture, I tell them that average life expectancy for a child being born now will have increased by one hour during my lecture.”

Average life expectancy in the developing nations has periodically risen even faster, by as much as one full year annually. In the 1930–40s many researchers thought that an average life expectancy of more than 65 was unthinkable. Although average life expectancy forecasts gradually changed, all estimates have proven to be on the low side.

“I think it will continue to rise at this rate for several decades, perhaps 50 years. Sooner or later it has to diminish; we will not live to 1,000 years of age, but we may well achieve an average life expectancy of over 100. Right now there is nothing to suggest that we are approaching an upper limit.”

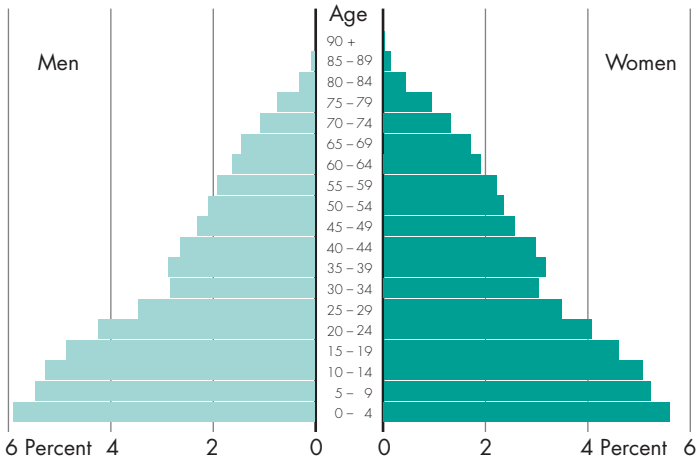
Tommy Bengtsson says that girls born today will reach close to

100 years of age. And we who are middle-aged will live longer than our relatives. “My grandmother lived to be 96. If I become as old as she did – but with the average life expectancy of my annual cohort – I’ll live to be 116.”

Tommy Bengtsson is Professor of Demography and Economic History at the Department of Economic History, Lund University.

FACTS

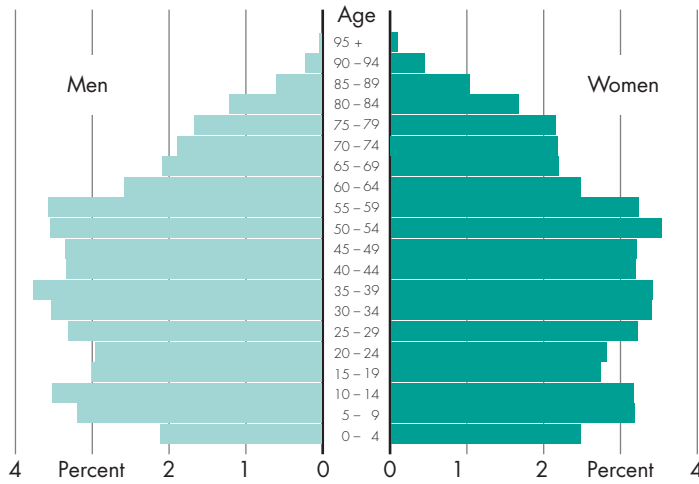
Population pyramid in 1900. Percent by gender and age.



Source: Bengtsson and Scott 2005.

FACTS

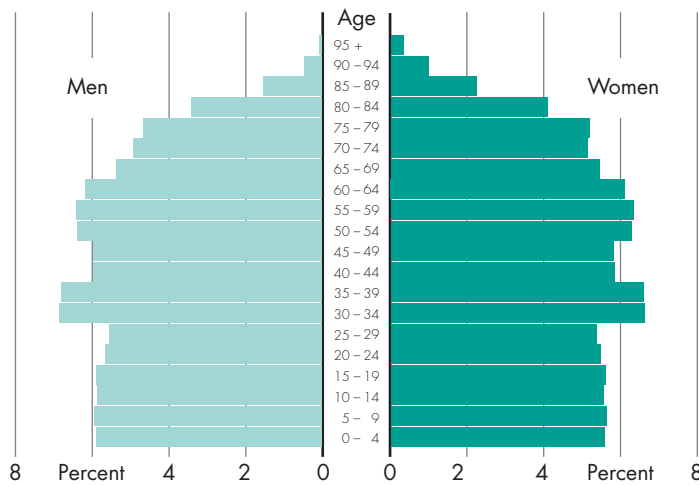
Population pyramid in 2000. Percent by gender and age.



Source: Bengtsson and Scott 2005.

FACTS

Population pyramid in 2025. Percent by gender and age.



Source: Bengtsson and Scott 2005.

CHAPTER 3

Seniors are less healthy – but cope better on their own

Are the very old getting healthier or sicker? That is a question researchers world-wide have long been interested in – and continue to debate. The question is politically highly explosive since the number of seniors is continuing to grow in most societies.

Mats Thorslund and his colleagues have reviewed the international research and found a pattern behind the disparate results.

“The conclusion has to be that seniors have become less healthy. There is nothing to show that they have become healthier. On the other hand, it seems that seniors find it easier to cope on their own in most developed countries – despite being sick and functionally impaired. The explanation is the availability of things such as microwave ovens, ready-meals and more disability adapted homes,” notes Mats Thorslund.

Mats Thorslund is Professor of Social Gerontology at the Aging Research Centre in Stockholm. His office has a view over the Stockholm rooftops and on the wall is a drawing by a writing-happy grandchild: “HUG KISS Granddad to Moa from”.

He started researching the health of seniors in the early 80s and discovered that many who had moved into assisted living were fairly healthy, being able both to cook and make their beds.

“It was misplaced largesse, a waste of public money, but

above all it contributed to growing numbers of seniors becoming institutionalised.”

Seniors were healthier than believed

Already in the 1970s, researchers conducting the H70 study in Göteborg discovered that seniors were far healthier than previously believed and subsequent studies found that they had become even healthier. This picture had a major impact and has continued to prevail – despite researchers long having warned that the positive health trend has been broken.

“Politicians have found it hard to accept that this is no longer true.”

One reason for the controversies about seniors’ health within the research community is the tendency for researchers to examine only one thing at a time: has the incidence of diabetes increased? What about myocardial infarction? Osteoporosis? Are they coping with household chores? Are they demented?

Mats Thorslund and his colleagues believe it is important to look at the overall situation of the elderly. How many have difficulty managing certain chores; how many have diseases; how many are functionally or cognitively impaired?

He calls it feebleness, or comorbidity to use another expression; the accumulation of disorders, diseases and functional disabilities that afflict many seniors around age 80 to 85. Why seniors become sicker we do not really know, but it is possible that one organ system after another becomes weaker, and that this is part of natural aging.

“Our Swedish analyses from 1992–2002 show that more are people are feeble, which reinforces the impression you get from international studies of individual diseases that morbidity is increasing among the elderly.”

Yet more seem to survive longer with their morbidity. In their study, individuals with age-related debility in 1992 and 2002 were followed up after four years. Very many more were still alive four years after the latter date – despite the greater incidence of comorbidity in 2002.

“Even the feeble survive. In other words, it seems you do not

die of your diseases as before, but rather of old age. This is high marks for the welfare system and the healthcare system – it's so well developed that even the sick and weak survive. At the same time it puts a strain on the system.”

Most have years of sickness late in life

This means that fewer people die healthy today. Men in particular often used to die “in their prime,” for instance from myocardial infarction. But survival in classical diseases such as myocardial infarction and stroke has improved dramatically since the early 1990s.

“If this trend continues, very few of us can expect to die quickly from disease when we are reasonably healthy. We have to expect a number of years late in life when we are more or less dependent on others. Care does not cure to the same extent that it prevents death.”

Our life expectancy is continuing to rise and Mats Thorslund sees no signs that we are approaching the ceiling. The rising life expectancy is both good and bad. It means that ever more of us will spend longer in the so-called third age, when you are retired and healthy enough to do more or less what you want.

More of us nevertheless face a longer period in the fourth age when we become more infirm and dependent on others. The conclusion is therefore that while we are getting healthier, we also face more years of sickness at the end. However, studies are still insufficient to tell whether this is a lasting trend.

Gender differences are major; despite being sicker, elderly women live longer than men. The reason is unknown. For women this means being alone in the fourth age. Old men often have a somewhat younger woman by their side, but when the woman is of the same age, the man has most often died.

“We sometimes say that elder care is a female industry since most who work there are women. But mostly it is also women who receive the care. This means that any deterioration in elder care primarily affects women.”

Care is not adapted to comorbidity

The care system is not particularly well adapted to individuals who

need different types of assistance and are infirm in several ways. The specialised healthcare system prefers to deal with one disorder at a time. Mats Thorslund knows this from personal experience since his father was seriously ill physically as well as demented.

“It doesn’t work that well if you break your hip while also suffering from dementia and blood cancer. I’m talking about my dad; these were surreal experiences. Having dementia and at the same time needing injections for your cancer ... He was lucky to have family members who could serve as advocates and act as walking patient records.”

Since the number of hospital beds has diminished radically, comorbid seniors who periodically are admitted for emergency medical care are soon discharged again with their diseases. That is when you really need primary care to take over, but all too often this does not happen. It is left to the home-help service and assisted living units to deal with the consequences of so many sick individuals needing assistance. Staffing at assisted living units has by no means kept up with the growing burden of care, notes Mats Thorslund.

Nor does collaboration between the healthcare system and elder care function very well. Assisted living units fall within the social services which are supposed to provide social care, but many in assisted living are in fact seriously ill, frail and in some cases dying people who need medically trained personnel.

“Everyone is aware of the problem, but much remains to be done.”

Besides the very sick, it is primarily those suffering from dementia who are accepted into assisted living units. For them there is simply no other alternative, unless they have a spouse who can shoulder the responsibility. With the growing proportion of demented people in senior housing, there will soon be no space left for those without dementia, regardless how frail they are.

“I feel the principle of staying in your own home has hit seniors too hard.”

One group which Mats Thorslund believes is poorly cared for today are seniors with mental disorders and existential problems. They are reasonably healthy but unhappy and want to get into senior

housing and some form of community. But there is no room for them there – and, being healthy, they may indeed not fit in – while the home-help service lacks resources and psychiatry does not work satisfactorily for seniors.

No help for spiritual suffering

Mats Thorslund claims that mental suffering – agitation, anxiety, depression and existential angst – are downgraded by the home-help service in its assistance assessments. While such issues are included in the assessors' instruments, research shows that assessors give them little weight. The material, basic physiological needs such as coping on your own and shopping for food weigh more heavily.

“Giving the senior food can be checked off on a list. But dealing with mental suffering and existential anxiety is more difficult.”

A major problem for the future is recruiting staff to elder care. Today 250,000 people work in elder care and we are facing large retirement cohorts in the next ten years. Social care is staff intensive and will remain so for the foreseeable future. Neither smart gadgets, robots nor pharmaceuticals will be able to replace personnel.

Care-related training is not particularly attractive to young people. It will therefore even be difficult to recruit replacements for the retiring cohorts. Mats Thorslund believes only a fraction of the staff requirement can be covered through the training programmes.

In fifteen years, when the large baby boomer generation starts to approach the age of 85, we will have large numbers of old and sick seniors. Mats Thorslund sees no quick solutions to morbidity among the elderly that would contradict this scenario. There is for instance still no vaccine against Alzheimer's disease on the horizon and we have no really good solutions for osteoporosis.

“I foresee no major breakthroughs in medical care in the next fifteen years that could solve these problems. At that time we'll need more staff than now.”

He sees three possible solutions: making elder care attractive to people in other occupations; attracting people who are not in the labour market today; and labour immigration.

However, we will have to compete for the labour immigrants; all

European countries are suffering the same labour shortages. Labour immigration therefore has to come from countries outside Europe.

