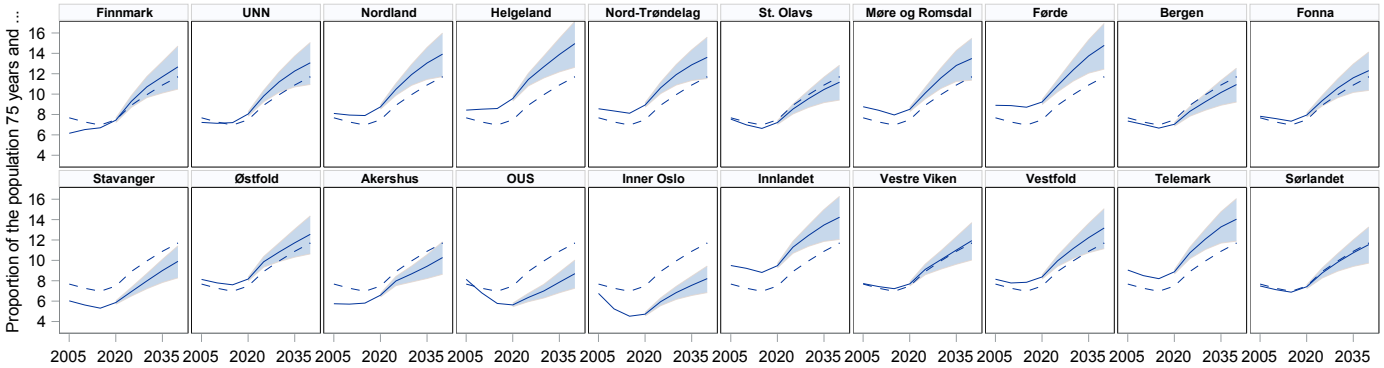
Healthcare Atlas for the Elderly, 75 yr and older

Demographic developments

Helseatlas SKDE

There are about 370,000 elderly people in Norway, and they make up 7% of the Norwegian population. The health trusts' hospital referral areas differ greatly in terms of both the number and proportion of elderly in their population. The number of elderly is expected to double by 2040, when the elderly will make up 12% of the Norwegian population. This change in the demographic structure will be a challenge to the health service, and this challenge will affect hospital referral areas differently.

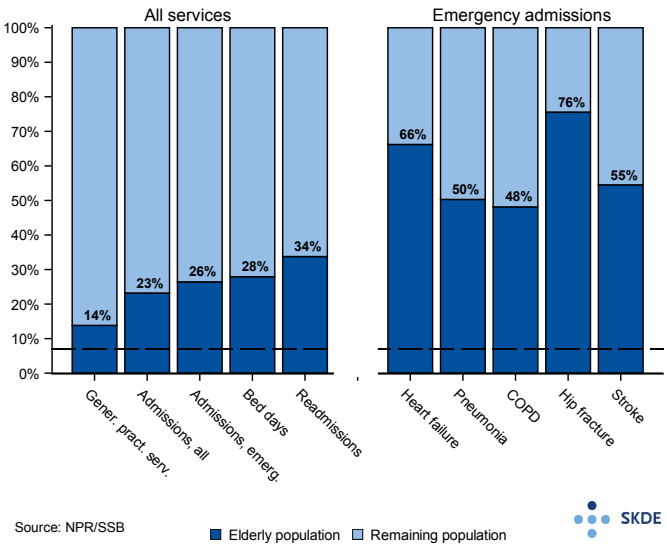


Proportion of the population who are 75 years or older, 2013–2017 and projected for 2017–2040 (Statistics Norway's main alternative and alternatives for strong and weak aging), broken down by the health trusts' hospital referral areas. The dotted line indicates the medium alternative for the country as a whole. Source: Statistics Norway.

Developments towards 2040

There are considerable regional differences in the proportion of elderly people in the population. The elderly make up twice the proportion of the total population in the Innlandet area (9%) as in Inner Oslo hospital referral area (4.5%).

There are considerable geographical differences in age structure. Some hospital referral areas currently have a proportion of elderly that is considerably higher than the national average and this is also expected to be the case in 2040 (Nordland, Helgeland, Nord-Trøndelag, Møre og Romsdal, Førde, Innlandet and Telemark). Some other areas have a considerably lower proportion of elderly than the national average and this is also expected to be the case in 2040 (Stavanger, Akershus, OUS and Inner Oslo).



The elderly's use of the general practitioner and specialist health services as a proportion of the use of the population as a whole, average for the years 2013-2015. The dotted line indicates the proportion of elderly in the population (7%).

Consequences

It is difficult to predict the consequences of such demographic changes for the health service. However, the challenges are expected to be particularly great in service areas where the elderly currently use a high proportion of the total services provided.

The elderly do not account for a particularly high proportion of all patients who are in contact with the general practitioner service, and the proportion decreases with increasing age. Therefore, the general practitioner service will probably not be affected to the same extent as municipal care services and the specialist health service. Different parts of the specialist health service will be affected differently.

The expected increase in the number of elderly will represent a particular challenge in relation to acute medical conditions for which a hospital bed will be required. Elderly patients account for about 50% or more of admissions for heart disease, lung disease, hip fractures and strokes in the population as a whole.

It is especially in the category hospital admissions that the elderly make up a large proportion of patients. The general shift from admissions to day patient treatment will probably continue, but this will apply less to this age group, since elderly patients who are admitted to hospital are a demanding patient group. There is reason to assume that the number of internal medicine beds available for the increasing number of acutely ill elderly will have to be increased in the time ahead in order to provide satisfactory services.

When municipal emergency bed units (KAD) were introduced, the intended target group comprised patients with acute deterioration of a known condition, such as COPD or heart failure. Elderly COPD patients have an average length of stay of 6.1 days for emergency admissions, with 29% of patients being readmitted and 21% dying within 30 days of their last admission. Elderly patients admitted for heart failure have an average length of stay of 6.3 days, with 26% of patients being readmitted and 15% dying within 30 days of their last admission.

Considering the long stays and the high proportion of patients who are readmitted and die within a short period of being admitted for these conditions, there is reason to question whether the KAD beds can be used for these patient groups.