

Marta Szebehely & Gabrielle Meagher: Nordic eldercare – weak universalism becoming weaker?

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ABSTRACT

This paper builds on recent research on the fortunes of universalism in European social policy by tracing the development of eldercare policy in four Nordic countries: Denmark, Finland, Norway and Sweden. Six dimensions of universalism are used to assess whether and how eldercare has been universalised or de-universalised in each country in recent decades and the consequences of the trends thereby identified. We find that de-universalisation has occurred in all four countries, but more so in Finland and Sweden than in Denmark and Norway. Available data show an increase in for-profit provision of publicly funded care services (via policies promoting service marketisation), and an increase of family care (re-familialisation) as well of services, paid out-of-pocket (privatisation). These changes have occurred without an explicit attack on universalism or retrenchment of formal rights but are threatening the class- and gender-equalising potential of Nordic welfare states.

Introduction

Several recent studies have explored the meaning of universalism in social policy, and sought to operationalise the concept in studies of its achievement – or reversal – in European welfare states (Anttonen et al., 2012; Béland et al., 2014; Léon, 2014). These studies recognise that universalism is a contested and ‘polysemic’ concept (Stefánsson 2012), and that it is ‘an ideal type that is always beyond reach’ (Anttonen et al. 2012: 187). Their findings, taken together, suggest complex patterns of achievement (‘universalisation’) and reversal (‘de-universalisation’) in many policy domains. Thus, Béland and colleagues advise, research that operationalises universalism needs to define the concept clearly, and to trace program development in specific policy areas (2014: 753).

We build on this research on the fortunes of universalism in European social policy by tracing the development of eldercare policy in four Nordic countries: Denmark, Finland, Norway and Sweden. We establish several dimensions of universalism that we use to assess i) whether and how eldercare has been universalised or de-universalised in each country in recent decades and ii) the inequality consequences of the trends thereby identified. In so doing, we also contribute to an overlapping body of recent research seeking to understand the direction and impact of institutional change in eldercare in European societies, as population ageing has increased demand for services and austerity has challenged their supply (Léon, 2014; Gori et al., 2015; Ranci and Pavolini, 2013, 2015).

Universalism is the ‘trademark’ of Nordic welfare states, notably in social services (Anttonen et al., 2012: 187; see also Anttonen, 2002; Sipilä, 1997), which makes the Nordic countries a particularly interesting set of cases. Eldercare is also a case-study in the sense that this is one service area, among several, that contribute to the Nordic countries’ reputation for service universalism. It is beyond the scope of this paper to systematically compare developments in eldercare with those in, for example, childcare and disability services in the four countries we study. However, we comment briefly in the conclusion on the significance of the trends we identify for Nordic universalism.

Measuring universalism, universalisation and de-universalisation

Universalism may be a contested and polysemic concept, but within the Nordic social democratic tradition, there is an implicit minimum understanding that the aim of universalising policies is to reduce gender and class inequalities. As Anttonen puts it: universalism ‘names the redistributive principle behind social policy’ (2002: 71). Nested under this broadest of principles, a range of dimensions of universalism have been identified, the specification and relevance of which varies with policy area (Anttonen et al. 2012; Béland et al., 2014; Goul Andersen, 2012; Kröger et al., 2003; Moberg, 2016). Drawing on this prior research, particularly from Anttonen (2002), Goul Andersen

(2012) and Vabø and Szebehely (2012), we have identified the following dimensions as ideal-typical for universal *eldercare*.

First is that there is a *clearly defined right to services* (Goul Andersen, 2012; Kröger et al., 2003). Thus, older people who need support should receive it as a legislated right, and should not have to rely on what Anttonen (2002: 77) calls ‘voluntary arrangements’: family members, their own purchasing power in a private market, or charity when these are unavailable. Since not all older people need help, implementing a right to services typically requires needs assessment; thus, the principle of universalism in eldercare is not violated by ‘selection’ of those in need as those holding a right to services (Anttonen, 2002: 78). However, the scope of ‘need’ to which older people have a right is clearly important in defining how universal an eldercare system is. The extension of rights to a higher level of support moves a service system in a universalising direction; the restriction of rights to a lower level of support moves it away from the universal ideal.

Second is that the *rules defining the right to service are the same for all* citizens or residents who could be relevant beneficiaries (Goul Andersen, 2012). Eldercare would be less universal if those who have, for example, more family support available, were assessed as needing fewer services. Using means-testing to determine which citizens are eligible for services is another clear de-universalising measure.