Future competition for workers

“My guess is that all EU countries will compete much more actively in future for labour immigration, and what is there to say that we in Sweden would be attractive in that competition?”

A failing birth rate is not limited to Western countries; the same applies to populous countries such as China, Japan and India. Preparing for a recent lecture in China, Mats Thorslund calculated the number of individuals of working age who can provide for the 80+ population – and who are potentially dependent on social care.

His calculations showed that in the 1970s Sweden had 25 individuals of working age per person over the age of 80. By 2007 this had dropped to 11. The prognoses suggest that we will be down to just 7 working age individuals per 80 year-old by 2040, and the picture is similar throughout Europe.

In China the decline has been even faster. In 1970 there were no less than 250 workers per person over the age of 80, but this number is now down to 50 and is forecast to drop to 12 by 2040. The one-child policy has obviously contributed to this rapid change.

“So it isn’t hard to realise that times are different today; that some welfare services are finding it difficult to obtain both funding and staff.”

Greatest savings already made

How then are we to prioritise the necessary resources and where will we find staff? Are there savings left to be made? Mats Thorslund believes both healthcare and elder care is cost effective today and that we are getting a lot for our money – even if not everything is perfect. When municipalities stopped expanding elder care in the early 80s, they invested in development instead: training programmes, new forms of care, evening and night patrols, group homes, day care and collaboration between providers.

“It was possible to do lots of good things that were effective, but the more efficient you were, the less there is left to do. My assessment

is that the major savings opportunities have been exhausted.”

He suggests that while options such as private enterprise, staff training and vouchers to be spent with the provider of your choice certainly can have benefits, they fail to solve the major problems of a growing number of seniors needing assistance and the difficulty finding staff.

What changes and modifications are then required within the system? If we can no longer do all we used to, what should we prioritise?

“I think it’s reasonable, and I believe there is consensus on this, that elder care and healthcare should be prioritised over other needs. In surveys of what people want to prioritise, healthcare and elder care are always high on the list.”

He points to certain issues that he believes are central and necessary for coping with the elder care of tomorrow, and these relate to staff conditions. First of all the work must be made more attractive in order to facilitate recruitment.

Higher pay and increased staffing necessary

“Obviously low pay is an important factor – the fact that we in Sweden today place such a low value on jobs that involve working with people. I also believe increased staffing would have an effect. The staff now have so little time to provide social and medical care. Many who work within social and medical care for seniors have chosen this occupation because they want a meaningful job – to work with people and make a ‘worthwhile’ contribution.”

Studies show that many workers find the present-day low staffing level inadequate – despite doing all that can be expected in a day of work. Such feelings can result in staff leaving; hardly a competitive advantage when it comes to recruiting new staff.

Mats Thorslund’s other conclusion relates to leadership. In the 1980s and 90s the organisations were streamlined – the elder care hierarchy was flattened by reducing the number of managers. As a result, responsible managers often have so many subordinates that they lack any real opportunity to provide feedback to their staff. Certainly not on a daily basis, and often not even weekly.

“Reducing the administration by removing a large number of

managers – which was seen as a way to economise and achieve greater efficiency – has in my opinion gone much too far.”

This means that real leadership is lacking in many places; a problem both in terms of staff management and getting everyone to pull in the same direction. But also in terms of reassuring staff who may have done their best and yet are forced to go home at night with a feeling of inadequacy.

Mats Thorslund obviously knows that these measures are costly in terms of requiring additional staff. He is not keen on private solutions, such as voluntary insurance, or those with money paying for their own care. He suggests that this is out of keeping with the welfare system to which we have become accustomed. The current elder care system is classless and does not differentiate between individuals. This has been a deliberate approach which was popular even when the home-help service was developed in the 1960s and 70s – among all categories of users. Providing public funding only to the impecunious will emasculate the Swedish model.

Mats Thorslund sounds a little pessimistic looking at the future. He believes the current welfare model will face difficulties.

“The equation is not soluble. I think the families, especially the children, will have to do more for their seniors in future.”

Mats Thorslund is Professor of Social Gerontology at the Aging Research Centre in Stockholm.

FACTS The age ladder

How old are you? In Sweden we place strong emphasis on chronological age. This is a problem, because age as such provides no information about a person's health or functional ability. To get away from the problem of chronological age when describing seniors, researchers prefer to speak about the third and fourth age.

The first and second age

The first age is childhood and youth and the second age the working period in adulthood.

The third age

The third age is the period in life after retirement when your ability to be active is not really limited by ill health. Most people today have many healthy and meaningful years ahead after retirement.



The fourth age

For many, the fourth age from 80 onwards is characterised by illness and impaired functional ability. You can no longer cope by yourself and become dependent on others. A Norwegian study showed that seniors who became dependent on help to dress and move around their homes on average had three years left to live. The women had just over three years left, the men had barely three.

Source, text:

Åldreforskningens Hus, The Gerontology Research Centre/ARC, Stockholm.

ILLUSTRATOR: GUNILLA KVARNSTRÖM

CHAPTER 4

Seniors are healthier and happier today

Ever more seniors enjoy an active love life well into old age and happy marriages are increasing. But there are also more who divorce at a mature age and many seniors develop depression and dementia.

These are the findings of psychiatrist Ingmar Skoog at Sahlgrenska University Hospital who has studied the health of seniors for many years. He has been involved in several major population studies in Göteborg: the H70 study, the population study of women, the 95 plus study (see facts at end of chapter).

“Seniors are healthier and happier today than thirty years ago,” concludes Ingmar Skoog.

He does not find this very strange; our lives have become much better. In the past, many seniors lived under difficult, even miserable, conditions with no hot water, an outdoor lavatory and no lift. He finds that younger people often are prejudiced against seniors, believing that seniors feel worse than they do. Ingmar Skoog has a long perspective, having joined the H70 study as a young doctoral student in the early 80s.

“It was a huge thing getting to interview 85 year-olds. They were 50 years older than I was and many had lived such rich and interesting lives. You got their life histories as a bonus.”

Ingmar Skoog has since interviewed close to a thousand senior citizens around Göteborg and got to know many of them.

Participation in the studies is high; the elderly are happy to give of their time.

Seniors have a better love life

He notes that seniors have a better love life today than thirty years ago. Those who consider their marriages very happy have increased from about one-third to one-half. At the same time the number of divorces has risen from hardly any to ten percent among men and sixteen percent among women. Perhaps divorce has become more acceptable today.

More are sexually active, many feel they have a better sex life and fewer sexual problems than those interviewed thirty years ago. Sexual activity continues well into old age: at age 85 one-quarter of married men and one-sixth of married women remained sexually active while even more experienced sexual desire. The gender difference is explained by women often being married to men who are a few years older and therefore probably more infirm than the women.

By contrast, single people in the same age group had no active sex life which suggests that it is good – especially for women – to have a steady partner if they want to continue having sex in old age. At the age of 85 there are five single women to every single man, and women therefore have limited choice.

One could expect existential crises to be common among seniors as their bodies become weaker and people around them get sick and die. But that is not really the case, suggests Ingmar Skoog.

“We tend to say that seniors are more robust when it comes to crises. Many crises that are difficult when we are younger, seniors are more prepared to face. If you lose your spouse at age 40, you also lose the dream of a life together. When you reach age 85 you are more prepared; it isn’t that strange. The grief may be profound, but the emotion is not quite the same.

He tells us that the researchers have met women who actually blossomed after the death of their husband, having been invigorated by the need to take more responsibility. For men who lose their wife, the risk of depression increases but women do not appear to be affected the same way.

Apparently the elderly also do not think that much about death. The most common interview response is that they are not worried about death. Ingmar Skoog suggests that even if seniors at one level are aware that time is getting shorter, most do not worry that much about it. They want to get on with their lives and assume that they have many years left, just as younger people do.

Loneliness among the oldest in society

Among the very old, many nevertheless suffer from loneliness. They no longer have any contemporaries, none who share their life events or have the same historic background and experiences.

“I think this leads to a lot of loneliness, even if our studies show that most seniors have a great deal of contact with their children and relatives. But many feel lonely even if they have contact with their children.”

Loneliness can lead to depression, but depression can also lead to loneliness because the elderly person withdraws, and it is hard to know which is the chicken and which the egg, observes Ingmar Skoog.

Depression is indeed the most common mental disorder among seniors. One-tenth of those over 70 are affected and mild depression increases among 75 year-olds. This makes depression more common than dementia. While dementia increases sharply with advancing age, the incidence of depression is roughly the same in all age groups.

Women are more affected by depression, and this is true in all cultures. Sixty percent of women become depressed at some point in their life; among men it is barely one-third, according to the latest figures. Ingmar Skoog considers depression one of the most underrated diseases among seniors.

“Undiagnosed depression is one of our greatest problems when it comes to the health of seniors.”

Among healthy seniors, world-weariness is the most important explanation for a short lifespan. Those who experience world-weariness, which is strongly linked to depression, have a shorter lifespan. Suicide is not the reason – this is after all quite rare – and the cause of death is most often cardiovascular disease.

“We have found depression to be the most important causative factor for stroke in seniors – a greater risk factor even than hypertension. We don’t know why, but depression affects the entire body and there are signs suggesting that it can influence blood coagulation, vascular function and blood pressure. Having to deal with depression is stressful for the body.

As mentioned, it is not very often that depression leads to suicide; yet among seniors who do take their own life, most have suffered from depression.

Failure to recognise the symptoms of depression

A fifth of 85 year-olds with depression had no antidepressant medication, according to a study published in 1993. This is unfortunate, says Ingmar Skoog, since this is a disease with many consequences. While depressed seniors seek more medical care than others, it is generally not because of depression but for other reasons. Perhaps they feel dejected and sick of life; they have lost their appetite, they have no strength to do anything and cannot sleep at night.

“But they don’t see the need to go to the doctor, because they don’t realise that these are symptoms of a treatable disorder. The big thing about detecting depression is to get people to recognise their own symptoms. We need to reach out more to the population and provide information,” notes Ingemar Skoog.

He points out that even though family doctors nowadays receive much information about depression, they may only have ten minutes for a consultation. And then it is easier to treat for instance sleeping problems, if that is what the patient complains of, than to review all the symptoms.

While some seniors do not get antidepressants when they need them, there are many others who are on several concurrent medications despite our having limited knowledge about the actions and interactions of drugs in the elderly. At age 85 it is very common to be taking psychopharmaceuticals.

“Pharmaceuticals are often tested in young and healthy subjects. It’s a general problem that medications are tested on groups other than those who will use them.”

Difficult life events early in life increase the risk of developing mental disorders in old age. The more traumas you have experienced, the greater the risk of developing dementia. The risk is greatest if the event occurred before 16 years of age, for instance with the loss of a parent.

Dementia affects life expectancy

Dementia is nevertheless the factor with the greatest impact on remaining life expectancy. For a person who becomes demented – whether at age 85 or 95 – dementia is in other words the most common reason for death within the next few years. Dementia increases the risk of premature death more than either cardiovascular disease or cancer.

Why this is so we still do not know, but since many bodily functions are controlled by the brain, the explanation probably lies there: as the brain is slowly broken down by dementia, it loses its ability to control bodily functions.

Dementia is more common among men and increases sharply with advancing age. At the age of 70, two percent suffer from dementia; at 80, ten percent; at 85, one third and at age 95 one half. This is because the risk factors grow in number; since dementia is caused by many different factors, the risk of encountering these factors increases the older you get.

“It’s important to remember that even if many people suffer from dementia at 95–100 years of age, there are also many who are not; who are clear-headed and lead a rich life,” observes Ingmar Skoog.

So what should we do in order to feel well in old age?

“Lead a healthy life when you are younger,” responds Ingmar Skoog.

In other words exercise, eat healthy food, keep your weight down and make sure you get treatment for hypertension. As a senior, you should try to lead an active life and keep both your brain and body going. Even among the healthy, brain function is the most important deciding factor for life expectancy.

“The brain is more important than you think. It is enormously complicated, an interplay of thousands of different substances and

functions. The more we learn, the more there is to study,” notes Ingmar Skoog.

Ingmar Skoog is Professor and psychiatrist at Sahlgrenska University Hospital in Göteborg.

FACTS The population study of women

The population study of women was started in 1968 by Dr Calle Bengtsson, specialist in primary health care (now Professor Emeritus), at Göteborg University. The purpose of the study was to identify risk factors for premature death and various diseases. At that time 1,462 women aged 38, 46, 50, 54 and 60 underwent medical examination and were interviewed about their life. The women have since been examined in 1974, 1980, 1992, 2000 and 2005. On these occasions, new women have been recruited to the study, making it possible both to follow a specific generation through life and compare different generations to each other. At the same time, additional women have continually been recruited to the study. Today there is consequently material which not only allows observation of medical differences between e.g. a 38 year-old woman in 1968 and a 38 year-old today, but also allows an age cohort of women to be followed over time.

FACTS The H70 study

The H70 study was started in 1971 by Professor Alvar Svanborg, Göteborg University; a pioneer in gerontology. H70, the first population study that tried to establish how seniors really felt physically and mentally, showed that seniors were healthier and more vigorous than expected. Until then the health of seniors had been interpreted on the basis of those who lived in old-age homes and nursing homes.

The original group of 70 year-olds, born 1901–02, were examined and interviewed 16 times and today none of them survive. However, new groups of 70 year-olds have been added, the most recent born in 1930. Several research groups within geriatrics, primary care and epidemiology are collaborating.

CHAPTER 5

Comorbid seniors forced to stay in their own homes

Seniors with multiple diseases are a vulnerable group. They have little access to assisted living and their relatives carry a heavy burden. No-one has overall responsibility for their care.

This is what Ingalill Rahm Hallberg has found as head of the Swedish Institute for Health Sciences – the Vårdal Institute – in Lund, a research and training institution, www.vardalinstitutet.net. She is in Göteborg to meet a new group of doctoral students and we are talking in the lobby of a city hotel. She is Professor of Health Science and for ten years has been the director of a research group.

Their research shows that the care system does not work very well for comorbid seniors. The comorbid make up 15–20 percent of the elderly and are major care consumers. They often go in and out of hospital and visit specialist clinics, regardless of whether they receive community care and nursing or are being cared for by relatives.

Seniors cared for at home more often end up in hospital than those in assisted living – even though you might expect the latter group to be the sicker.

“We were somewhat surprised to find that those who are major consumers within one care system are also major consumers within other systems. In other words, the systems seem not to compensate for each other. The healthcare system is designed for reactive care, not preventative. We only react when there is an emergency, and then the

senior may at worst be shunted between emergency care, primary care and specialist care. No-one takes overall responsibility.

A lot falls between the cracks

An ongoing study has been following a group of community nurses. They have a coordinating individual responsibility for a number of comorbid people whom they visit at home and assist in various ways. These nurses were recruited from emergency care and collaborate with all parties but are employed by the healthcare system.

It is too soon to comment on results, but the study already shows that despite the comorbid having many different care contacts, many things fall between the cracks, as these nurses are discovering.

A few examples: One woman had a foot ulcer which would not heal despite the dressing being changed daily by staff. It was painful and the foot was threatened by gangrene. The nurse discovered that the woman was suffering from undertreated diabetes and when this was brought under control and vascular dilatation performed, the woman recovered.

In another woman who suffered from unexplained pain, it was found that a pin from earlier hip surgery had come loose.

“In spite of all the contacts, the overall perspective was missing. The key to optimal care is for someone to have overall responsibility. It can be organised in various ways, but the important thing is to identify these seriously ill people so that they get the help they need.”

Anxiety and depression are also common among seniors, even among those with no history of psychiatric disorders. Some access emergency health services because they feel lonely, abandoned and frightened. They know they are dependent on the home-help service being available if something should happen. Or, if they do not have home-help service they worry about “who would find me if I should fall?” Many also worry about developing dementia.

Yet we have no strategies today for dealing with agitation and feelings of loneliness among seniors, suggests Ingalill Rahm Hallberg whose own background is in psychiatric nursing. We know too little altogether about mental suffering among seniors – is it a natural part of aging or is it worry about one’s own life situation?

The dying are forced into hospital

Care at the end of life also does not function particularly well for seniors. Ingalill Rahm Hallberg believes the ideal care for seniors at the end of life would be to let them remain in their usual environment, give them pain relief, avoid acute interventions and let them “die while they are still alive” rather than lie there as a care-requiring bundle. Instead, many find themselves in hospital towards the end – no less than 40 percent of those cared for at home and 20 percent of those in assisted living.

Why does it turn out this way despite good intentions? A possible reason is that the family does not expect their relative to die, and is taken by surprise.

“Staff do not seem to talk very much to the relatives about death and dying. So when the senior deteriorates, the relatives become very anxious and call for emergency interventions.”

Many seniors also find it painful to think about the process of dying, although not about death in itself – which they know will come sooner or later.

It may also be that staff working in the sick person’s home are insecure. They may not know how serious the situation is – is this part of a natural phase or is emergency care required? During weekends and evenings it can be difficult to contact healthcare professionals for advice, and such situations often end with an ambulance ride to the hospital.

“We are good at providing terminal care for younger individuals, for example in hospices, but not for seniors who are cared for at home. It’s not a matter of ill will or ignorance among the staff, but about the system failing both the staff and the seniors.”

Poor training level within elder care

In general the staff do the best they can, but many have little or no training at all. The training level within the home-help service, home health care and assisted living is not high.

“There is nothing wrong with the staff in general, they do their best and most are able and willing to learn. But they lack tools in the form of knowledge and time. It borders on the immoral when staff

with no knowledge are sent to deal with difficult situations. They don't have access to what they need; both support and leadership are missing.”

The transfer of information is also deficient. Because of a zealous approach to confidentiality, home-help service staff receive too little information about the seniors' physical diseases. Ingalill Rahm Hallberg believes the Ädel reform which transferred responsibility for care of the elderly to the municipalities, created a boundary between the social and the medical spheres; between body and soul.

We need better healthcare knowledge within community care.

However, it is possible with quite modest means to support staff to do a better job. In the 90s Ingalill conducted research on dementia and was responsible for an intervention study which investigated whether staff guidance and individual care planning could influence the seniors' behaviour. Staff received guidance for half a day every other week.

The intention was to make the staff feel secure enough not to take offence, for instance from outbursts of rage, but understand the possible reasons for the seniors' behaviour.

“The attitude to the seniors changed dramatically. The strengths released through the guidance were amazing. I developed great respect for the consideration, care and empathy of the staff once they had a chance to express it.”

Ingalill Rahm Hallberg talks about a group from China who recently paid a study visit to a senior housing establishment in Skåne and got to speak both to the staff and the seniors. It was amazing how well it all turned out and how proud the staff were of their job.

Ingalill points out that staff are crying out for knowledge, as shown, not least, by the study circle programme at the Swedish Institute of Health Sciences. Research-based study material is available both on the institute's website in what are known as thematic rooms and through the training of study circle leaders. The website comes up high on the list, for instance when you search for “dementia” on Google, indicating that it is much in demand.

Relatives have to shoulder a great deal of responsibility

Relatives also become increasingly involved with care. More and more care is provided at home, which automatically pushes responsibility onto families. A study about caring for relatives showed the family to be the major carer.

Relatives take responsibility not only in the care recipient's home, but also at other times for instance by shopping, running errands, keeping in touch by telephone and checking that everything is OK. The phase that affects relatives the most is the period before a real care situation has arisen; when the senior starts to totter and they themselves shoulder all the responsibility.

“This is when many relatives feel very anxious and insecure. Then it is important for caregiving staff to have good relations with the family in order to transfer the necessary knowledge.”

One study showed that among care-requiring seniors who continued to live at home, one group was cared for only by their relatives, another group by both relatives and staff, and a third group – those with no relatives close by – by staff alone. The most care-intensive received care from both staff and relatives. However, those who received the most community services were not the most care-intensive, but those who had no relative to help them. Relatives consequently shoulder a heavy burden.

Ingalill Rahm Hallberg sees a systemic fault within elder care: we have concentrated so much on seniors with cognitive functional disabilities that we have forgotten those with physical diseases. People with dementia are accepted into assisted living units while those with physical conditions stay on at home.

She asserts that today's elder care is a response to the way things used to be, before the Ädel reform appeared in 1992, when elder care was characterised by large chronic care hospitals and old people's homes with an authoritarian attitude towards seniors. Reaction to what went before resulted in the approach of reducing the number of chronic care and nursing home beds. The process was hastened by the difficult economic situation in the 1990s.

“The disappearance of that mode of operation was probably a good thing, but the reduction in living facilities with a high level of

medical and social care has gone too far. It became like a mantra that seniors were best off remaining in their own homes. But in reality it was best for the municipalities. The problem is that we always respond to the past, not to what is coming.”

Communal living needed

Ingalill Rahm Hallberg points out that seniors must be allowed to decide for themselves where to live. There is no scientific evidence whatever to suggest that a sick old person would be better off at home. Surveys directed at younger respondents provide no reliable answers – younger people cannot possibly know where they would rather live in the autumn of life; you only understand that when the day arrives.

The more functionally impaired seniors become, the more their social network contracts; a cornerstone also in the life of seniors. If I can't go out, how can I get together with my friends and acquaintances? Disability modifications are obviously good, but do not help combat loneliness. We need different forms of group living that suit seniors with physical functional disabilities, says Ingalill Rahm Hallberg.

She is fully aware of the economic reality, but suggests that we must identify what the public mandate includes. What can I expect in terms of public support when I am old, and how should the care be organised?

Do we perhaps need another Ädel reform?

“Yes, I've thought so for a long time!”

Ingalill Rahm Hallberg is Professor of Health Science and head of the Swedish Institute of Health Sciences in Lund.

CHAPTER 6

Dementia – a disease with a dramatic course

Dementia is perhaps the disease most often associated with aging. It becomes common only at 65–70 years of age, after which its incidence increases dramatically. However, you can prevent dementia; with the right kind of stimulation the brain can develop reserve capacity.

“It’s important to explain the significant role played by dementia. This is the most common disease among seniors along with hypertension and heart failure. It is also the disease which more than any other results in functional impairment,” says Laura Fratiglioni, Professor of Geriatric Epidemiology and Director of the Aging Research Centre (ARC) in Stockholm.

Laura Fratiglioni is originally a neurologist and has been fascinated by the brain since her early student days.

“I have thought of it as the home of the soul and thoughts. The brain is fascinating. There is so much we don’t know about the way it functions; so many parts that we don’t use and don’t even know why they are there.”

Laura Fratiglioni grew up and trained in Italy. She started her medical career as a neurologist in Italy in 1977, but often felt frustrated because there were so few treatment options for neurological diseases at the time.

“You needed something to give to people. I often thought that we should start preventing instead because treatment is so difficult,” says

Laura Fratiglioni.

She became increasingly interested in epidemiology and prevention. Epidemiology brought her closer to gerontology since she was working extensively with diseases such as stroke, dementia and Parkinson's which are all common at an advanced age. She has since taken a growing interest in the aging process and what influences the health of seniors.

When Laura Fratiglioni decided to obtain her doctorate in the early 1990s, she wanted to study Alzheimer's disease and moved to Stockholm because that was where the Kungsholm project was being run, a world renowned older population study which already at that time had an extensive and – for a researcher – very attractive database.

“It contains masses of data that we still use, go back to and find new ways to analyse. Questions are always arising that haven't been asked before.”

New knowledge about dementia

The Kungsholm project has given researchers much new knowledge about dementia. Dementia is actually caused by several different diseases, Alzheimer's being the most common, but since the various types can be difficult to differentiate, it is more relevant to study them as a single disease in terms of public health.

Dementia is a chronic disease causing dramatic changes for the individual, family and society.

The number of cases doubles every five years and half of all seniors have dementia by age 95. The disease progresses rapidly: after three to four years, half of dementia patients are completely care dependent. Overall the disease tends to run its course over five or six years, even less if you are very old.

Dementia is becoming ever more prevalent world-wide, not because the disease is becoming more common as such, but because the number of seniors is growing. While the Western world already has an aged population, the developing nations are now going in the same direction – and since they are more populous, the increase in dementia will be more dramatic there. Forecasts point toward 100

million dementia patients world-wide by 2050, compared to 30–35 million today. The resulting cost to society is enormous.

There are numerous hypotheses about the causes of dementia, some proven and others requiring more research. Briefly, the risk of developing dementia depends on genetic vulnerability and the number of risk factors and protective factors you are exposed to in your life. Risk factors which researchers are absolutely certain of are:

- Genetic vulnerability, where so far one gene, apolipoprotein E (APOE), has been identified although other genes are also vulnerable.
- Vascular risk factors related to the body's circulation, for instance hypertension. In old age, low blood pressure is also a probable risk factor since it becomes more difficult for the heart to send blood to the brain if the pressure is too low. At a younger age the brain can nevertheless regulate the pressure, but those mechanisms do not function as well later in life.
- Smoking is also a risk factor, as is diabetes, but we still do not know why.

Protective factors against dementia

Among the interesting but still unproven hypotheses about risk factors are exposure to substances such as aluminium and solvents as well as occupational exposure to electromagnetic radiation.

There are also protective factors against dementia. According to the “brain reserve hypothesis”, we are able to influence our in-born mental function throughout life. Mental activity can increase the reserve capacity of the brain, in terms of nerve cells and the connections between the cells, the synapses, and through increased activity in different areas of the brain. This means that in people who actively exercise their brain, it will take longer for symptoms of any dementia to appear.

In the Kungsholm project researchers discovered that cognitive tests can reveal changes in the intellectual ability of the brain as much as six years before a person is diagnosed with dementia. The changes can remain stable for several years until something suddenly happens that triggers the onset of the disease. The cause of this is still unknown.

The “brain protection factors” include education, a mentally stimulating occupation, active leisure time and a social network.

“It’s about using the brain, just as you must use your muscles to prevent them from atrophying. We often think of aging as something that starts after age 70 or 80 – but that’s not true; we age throughout life.”

Researchers are also studying whether folic acid, vitamin B12 and antioxidants can protect against dementia, but these are still unproven hypotheses. In such case they would protect against oxidative stress that breaks down the nerve cells.

We can prevent dementia in more or less the same way we prevent aging in general: by taking care of our body, being physically active, avoiding stress, eating healthy food, keeping our weight down and avoiding smoking.

“As one of my colleagues says, ‘what’s good for the heart is also good for the brain’.”

Keeping your blood pressure under control is very important, especially for preventing dementia, as is keeping active and occupied in various ways after retirement. Laura Fratiglioni recommends choosing activities that have several components, such as attending courses. This provides both mental and social stimulation and – if you walk there and back – physical exercise as well. This can halve the risk of dementia.

Dancing is an excellent example: it offers mental, physical and social stimulation and was shown to prevent dementia in an American study. But most important is doing something you enjoy, notes Laura Fratiglioni.

“People always ask what activities I recommend, and my usual response is: continue doing what you enjoy. Don’t force yourself.”

Laura Fratiglioni is Professor of Geriatric Epidemiology and Director of the Aging Research Centre (ARC) in Stockholm.

FACTS The Kungsholm project

The Kungsholm project is an epidemiological study of seniors initiated by gerontologist Bengt Winblad and psychologist Lars Bäckman in 1987. They chose to carry out the study in Kungsholmen, at that time the urban district with the highest percentage of seniors anywhere in the world – one-third of the population was over the age of 65. Everyone born before 1913 was invited to participate in the study and 1,810 individuals accepted.

They have since been examined four more times and new cohorts of seniors have been added. Study participants have been aged 75 and older. Today there is an extensive archive containing data on about 2,500 older individuals whose health has been followed over time. The last examination took place in 2000.

CHAPTER 7

The elderly are growing in number – but fewer are receiving elder care

Since the late 1970s there has been a steady decline in the number of seniors who receive elder care. In the same period, seniors have grown considerably in number.

“This means that fewer seniors are receiving assistance from the public system and we have to ask ourselves what the consequences will be. Are they without help or are there others who step into the breach?” wonders Marta Szebehely who is a Professor in the Department of Social Work at Stockholm University.

We meet at her home in the Söder district of Stockholm over a pot of green tea. She is at home preparing for the annual research day on seniors and elder care to be held in the department the following day. It generally attracts hundreds of interested participants from healthcare, the general public and government agencies.

Her research shows that the 80+ population has risen by 240,000 since 1980 – but 100,000 fewer seniors over the age of 80 received assistance in that period. Since 2000, home-help service to seniors has again increased slightly, but this is countered by a cut in the number of senior housing units.

“We have definitely improved the institutions, even if the number of places has been reduced too much. At the same time the home-help service has become increasingly institutional – and definitely poorer.”

Elder care can be organised in many ways. By far the greatest part – in all countries – is unpaid care provided by the family. This

can be supplemented by publicly funded elder care provided by public agencies, non-profit organisations and private companies, or by financial support to relatives.

Publicly funded and publicly provided

Swedish – and indeed all Nordic – elder care has been unique by being publicly funded as well as publicly provided in the form of the home-help service and senior housing.

“We are now seeing clear shifts. Both from publicly paid social care to the family as “unpaid social care” provider, and from publicly funded services to privately purchased services. Whether they are purchased on the white or black market is something we know very little about.”

Marta Szebehely notes that a clear class pattern is discernible:

“It’s above all poorly educated seniors who get more help from relatives than 20 years ago while well-educated seniors get more private help.”

She believes the shifts are due not to legislative changes, but to changes in municipal guidelines. Municipalities have raised their requirements and resources have diminished. But another very likely reason is that seniors refrain from applying for assistance to which they may be entitled.

It is not very common for seniors to be refused; the mechanisms come into play earlier – they simply refrain from applying. It may be because they expect to be refused, because they believe or know it will be too expensive, or because they do not want the help the way it is organised.

Many for instance only get help with cleaning every three or four weeks, and then it hardly seems worthwhile. They expect to see different staff each time; “I just can’t cope with so many different people coming,” or they would like help with cooking but expect that “they’ll just give me meals on wheels and I don’t want that.”

“That may not be true, because in many places they have started going back to cooking. But if I as a researcher barely know this, how would the seniors know?”

There used to be an assigned care worker

Marta Szebehely looks back on how the home-help service was organised in the 50s, 60s and 70s.

“Back then you had an assigned care assistant; you were given a time and agreed on how that time should be used. There was a basic decision about the senior’s needs, but exactly which day to shower and which day to go for a walk – that was left to the staff. In many places that flexibility is now gone.”

Its organisation has gone from one assigned worker to many and perhaps not at fixed times. The decisions are more detailed. If you do not wish to shower that particular day, the staff is expected to leave and write a nonconformity report – even if some staff members quietly show more flexibility.

“The general trend has been to deprive staff of the freedom to make decisions.”

She maintains that this is linked to the introduction of private providers – which led to demands from the funding providers who needed to know that staff were really doing what they were supposed to do.

“Still we mustn’t forget that these are general trends. In many places the home-help service is still very good. That’s something we should pay more attention to,” notes Marta Szebehely, “otherwise seniors will think that it is always poor, everywhere.”

The home-help service is still popular; it has had a good reputation among people ever since its inception in the 1950s. Among those who have no spouse, the vast majority want help from the home-help service. Few want to purchase private help and few want help from their children, according to the research. There are more children wanting to help their parents than there are seniors who want them to help.

Seniors might perhaps allow their children to help them with their income tax return once a year, but not with cleaning, laundry – and definitely not with personal hygiene. Marta Szebehely thinks the reason could be that seniors feel that their children have their hands full and do not want to burden them.

Seniors do want contact with their children, but would rather

spend the time sitting around the kitchen table talking about everyday things, about how things are right now or about more existential questions, reminiscing about life. If the child has to do cleaning, perhaps you shouldn't add to the burden by talking.

What has happened in the 2000s with the decline in assisted living units is that seniors who would previously have been in senior housing now live at home and get home help. This has given the home-help service more clients with major needs who are frail and lonely, while those with more modest needs are being excluded. Those who have major needs, but are married, also tend to be excluded. Even if they could get help, they do not ask for it.

Unpaid family help has increased

While the home-help service has diminished, unpaid family help has increased. It has replaced the home-help service for those with minor needs and supplements the home-help service more than before for those with major needs. And most helping family members are daughters.

When the home-help service was being established, various forms of family allowances were also introduced, but these have diminished considerably since the 1970s. At the peak there were 25,000 paid family carers; today there are only a couple of thousand. This is entirely contrary to the European trend of investing heavily in allowances to family members who act as carers.

“There is a certain scepticism in Sweden about paying family members; it's seen as a trap for women. But you have to wonder if it isn't an even bigger trap for women to provide care without pay, if that is the alternative,” says Marta Szebehely.

In Stockholm there is a new trend: seniors can choose their home-help service provider and some firms have specialised in hiring family members. They primarily target immigrant families, who then know that they will receive their own daughter as a carer.

Hence the trend is for more family members to become carers – but not for more family members to receive allowances. It is likely that increasing numbers are also giving up paid work to provide care, particularly women. In 2000 for instance, 45,000 women and 15,000

men aged 55 and older reduced their working hours or stopped working to care for a relative. Undoubtedly there are also women who never got beyond working part-time, having taken on a care responsibility ever since their children were small. But they are not visible in the statistics.

Seniors forced to ask their children for help

Care by family members has consequently increased, but few seniors want their children as helpers. What consequences does this have for intergenerational relations?

“I call it forced assistance. It is primarily poorly educated seniors who end up with family members as carers, and it is working class daughters whose family responsibility has increased. How does this affect them? What does it mean for their future pension? That’s something we know little about. Sometimes there is a perception among politicians that family work is a good thing – and that it carries no price tag. But that’s not true.”

More affluent seniors can to a greater extent purchase private services and claim tax deductions for household services. For someone with a good pension who needs moderate assistance, it is even cheaper to purchase household services than to use the home-help service since the home-help service charges are means-tested.

Many municipalities are now introducing options into elder care where seniors can choose between private and municipal providers. However, there is a difference between private and municipal home-help services: The private – but not the municipal – home-help service can offer supplementary services which you pay for personally. Examples include more frequent or extra thorough cleaning.

“This means that if you choose a private provider, you can top up with extra services that are tax deductible. This provides a clear incentive for the more affluent to choose a private provider since they can get the same staff to do that little bit extra over and above the basic provision.”

She suggests that what remains of the municipal home-help service risks becoming social care for the poor, just as it was before home-help service was introduced in the 1950s. Middle-class seniors will

either be left entirely outside the system to purchase private services, or they will enter the system when they develop major needs and use a private provider for unsubsidised services which they will pay for out of their own pocket.

Working class daughters carry the burden

“That won’t make them over-eager to defend the general welfare system, and its legitimacy will then be threatened. I regard this as a major risk; we are in a period of transition. The worse the municipal home-help service becomes, the more people will look for other alternatives. This will soon get us into a situation where people start wondering, ‘should I be paying taxes for something I don’t think is good’. Working class daughters will once again have to carry the burden; they can’t buy services for their parents because they don’t have the money,” notes Marta Szebehely.

Moreover, she points out, these daughters often work as staff within elder care. Most who work in elder care are women, and since one-third of them are 55 or older, they often have aged parents who are being affected by cutbacks in the self-same elder care system.

When you ask seniors what they want to have influence over, choosing the provider is rarely mentioned. Being able to influence the assistance is much more important. They want to decide who should come; they want someone they like and they want continuity; they want to decide when the care worker should come and what needs to be done. But this is not part of the client option model. All it lets you do is choose between provider A or provider B.

“The client notion is based on a different category of seniors than those focused on by the home-help service. It’s a good idea to give seniors more influence over their everyday life. But we’ve focused only on which organisation should be the service provider, not on having more power to decide what they should do, which would be more relevant from the seniors’ standpoint.”

Good situation compared to other countries

Marta Szebehely is nevertheless optimistic about the future. She points out that we have economic growth and that much of the rise in

the senior population is behind us, compared to many other countries. At the moment we are the country in the world with the highest proportion of seniors over the age of 80. However, other countries will soon overtake us with a steeper increase and less well developed welfare systems. We are consequently in a good position to adapt our social care and prepare for the next elder boom in fifteen years' time.

“We can't afford not to have good elder care, because that affects the careers of women. If I know that there is good elder care for my mother – and for me too when the time comes – then I can concentrate on my work, and that's something I think is of benefit to society.”

Marta Szebehely believes that resources are available; it is simply a matter of how they are distributed and utilised. More could be done with existing resources. In Denmark for instance, elder care works more aggressively with active prevention and outreach – which saves money. Voluntary home visits twice a year to senior citizens made it possible to uncover needs and offer assistance that prevented emergency situations.

“They were able to show that small amounts of assistance could prevent seniors from ending up as emergencies in hospital or in senior housing. This way you can phase in home-help service gradually.”

Modest assistance profitable

In Sweden today, a woman will often care for her sick husband at home without help until she, for instance, breaks her wrist which turns the situation into an emergency and forces the husband to be hospitalised. It then turns out that she is actually totally exhausted and cannot manage having him at home again.

“It wasn't that way before; in the past the home-help service would already have been there providing modest assistance. Excluding those with minor needs from the system is not very smart from the economic standpoint.”

When Marta Szebehely was asked twenty years ago whether she would be interested in doing research into elder care, she thought it sounded extremely boring. The person doing the asking was Rosmari Eliasson-Lappalainen, legendary professor of social work at Lund,

today Professor Emeritus. But then Rosmari asked her to compare work in the home-help service and other poorly paid women's work.

“That made it interesting; it sounded more like women's work than elder care.”

Marta Szebehely conducted a major study where she followed care workers at work and interviewed both them and the seniors. Ultimately this became her dissertation. She discovered that elder care issues had much to do both with class and gender differences.

“The inequality you have lived under becomes even more accentuated in old age. People who have worked in a physically demanding occupation, for instance, often decline with advancing years, and the difference in health compared to those whose occupation was less taxing continues to grow.”

Marta Szebehely is now receiving a six-year programme grant from FAS for her study “Social care in transition – daily life, organisation, welfare policy.” Characteristic of her research is a broad perspective and an attempt to link the daily reality and the conditions of elder care.

When we meet for the interview, Marta has just returned from Australia where she has spent four months, partly to devote time to a major study on what it is like to work in assisted living units in Canada, Australia and Sweden. It helps to give her a perspective on the Swedish elder care system.

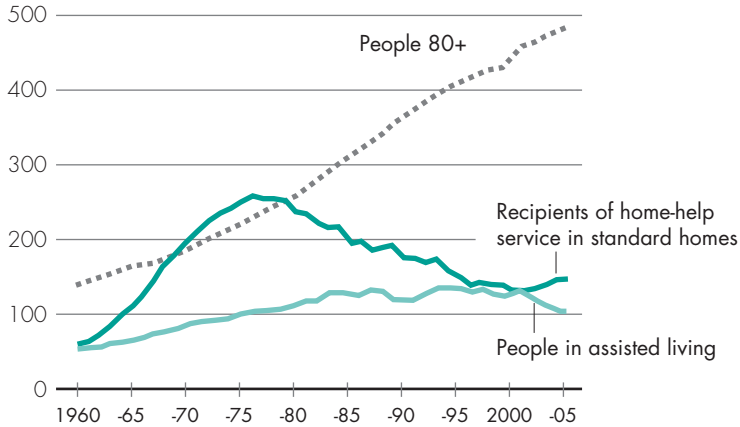
“Comparisons with other countries can make us aware of things that we otherwise tend to take for granted,” concludes Marta Szebehely.

Marta Szebehely is Professor of Social Work at the Department of Social Work, Stockholm University.

FACTS

Number of recipients of home-help service in standard homes, number of people in assisted living accommodation and number in the population aged 80 and older. 1960–2005.

Number of people, thousands



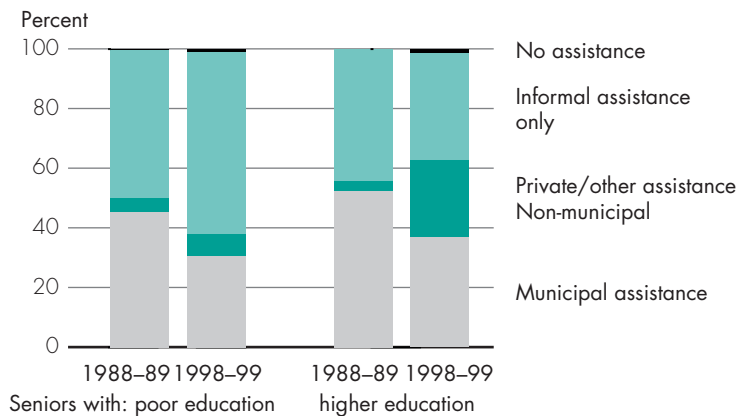
The number of home-help service recipients increased sharply from 1960 to the early 80s but has since gradually declined. The population of old people's homes, nursing homes, seniors' housing and other forms of assisted living for seniors increased until the mid-1990s. After remaining stable during the latter part of the 90s, the number of living units has diminished in recent years while the number of home-help service recipients has increased.

The above figure shows that the 80+ population, which is where most care recipients are found, has trebled since 1960. Compared to 1980, about 100,000 fewer seniors today receive home-help assistance. At the same time the 80+ population has increased by more than 20,000.

Source: Larsson K & Szebehely M (2006) Äldreomsorgens förändringar under de senaste decennierna. In: Vogel J & Häll L (Ed.) Äldres levnadsförhållanden. Arbete, ekonomi, hälsa och sociala nätverk 1980–2003. Stockholm: Statistics Sweden.

FACTS

Assistance pattern among seniors aged 75–84 living at home and requiring practical assistance, 1988–89 and 1998–99.



With the drop in municipal assistance in the 1990s came an increase in informal assistance, i.e. help provided by a senior's spouse or other relatives. Help purchased in the private market, primarily with laundry and cleaning, has increased even more. These shifts which can be called, respectively, the informalisation and marketisation of elder care are unequally divided between the classes: better educated seniors tend to replace the home-help service with market-based assistance, while poorly educated seniors more often receive help from relatives.

The shift from publicly funded elder care to family care or privately purchased help is probably a result of tighter assistance allocation as well as increased fees and organisational changes in the home-help service. Tighter assistance allocation is a consequence of stricter municipal guidelines concerning the needs for which municipalities accept responsibility.

Source: Szebehely, M (2002) Vålfärdstjänsternas förändringar och medborgarnas välfärd. In: Solidaritet med undantag. Fakta & Debatt, No. 2:2002. Stockholm: National Social Insurance Board.

CHAPTER 8

Little knowledge about older immigrants

Older Swedes who were born abroad are sometimes described as an entirely separate group of seniors who will place a great strain on the elder care system. However, this is hardly a homogeneous group; they represent some 145 countries and live under widely different conditions.

“We really know very little about the so-called “older immigrants.” I say so-called, because this is a designation which doesn’t describe the separate realities under which foreign-born seniors are living,” says Sandra Torres.

Sandra Torres is a sociologist with a long-standing interest in seniors and ethnicity. It was a couple of years ago, when she was asked to prepare an overview of Swedish research on foreign-born seniors for the European Science Foundation network to which she belonged, that she came to realise how deficient the state of knowledge was.

While there are a number of studies in the area, Sandra Torres finds that participants have not been selected on a scientific basis. They are therefore representative neither of the group of older immigrants, of a specific ethnic group, or of the group of immigrants who arrived here late in life.

“Besides, the earliest studies were theoretical, meaning that they were not based on the actual situation of older immigrants, but on assumptions about what it is like to grow old in a foreign country.

The premise was the notion of ‘the others’, those we have to have a grasp of, those who aren’t like us.”

Among elder care politicians and staff there is a great thirst for knowledge about foreign-born seniors. Sandra Torres suggests that many municipalities are afraid that today’s elder care resources will be inadequate for this group; that language difficulties and acclimatisation problems will arise, and that the entire elder care system therefore must be “culturally adapted.”

Foreign-born Swedes – many categories

However, since there has never been a fundamental mapping of older immigrants in Sweden, much of this is pure speculation, maintains Sandra Torres.

“The questions we really need to ask are: who are the older immigrants, where do they come from, and what are their needs?”

We do not even know how many they are since the statistics are so inadequate. According to one of the latest elder care reports, 12.7 percent of all people aged 65 and older were born abroad while 8.2 percent of those over 80 are foreign-born. The problem with these numbers is that the term foreign-born includes those with Swedish citizenship, those born in a Nordic or other European country, those who come from other cultures, those who immigrated at an early age, and those who arrive here as seniors.

“You can imagine what major differences there are. For instance, it’s one thing to grow old as an immigrant in a country and something entirely different to immigrate to a country in old age. These are two entirely different groups with different needs. But we lump them all together and talk about older immigrants as one category.”

Older Finns, Greeks and Yugoslavs who came in the 1960s as industrial workers, and whose children and grandchildren were born here, are in an entirely different position from those who arrive as immigrants with family ties; as the parents of someone who has already moved here.

A different outlook on age

It is also unclear at what age you are considered a “senior”. In Wes-

tern countries the categorisation is based on retirement age, 65 years, but the retirement concept does not exist in all countries. Our premise is also the high life expectancy in the industrialised world, but this does not accord with life expectancy in a number of other countries. In many cultures you are considered old at a much younger age.

“Aid evaluation officers around the country have told me that immigrants sometimes come to the elder care system for needs assessment thinking they’re already old at age 50. I therefore tend to recommend that we think in terms of 55+ when it comes to immigrants.”

Sandra Torres also points out that the different definitions of the word “immigrant” around the world cause problems in international contexts, for example when researchers want to make comparative studies. In most European countries, “immigrant” means those who have recently emigrated, not foreign-born people who are long-term residents as we define the term in the Nordic countries.

So who is it the politicians are really concerned about – those they think could become a major challenge for the elder care system? Sandra Torres suggests that these are seniors from countries outside the European Union, EU, who come here late in life to reunite with their children. As mentioned, the immigration statistics are inadequate and hard to access, but as an example only 5.8 percent of those who immigrated in 2000 were over 55 while 2.1 percent were over 65.

“Late-in-life immigrants, in other words, make up a fairly small proportion of those who immigrate to Sweden, especially in relation to the anxiety these seniors seem to have created.”

Sandra Torres has often pointed out to elder care planners, politicians and practitioners that the category of “older immigrants” is far too broad and meaningless.

“All these studies and problem reviews about older immigrants have given rise to hysteria among elder care politicians. It has also stimulated recruitment of foreign-born personnel to elder care. This does not mean that it couldn’t become a challenge for some municipalities, such as major cities with high-immigrant areas.”

Sandra Torres, herself an immigrant from the US, came here just over 16 years ago. She had started on a Master’s programme in psychology at New York University, but moved to Sweden as

an immigrant with family ties having fallen in love with a Swedish man. She has always been interested in older people and grew up in a tradition where you were active in volunteer organisations. She herself did volunteer work among vulnerable seniors throughout her adolescence. She was also interested in migration and ethnicity and realised that this field of research was fairly new in Sweden.

“Considering my background, perhaps it isn’t so strange that I am interested in studying the ethnic aspects of aging.”

In Uppsala she came into contact with social gerontologist Lars Tornstam and his research team and completed her postgraduate training there. She is currently Assistant Professor of Sociology and divides her time between Mälardalen University and NISAL, the National Institute for the Study of Ageing and Later Life (formerly Tema äldre) at Linköping University.

Day care centre could be the model

During her doctoral studies she participated in an ethnographic study conducted by one of her fellow doctoral colleagues at the time, Azita Emami – now Associate Professor, Department of Neurobiology, Care Sciences and Society at the Karolinska Institute – as part of her dissertation. Azita Emami followed the operation of a day care centre for elderly Iranians in Kista over a one-year period.

One of the people interviewed by Azita Emami explains:

“These courses are totally different from the regular SFI¹. None of us could keep up with that. Can you imagine that in the SFI course we were placed in the same group as very ambitious people who were trying to learn Swedish quickly so they could go to university? No matter how hard we tried; we just couldn’t keep up. Never in my life have I felt so slow as I did during that time. I left the SFI course. It just wasn’t for me. I had no ambition to study Strindberg’s imaginative literature.

“It was enough for me to learn sufficient Swedish to go shopping in my local store. Here it is different. The pace is such that I can keep up. I’m learning a language that I can use in daily life. Nobody

1. SFI – course in Swedish for immigrants.

complains if it goes slowly. We are all at the same level.”

At the day care centre, courses in Swedish were arranged. You could choose between three levels and the teaching was based on practical learning from everyday situations.

323 people over the age of 55 participated in the study, slightly more women than men. Just over half were widows or widowers, three-quarters had at most a high school education and five percent were illiterate. (Source: *An Ethnographic Study of a Day Care Centre for Iranian Immigrant Seniors*, *Western Journal of Nursing Research*, 2000, Vol. 22, No. 2, Azita Emami, Sandra Torres, Juliene G. Lipson, Sirkka-Liisa Ekman).

Wanted to join the family

One of Azita Emami's findings was that many elderly Iranians who had migrated late in life came because they wanted to be reunited with their adult children. They had imagined living with their children and their families, but that is not how it worked in reality.

Many of these elderly Iranians had social needs that were not met – their adult children had no time since they were working and fighting their own battle to integrate into Swedish society. Azita Emami observed that many of them were dubious about the day care centre operation; they were not used to such things from Iran and linked it to stigmatising perceptions about seniors whom nobody wanted to care for.

However, as time passed, these seniors started to feel better; they were exercising more and the operation served as a bridge between Swedish society and their families.

Social activities and lecture series allowed them to gain insight into Swedish society. The study showed that their quality of life improved after joining the day care centre.

“The study showed that this culturally adapted operation suited this group very well. But that does not mean that all older immigrants need this type of programme.”

Other interesting studies she cites are Emilia Forsell's dissertation on relatives of older immigrants and Linda Lill's dissertation on how elder care staff handle ethnicity in their working day.

Contrary to the fears that foreign-born seniors would be unhealthy and put a major strain on the elder care system, there are also studies showing that they feel better than the native-born. Sandra Torres also notes that there are studies showing that many migrants are highly satisfied with the Swedish elder care and healthcare system, suggesting that far-reaching changes perhaps may not be necessary.

Adjusted conceptions

“It is a problem that we acquire conceptions about a group without having sufficient knowledge. This adds fuel to prejudice about immigrants; that they are people who need extra measures. We start to wonder how we should change our elder care – in view of a target group whose needs we don’t even know.”

Sandra Torres’ doctoral dissertation deals with connections between cultural values and people’s conceptions of what good aging entails – and what happens to that conception when you migrate. She interviewed about 40 middle-aged Iranians, who had come here as adults and lived in Sweden for a number of years, about their conceptions of aging. It emerged that many had reassessed their values.

“They had to a large extent got used to the idea that ‘when I get old, I cannot expect my children to take care of me, the way my parents expected me to do’. In other words, it’s not true that they carry a cultural backpack and die with it. People who migrate are not always the rigid cultural stalwarts that we tend to imagine.”

There is today an acceptance of ethnic living and day care centres which are being endorsed by immigrant associations and municipal politicians alike. Sandra Torres thinks they may be needed for groups who do not speak Swedish and live in the most vulnerable and excluded conditions, but not for all immigrants.

There are also municipalities that offer elderly immigrants financial assistance to repatriate. There is no research on the extent to which foreign-born people in Sweden move home, but studies from other countries show that not many move back. Most want to be close to their children and grandchildren, and the children do not want to leave the country where they feel at home. The country of origin is no longer theirs. The seniors may dream of moving back,

but know that if they do, they will have to give up their children and grandchildren.

“I don’t think municipal politicians should take it for granted that very many will move back. Our premise should rather be that they will grow old here and therefore it is important for us to get to know that part of our aging population.”

Investigate their needs!

Sandra Torres points out that until we have mapped the older immigrants and their needs, it is hard to see them as a resource. They could be a resource not least for research. Many for example have a life history far different from those who live in the same country all their life. They live in a diaspora², have families who are spread around the world, and yet manage to preserve their family ties. Their and their families’ lives would therefore be interesting for researchers to study, she suggests. Not because they are immigrants but because of their life histories.

“Ethnogerontological research must not be reduced to dealing only with ‘immigrants’ or the organisation of elder care; it involves many other issues.”

Sandra Torres recently received one of the prestigious FLARE grants awarded by the European Area on Aging Network and funded by FAS in Sweden. FLARE stands for Future Leader of Aging Research in Europe and the intention is for Sandra Torres to carry out a project on cross-cultural encounters in Swedish elder care. As part of the grant framework, she is also expected to spend time as a guest researcher at King’s College in London.

Sandra Torres is Associate Professor of Sociology. She divides her time between Mälardalen University and NISAL, the National Institute for the Study of Ageing and Later Life, at Linköping University.

2. Diaspora is a term applied to the settlement of ethnic groups abroad, often but not always as a result of involuntary migration.

CHAPTER 9

Few want to keep working after retirement

We will be expected to work beyond age 65 in order to support both our own and the government's finances in the future. Yet only six percent of employees want to continue working after retirement and half would like to stop even sooner. Men in high positions in industry often retire as early as around age 60.

Tiiu Soidre, Associate Professor at the Department of Sociology, Göteborg University, is herself 68 years old and continues to work because she enjoys it. She has studied attitudes to retirement among people aged between 55 and 64 and what influences their desire to stop sooner or remain working.

Although we are living longer, we are spending less time in the labour market, relatively speaking. Today the actual retirement age is around age 62. Tiiu Soidre believes one reason why so few want to continue working is that many are healthy and vigorous and want time to do other things in the last active part of their life – the “third age”.

She notes that men and women not only have different attitudes to work, but that their labour markets also differ to a certain extent.

Women work primarily for municipalities while men to a greater extent work for the government and, above all, for private employers.

Women and men have a different outlook

Women responded more or less as expected: those doing heavy work wanted to retire earlier while those with mentally stimulating work would consider staying on after age 65. Men with heavy jobs would rather reduce their working hours than take early retirement.

“It could be that men still see themselves carrying a greater share of the bread-winner’s burden and feel the need to keep working: ‘this is my bounden duty’. It is part of the male gender role to work and show that you are still useful.”

Well-educated men by contrast wanted to retire before age 65 – having a stimulating job was no reason to stay on longer. On the other hand, feeling appreciated by superiors and colleagues was important for men – and would make them consider staying on. This factor was of no consequence to women.

“Men want to stay in working life more for social reasons. It seems that men’s self-esteem is more closely tied to working life. Women have more of a double identity.

Among women, finances played no role in the wish to retire. A positive attitude to life outside work on the other hand made women more inclined to retire early. Both female and male entrepreneurs were by contrast more interested than employees in working longer. There may be several reasons: self-employment may be a special lifestyle that entrepreneurs enjoy, or they may feel forced to continue working because of poor pensions.

Women in the study worked part-time to a much greater extent than men: only 58 percent of the women worked full-time versus 88 percent of the men.

Tiiu Soidre was perplexed by one finding in her study: that well-educated private sector employees often retire early. She became curious as to why these men did not stay working, even though their level of education should make them desirable. This mostly concerns men, since women rarely occupy high positions in industry.

She therefore went further and interviewed four well-educated men in the private sector. They explained that a culture has evolved in the private sector – at least in large companies – where, when you start approaching sixty, you receive a pension offer and are “bought out”.

There are few who decline since that would be considered a little suspect; as if you had no life outside your job. This is an offer which is hard to refuse since advantageous pension solutions are involved.

“One informant said he felt squeezed dry. He believed they had sucked the “best” out of him.

Highly qualified staff are pensioned off

It used to be the case that it was unwanted staff who received such offers which were considered somewhat stigmatising, but today it is very common and generally accepted. Most receive an offer around age 60, and those who do not start to worry, suggests Tiiu Soidre. An offer often arrives quite suddenly and then you have to climb on the bandwagon. One informant received no offer because he was still regarded as highly productive. But for personal reasons he kept nagging until he too had an agreement.

“It seems that agreement solutions have become a way for private companies to revitalise their organisation. Firstly, it lets them trim the organisation; secondly, the training these men have may not be entirely up-to-date considering the fast pace of technological and knowledge development. Some may also resist change which makes them something of a stumbling block. The company may also have been purchased and the new management wants its own way.”

Privately these men may wonder, “what’s wrong with me”. Outwardly it is nevertheless a legitimate way to end your working life with a tidy retirement pension. Nor does it have to give the company a bad name since this is what “everyone” is doing.

“It’s a paradox that all stakeholders, not least industry, want people to keep working beyond age 65. At the same time many companies retire their most qualified employees. It is unreasonable that highly qualified men should be dumped from the labour market at the age of 60. Here there are clear conflicts between what is good for society and what is good for companies and individuals.”

Part-time no real option

Tiiu Soidre suggests it would be better for these men to stay at work and serve as mentors. Not necessarily full-time, but perhaps part-time

and without losing pension benefits.

Without these special pension solutions, changing to part-time in the final phase of working life is impossible in practice. The benefit-based service pension system is so designed that it is the earnings in your final years – when income is generally highest – that are considered pensionable.

This also makes it more difficult to employ older individuals because the employer has to make very high contributions to the pension funds. The older you are, the greater the pension contribution. In other words it becomes more expensive for employers both to retain and employ the elderly. The system also creates a locked-in situation since older workers lose financially by reducing their hours or switching to a less well-paid job.

Since 2006 it is true that there has been a new service pension agreement which is differently designed. But it applies fully only to those born in 1979 and later, and it will therefore take a long time for it to impact on older workers.

Within the government and municipalities, well-educated employees remain in work to a greater extent than the poorly educated. Many poorly educated people doing heavy work retire early with a disability pension. Civil servants are entitled to go on partial pension at age 61, but then receive a somewhat lower old-age pension.

Generally speaking, everyone is legally entitled to stay at work until the age of 67. However, you have to stay in your present job and have no obvious right to reduce your working hours. This can have strange effects. Tiiu Soidre herself has a one-third position, which she considers just right. Yet if she had been working part-time in a full-time position, she would have been forced to work full-time after age 65, had her employer so demanded.

More research needed

Tiiu Soidre feels that society should work against ageism, discrimination of the elderly, by making it easier for those who so wish to work longer.

“The ball is in the employers’ court. How can they make use of older workers?”

One possibility is more adapted job tasks, being relieved of certain tasks or having the option of shorter working hours without your pension being affected. A 40-hour work week need not be the norm. The delivery company Malmö Tunggodts is testing a model where older drivers can reduce their working hours to 90 percent on full pay providing they exercise three hours per week. Their jobs are heavy and it is hoped that they will have the strength to stay on in the job until retirement.

Finland has been at the forefront of designing working life to suit the elderly by means of “age management”. This is partly about giving management a positive view on aging, giving active support to employees, developing individual solutions and speaking openly about organisational changes. Some of these methods are also being tested in Sweden.

“There isn’t much research about this. What would make older workers remain longer in the labour market? That’s something we know little about,” says Tiiu Soidre.

Tiiu Soidre is Associate Professor at the Department of Sociology, Göteborg University.

CHAPTER 10

Risk of greater poverty among seniors of tomorrow

Tomorrow's pensions will fall behind working wages – more and more with every passing year. As a result, poverty among the oldest in society will increase. This is an effect of the pension system which many are totally unaware of, maintains economist Anders Klevmarken.

Anders Klevmarken and his research group have run simulations of how the earnings of seniors will develop in the future. They show that by 2040 the disposable income of people over the age of 65 will only be about 55 percent of the average disposable income of the working population.

We are talking in the dining room of the old farm, a stone's throw from the shore of Lake Vänern, where Anders Klevmarken and his wife now live part-time. Last autumn he left his professorship at the Department of Economics, Uppsala University, but still retains a few weighty assignments. The large British publishing house Emerald will shortly publish a book about the 'Old Baby boomers' research project which he and his research group have been working on since 2000. Here ten researchers have studied among other things the health trend in Sweden, the income trend for seniors relative to wage earners, and the use of sick leave, institutional care and social care among seniors (Klevmarken, A. and Lindgren, B (Eds.) (2008), *Simulating an Aging Population: A micro-simulation approach applied to Sweden*. Contributions to Economic Analysis 285, Emerald, Bingley. ISBN: 978-0-444-53253-4).

Baby boomers have accumulated assets

The project has studied the baby boomers who as of 2020 will comprise a record cohort of 80 year-olds. This is a group which has done remarkably well, financially speaking, but will experience increasing poverty in old age. They entered working life in the high-growth years of the 50s and 60s when jobs were plentiful and they could purchase homes which have since risen sharply in value. At one time there were even government subsidies for home buyers, notes Anders Klevmarcken.

“We baby boomers have accumulated assets more than any other generation. But we have not been saving privately for our own pensions since this is something we have counted on society to provide.”

Economists speak of lifecycle saving, which involves setting aside money during our working life to draw on when you retire. But in Sweden the public pension systems have been so well developed that the need for private lifecycle saving so far has been limited. The question is what will happen to the baby boomers’ assets. Will these vigorous and active seniors spend their money on things such as travel or will they be saving for the future?

“I don’t think that the baby boomers will spend all their money. Most of us see the uncertainty of the future. You don’t know what you will need in terms of care and nursing, or how long you will live.”

Anders Klevmarcken notes that some will have time to die before they run out of money and their assets will therefore be distributed to younger generations through inheritances.

But there are also groups who have not accumulated assets. The number of poor seniors will increase, largely because pensions are not indexed at the same rate as wages. Among those born in the mid-fifties – the youngest age group studied – one-quarter will be poor by 85 years of age.

Risk of greater poverty among seniors

According to calculations, fifty percent of baby boomers will be considered poor at age 65. However, at age 80 as many as 20 to 30 per-

cent, depending on their year of birth, will be considered poor. Today about one-tenth of the entire adult population is regarded as poor.

“Historically we have always had poor seniors. The goal of Social Democrat governments in the post-war era was to eliminate that type of poverty through the public pension systems. Now there is a risk that we will see new and extensive poverty among seniors.

Anders Klevmarcken notes that individuals in poor health will be the worst off financially in old age, having both the lowest earnings and the fewest resources.

“This group needs help and society has to take responsibility for it.”

This is because there is a strong connection between health and income. However, in which direction this connection applies is not known for certain. If you develop health problems early in life, you may suffer difficulties in the labour market, poor income development and a low pension. Then your opportunity to accumulate assets may also be limited. However, it is also possible that poor earnings create ill health.

Good earnings allow you to invest in your own health, lead a healthy life and buy costly sports services. You can afford to consult specialist doctors outside the insurance system and may have an occupation that is less hard on your health. Good health can also provide the opportunity to create a good financial situation.

“We still don’t know whether health or income is the greater force; there is little Swedish research about this. We need to go deeper and learn more, for instance about the significance of preventative public health for national and individual financial development and how this can be translated into economic growth.”

Another group that will fall on hard economic times is elderly women who live alone and have no children within commuting distance. Because men generally die earlier, there is a great preponderance of women among the oldest in society.

“We don’t think children will be able to help to a greater extent than today; rather the opposite. It’s becoming less and less common for children to live within commuting distance because younger people are so geographically mobile.”

Migration from Norrland and other under-populated areas to the major cities leaves those municipalities with many elderly inhabitants whose children have moved south. Stockholm will also have a large population of unattached elderly women – the percentage of one-person households is greater there than elsewhere. Many of these women will have no relative who can help them when their strength fails, and will need outside assistance.

Pensions are not indexed at the same rate as wages

Anders Klevmarken believes many are unaware of how the new pension system will affect their own finances. Many think that pensions are indexed by the sum of the inflation rate and the average rate of real wage increases. However, in reality this sum is reduced by 1.6 percentage points. If wages increase by e.g. two percent per year, the real pension increase will therefore only be 0.4 percent – and thus fall further behind with every passing year.

In addition there is a brake function under which pensions do not have to be indexed at all if it is estimated during one or several years that the system has insufficient funds to meet future payments. This can occur during periods of low growth or unfavourable demographic conditions.

The brake has not yet been applied, but when the Swedish Social Insurance Agency recently reported its 2007 results, it showed that the pension system had run a deficit with the surplus dropping from SEK 100 billion to SEK 18 billion. In such a situation there is a growing risk of the brake being applied. When calculating future pensions, Anders Klevmarken and his research group have not counted on the brake being triggered. If it does, pensions will fall behind even more.

Public and contractual pensions may have to be supplemented by private pension contributions to avoid the risk of living in poverty in old age. Ever more people are indeed starting to realise this and growing numbers are contributing to private pensions, although amounts are not always that large.

We also risk having to pay more for our personal care, or at least for a home-help in the future. The cost of care and nursing will rise

in tandem with the growing senior population. For care to remain as accessible as today, the cost of e.g. 24-hour care is expected to quadruple between 2000 and 2040. If expectations rise, the costs will be even higher.

The question is how this should be paid for. Through fees, taxes and/or insurances, or straight from your own pocket to private carers?

“It all depends on which political majority is in power. A Social Democrat government would probably try to provide us with these services from public means. This could entail higher taxes as well as increased fees. A conservative government may be a little more careful with tax increases, but larger groups would then probably have to pay more themselves.

Insurance a possible way

A possible way of funding some care in the future is through elder care insurance which could be paid for during your working years. There are various options for the design of such insurance: compulsory or voluntary, perhaps as group insurance through the trade unions.

However, Anders Klevmarken points out that the greatest factor influencing the need for costly elder care is whether people are fairly healthy or severely ill when they die. If seniors are healthy and do not require that much care, then there are no problems. But if these groups suffer from dementia in large numbers or develop other chronic diseases, the cost of elder care will skyrocket.

“If we knew more about the connections between health and risks of death, we would be able to say more precisely what’s on the cards. It also depends on the economic development in our country. If the economic development is good, perhaps it won’t be such a big problem.”

He suggests that the most important thing for Sweden is to have good economic growth with as many people as possible working and paying taxes. One way to get more people working is to raise the retirement age and he expects within a few years to see a law proposal concerning the right to remain at work until age 70.

Raised retirement age a probable measure

“According to our calculations, the most powerful measure is to raise the retirement age. It’s a waste to let people retire as early as age 62, which is the average today. In the past, no-one wanted to stay on longer than necessary but today more and more are thinking about working longer. When people see the consequences of retiring early, in terms of low pension, they will think twice. The more who contribute to production, the better.”

Increased immigration has sometimes been proposed as a solution to the aging problem since that will increase the number of workers. However, the Uppsala researchers show that immigration is of marginal importance. For it to have a lasting effect, you have to increase the number of immigrants continually to compensate for those who retire.

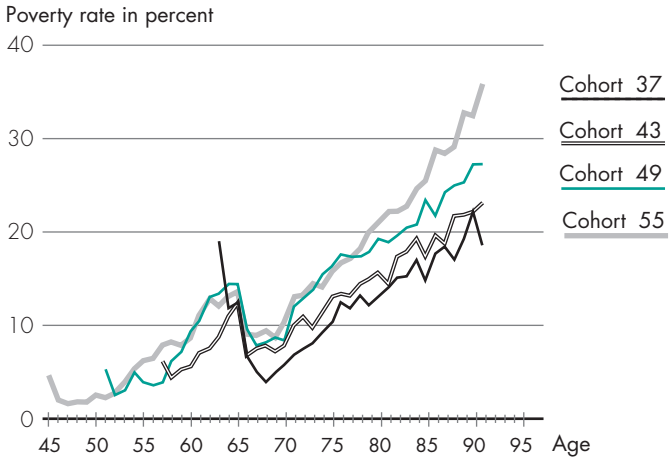
Anders Klevmarken is nevertheless not too pessimistic about the future.

“So far we cannot speak of a crisis. Sweden has far more manageable demographic problems than many other countries. We also must remember that as the seniors grow in number, the younger become relatively fewer – and day care and education costs will consequently go down. But you still need to be proactive and I feel the politicians have woken up rather late.”

Anders Klevmarken is Professor Emeritus in
Economics at Uppsala University.

FACTS

Poverty rate (disposable income less than 50% of the adult median income) by birth cohort* and age.



* A birth cohort consists of individuals born the same calendar year.

CHAPTER 11

Many unnecessary obstacles in seniors' living environments

Much remains to be done before society becomes accessible and usable for all, according to Professors Susanne Iwarsson and Agneta Ståhl, co-ordinators of the Centre for Aging and Supportive Environments (CASE) in Lund which focuses on environmental gerontology.

The interaction between humans and the environment is complicated and not well researched. Susanne Iwarsson, originally an occupational therapist, has worked for many years with seniors' living environments and suggests that we have made a poor job of listening to the seniors' own perceptions. Instead we have placed the greatest emphasis on what is objectively measurable, for instance how wide the doors are and how many thresholds there are.

But in order to assess the seniors' living environment you have to speak in terms of usefulness to the individual, she suggests. There can be major differences between what seniors think of as poor and what staff considers problematic.

"I have made countless home visits and it's happened that I've followed a 90 year-old lady on basement stairs where I could barely make my way. Her sense of balance was poor, she couldn't see or hear well, but still she walked those stairs. And after she moved to assisted living, not many weeks passed before they phoned to say that she had slipped on the polished floor and broken her hip. And we had actually

moved her for safety reasons so that she would not have to walk up and down those stairs,” recounts Susanne Iwarsson.

Within the EU funded project ENABLE-AGE³ Susanne Iwarsson and four colleagues in other countries have studied the connection between objective and subjective factors and seniors’ perception of health. As a result the researchers have been able to develop a list of the 61 most serious environmental obstacles for seniors in and around the home, based on scientific findings.

Many unnecessary environmental obstacles

Half the environmental obstacles are found inside the home and half in the lobby or close outdoor environment. Common obstacles include excessively high thresholds, kitchens or bathrooms on another floor, heavy non-automated doors, high, low or uneven stairs, and controls on kitchen equipment, windows and doors that require complex manoeuvres and good precision.

The list is based on systematic mapping of functional disabilities and environmental obstacles in the homes of more than 2,000 individuals in five European countries. It is intended to be used in the planning and adaptation of living quarters by occupational therapists, municipalities, housing companies, architects, building contractors and individuals.

Susanne Iwarsson explains that the list has aroused much interest. As an example, planners from several municipalities have called to say, “Send me the list right away, because our municipal board will be deciding on our basic home adaptation programme next week.”

“It shows that they really want to do this well – after all, the politicians have decided that all of Sweden should be accessible by 2010. But it also shows how little research there is to build on,” notes Susanne Iwarsson.

When is the best time to move?

Susanne Iwarsson points out that the CASE research is very important for the work on seniors’ housing: at what stage is it most important to

3. Read more about the Enabler project at www.enabler.nu

do something about physical environmental obstacles in the home and at what stage are other aspects more important? And when is a better or worse time for seniors to move?

Seniors' subjective assessments may deal with what it means for them to be living precisely where they live, with what is meaningful, and whether they feel in control of their living conditions.

"The more independent a senior is, the more important the physical environmental obstacles appear to be. And the more dependent you are on daily assistance, the more important the subjective perceptions of how you regard your health and manage your day are," says Susanne Ivarsson.

This means that as long as you are mobile, the objective physical obstacles play an important role. Then it can make a big difference being forced to negotiate stairs rather than taking the lift. But when you start to become dependent on others and need help to wash and get dressed, then the physical obstacles no longer matter that much.

Many seniors are happy in their home even if it has deficiencies, objectively speaking. They have lived there for a long time; they have their memories and feel secure and comfortable. They know their neighbour is there to look in on them, and their environment bears the mark of all their belongings. "If I'm going to move, can I bring my furniture? What will I do with the piano and chest of drawers? I can't have twenty photos on display and have to choose five."

These are obvious things that many seniors are forcibly torn away from. A primitive toilet or poor kitchen fixtures can be things that force a move. Researchers at CASE have just completed a study on the relocation process where they have followed a group of seniors for eleven years.

They have been able to discern four phases:

- In the first phase seniors do not clearly express that they want to move, but start negotiating with themselves, comparing themselves to others in similar circumstances and perhaps gradually start discussing the matter with their family.
- In the second phase the question of moving starts to become urgent, perhaps because something happens that makes it necessary.

- In the third phase the senior has finally, after a long period of deliberation, decided to move and contacts the municipality. But only then does the municipality start its investigation and it is by no means certain that a space can be found. This phase can take a long time and is very frustrating for the senior.
- In the fourth phase, if the senior is able to move and gets settled, the outcome is nearly always positive.

Painful having to move

In cases where the move is triggered by an acute illness or accident and the senior must go to hospital and from there to a new residence, the process takes on a different aspect and not infrequently becomes difficult. Often the children have to empty and sell the house, which in itself can be a painful experience.

“We know far too little about relocation processes. There are few in-depth studies; you have to follow people over time which is not that easy with seniors,” notes Susanne Iwarsson.

She sees two important measures for reducing forced relocations. Firstly, residential planners must eliminate at least the most common environmental obstacles in the home (the 61 obstacles on the list developed by the researchers) to prevent moves becoming necessary for such reasons.

Secondly, we must all start planning for old age living in time. When you for instance renovate your house in middle age, you should already think about adapting the home so that you will be able to stay there longer. However, it is difficult to get help from building suppliers and contractors in such matters since they generally know nothing about building a home that will function also for seniors, with the functional disabilities than usually appear with advancing years.

Susanne Iwarsson and Agneta Ståhl have combined two separate fields of research, Susanne is Professor of Gerontology at the Faculty of Medicine while Agneta is a traffic environment researcher at the Lund Institute of Technology. Their collaboration started when Agneta heard about Susanne’s research and came to attend her doctoral disputation. They started to talk and embarked on an interdisciplinary collaboration around seniors’ living environments

which has now continued for eleven years.

“The combination is very challenging. Much elder research tends to be conducted along parallel tracks and the competences never meet,” says Susanne Iwarsson.

In addition to the home, the seniors' physical environment includes several other arenas: the immediate private environment, public outdoor environment, public premises and transportation. Agneta Ståhl has spent many years researching the traffic environment for seniors and the functionally impaired. Since the pedestrian environment and public transport are the most important transport options for the elderly, CASE has also concentrated its activities on these areas.

“When you leave your home, you should be able to get from your door to your destination without obstacles,” says Agneta Ståhl.

The ambition is to develop an instrument for assessing accessibility of the pedestrian environment, similar to the instrument for housing. Within the project “Come, let's go” they have investigated what obstacles the senior population encounters in the pedestrian and traffic environment.

The project was conducted in a part of Kristianstad with about 3,000 inhabitants, over 600 of them over age 65. The seniors themselves were asked to identify the greatest environmental obstacles and develop solutions through discussion in study circles, together with representatives from the municipality and the Swedish Road Administration. The seniors were also monitored by the researchers when moving about outdoors.

Small obstacles in the pedestrian environment caused problems

“The greatest problems aren't lack of signals at crossings, as you might have expected; it's the small details that have been found more important than the large ones,” notes Agneta Ståhl.

Seniors want minor barriers in kerbs and paving to be smoothed out. They want benches so that they can sit down and rest when out walking. They consider colour contrast markings between pavements and footpaths important so that you can clearly identify the kerb when your eyesight starts to fail. Pavements should be wide enough to

meet someone coming the other way without having to step into the street.

The municipality has made modifications throughout the area, both by specific measures at certain points and by general measures. Something has been addressed on almost every street, at a cost of SEK 2.5–3 million.

Unevennesses have been eliminated on walking surfaces and materials replaced with better options – attractive but rough paving has for instance been removed from the walking surfaces. Pavements have been widened and on streets with narrow pavements, one has been removed and the other widened.

Pavements have also been bevelled at crossings to give seniors a smooth passage without the need to lift their rollators. Many benches have been placed and cyclists have been separated from pedestrians on shared foot and cycle paths.

To make it easier for the visually impaired, guiding and warning plates with wave patterns – known as sinus plates – have been placed at crossings. This allows the visually impaired to use their white cane to guide their way forward. Right at the kerb is another type of plate, a convex plate with round lugs, alerting you that a street or platform edge is near.

The seniors felt less afraid

The evaluation indicated positive results; the seniors felt less afraid and insecure and no longer experienced such major obstacles when moving about outdoors. On the other hand they did not go out more than before.

“We thought they would be going out more, but this has not happened. On the other hand the project has taken a long time; the municipality has been building for three years and the interviewees are now four years older, which has a major impact,” notes Agneta Ståhl.

A problem e.g. with plates in the street is the lack of evidence-based norms and standards. Standards vary between countries and municipalities build in different ways, according to their own ideas.

“You find plates like these all over the world. But when you

start to look, you find that they may be strangely placed; you don't understand what the thinking is. So putting down plates is not enough; the research question is: how should they be placed?" says Agneta Ståhl.

One issue is for instance the shape of the lugs on raised warning plates and how high they should be. Is one row of plates enough for a blind person to detect the warning surface before a street, or do you need several? The CASE researchers have shown that a minimum of one metre is necessary. International collaboration is now in progress to create common standards.

Susanne and Agneta describe their research as painstaking work where progress is measured in small steps. An immense amount remains to be done before society is accessible and usable for all – in the outdoor environment and public environments such as libraries, pharmacies and doctor's offices. Evidence-based norms are needed in many different areas and we have a long way to go.

"If we cannot adapt all environments throughout society, it would be reasonable to start with those places where most people most often want to go," observes Susanne Iwarsson.

Shopping malls most popular

In an earlier study, CASE researchers investigated which environments people considered most important to be able to visit. It was found that people with functional disabilities, regardless of age, preferred shops under cover, for instance a downtown shopping mall, which is comparatively accessible and where you can buy most of what you need.

For seniors the pharmacy, bank, post office and convenience store are important. They also want to be able to visit cemeteries, parks, hospitals and friends. They would like public transport close by, preferably a stop no more than 50–100 metres away, which calls for flexible traffic solutions.

"Much of the ongoing aging research is related to care where the elderly individual primarily is a patient. We regard the seniors who participate in our research as citizens in society; they are bus passengers, pedestrians or customers at the local grocery store.

We are therefore moving in a research field which, although fairly untravelled, is an important complement to other aging research,” says Agneta Ståhl, and Susanne Iwarsson concurs.

Professors Susanne Iwarsson and Agneta Ståhl are coordinators of CASE, the Centre for Aging and Supportive Environments, in Lund.

FACTS CASE

CASE, the Centre for Aging and Supportive Environments, is an interdisciplinary centre for research into seniors' living environments initiated in 2007. It is a FAS centre with funding from FAS in cooperation with the faculties of Medicine and Social Sciences at Lund University and the Lund Institute of Technology.

Research within CASE is focused on the importance of the indoor environment for the activity and health of seniors, and on accessibility and safety for seniors in the outdoor environment and public transport system. An general objective is for the research findings to be converted into practical solutions that can make society more accessible for seniors.

Concrete issues being studied include the importance of the environment for the prevention of accidental falls, which factors are important when elderly unprotected road users are involved in traffic accidents, and how seniors regard the usability of their home and how this influences their health and quality of life. Researchers will also monitor the conversion of a nursing home to seniors' residences.

At present CASE is involved in more than 20 research projects.

FACTS FAS participates in an international network for aging research

ERA-AGE is a four-year programme investment (2004–2008) with funding from the EU within the Seventh Framework Programme's investment in ERA-NETs, thematic networks for research funding agencies. The purpose is to support the development of a European strategy for aging research in order to maximise Europe's return on the investments made. In total, research funding agencies from 14 countries are involved: Austria, Finland, France, Germany, Israel, Italy, Latvia, Luxembourg, the Netherlands, Norway, Rumania, Spain, Sweden and the United Kingdom.

The network is coordinated at the international level by Professor Alan Walker at the University of Sheffield, United Kingdom. ERA-AGE has among other things established Future Leaders of Aging Research in Europe, FLARE, an interdisciplinary exchange programme which offers recent Ph.D. graduates the opportunity to conduct research for three years, 2–2.5 years in their home country and 6–12 months abroad, and within a research field other than their own. Under discussion at present is a new proposal to the EU for a more extensive programme entitled the New Dynamics of Aging.

Read more at www.era-age.group.shef.ac.uk/

FACTS Innovations for seniors' living environments

In 2007 VINNOVA initiated the project Needs Analysis – Innovations for the Living Environments of Seniors. The purpose is to promote innovation in services and products based on the needs of seniors with the participation and influence of the seniors themselves.

In the initial stage, non-profit associations and interest organisations were invited to analyse the needs of seniors in collaboration with researchers and industry and develop concepts for innovations in seniors' living environment.

The following projects were granted SEK 100,000 to develop their concepts:

- Mobile telephone use among seniors, Swedish National Pensioners' Organisation (PRO)
- Social Care Chalmers – The living environments of seniors, Chalmers Seniors Society
- Secure living, Design Södertörn/Royal Institute of Technology (KTH), Stockholm
- IT-Seniors needs, SeniorNet Sweden
- Bicycle for seniors – analysis of needs and possibilities, Swedish Pensioners' Association (SPF).
- Business solutions for local support in the third age, Adolf Fredrik Parish – Church of Sweden.

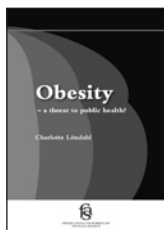
The projects have now been reported and Vinnova is in the process of compiling the results. In some of the projects, work is continuing independently and with external funding.

Source: Website of research funding agency VINNOVA: www.vinnova.se

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