Third is that *services are financed by general taxes*, rather than by user contributions (Goul Andersen, 2012). As Anttonen puts it ‘[t]ax financing is one of the cornerstones of the Scandinavian social care regime’; it enables services to be made systematically available to those holding a right to them, irrespective of their own resources, and is thereby class-equalising, and it coheres communities in which the funding and use of social services is shared (2002: 76). For public funding to achieve its universalising potential, however, it needs to be sufficiently *generous*. Thus, the *level* of public spending, and trends in its development are important measures of universalisation (high or rising expenditure; low or no user fees) and de-universalisation (low or declining expenditure; high or growing user fees).

Fourth is that *services are used by those who need them*. As Goul Andersen notes, this can be considered an outcome measure of universalism that captures coverage of (in our case) eldercare services among older people in need of support. If a clear majority of those who need services receive them, the service system is more universal than one which covers a smaller fraction, leaving those not covered to seek assistance within alternative institutions (Goul Andersen 2012: 170), such as the market or the family. Thus, changes in service coverage can be universalising (rising) or de-universalising (falling).

Fifth is that *services are of good quality*. As Anttonen (2002) and Vabø and Szebehely (2012) point out, the Nordic ideal of universalism is based on integration of the working and middle classes into unified service systems. Good quality is both a goal and means of cross-class integration, since services must be of high enough quality to be attractive to all social groups. Thus, high quality services maintain universalism, *ceteris paribus*, while service quality that declines (or fails to rise in line with the expectations and preferences of those with more resources) may be de-universalising, as self-selected groups with more resources exit the system to purchase premium services on the market.

Sixth, that *services are publicly provided*, has been a defining feature of Nordic service universalism (Moberg, 2016:4). In Nordic countries, publicly-provided social services have formed part of the cohering social, economic and democratic infrastructure of municipal self-government (Anttonen, 2002: 76). From this perspective, public provision is a means to guarantee access to good quality services for *all* social groups, according to need and not purchasing power (Sipilä, 1997; Blomqvist, 2004). Thus, de-universalisation may occur if some or all service provision passes to private providers. The extent to which private provision is de-universalising depends on the kinds of private organisations that enter the field and the design of policies that enable their entry. Key variables are whether or not a) private providers operate *for-profit*, b) the care system is organised by market mechanisms, such as *competition* for contracts and consumer *choice* models, and c) market rules enable private providers to offer '*topping up*' services. If for-profit providers compete for contracts or customers and are allowed to offer topping up services, the likely result is de-universalising in the form of a wider spread of service quality: *lower* in many private services, as the profit motive diverts resources from care provision (Ronald et al., 2016), and *higher* in others, as members of highly-resourced social groups are better able to navigate the market to find the best services, and to use their own resources to top up the publicly-subsidised offering (Moberg 2016). By contrast, de-universalisation is less likely if private provision takes the form of non-profit organisations offering services within communitarian, rather than competitive institutional arrangements, without the opportunity to top up.

It is important to note that these six dimensions are mutually interdependent and their dynamic interaction is essential for realising their universalising potential. Eldercare services can enhance the welfare of the older people to whom they are provided, of their families, and of all members of society (as an insurance against future need). *Universal* eldercare services have the potential to equalise access to, and quality of, support for older people, and by replacing unpaid family care, are a precondition of gainful employment, especially of middle-aged women. To achieve the aims of universalism – to be both *equalising* and *defamilialising* – high quality eldercare services should be

offered to and preferred by all social groups (Blomqvist, 2004; Esping-Andersen 1990: 27). High quality and high coverage are connected: if all social groups use the same services, the stronger voice of middle-class users can improve quality of services for all, including those with fewer resources. Formal eligibility and formal equality are necessary but insufficient for universalism in eldercare: services also have to actually be *available* (as a right; high coverage; public provision), *affordable* even for those with fewer resources (publicly funded to a generous level) and *attractive* enough to be preferred by the middle class and various minority groups (high quality) (Vabø and Szebehely, 2012).

There has been some debate about the relationship between universalism, equal treatment and uniformity of service design (Anttonen, 2002; Anttonen et al., 2012). In our view, *equal treatment* for all does not imply *uniform services*. On the contrary, universal eldercare services need to be individualised; that is adapted to the diverse needs, lifestyles and values of a heterogeneous population. However, if they are to live up to the egalitarian ambitions of universalism, individualised services should not increase inequality.

Assessing universalism in Nordic eldercare

The Nordic countries are often seen as an homogenous group characterised – indeed distinguished – by universal social service provisions. In what follows, we draw on policy documents, official statistics and existing research on Nordic eldercare to assess the development of universalism in this key service domain in all four countries. A particular challenge of comparative social services research is that even within groups of highly similar countries, how services are organised, defined and measured can vary significantly. Considerable effort has been taken here to develop comparable measures and to ensure more generally that like is compared with like. Any disparities or gaps in data are clearly acknowledged. Unless otherwise stated, ‘all countries’ means Denmark, Finland, Norway and Sweden.¹

Clearly defined rights to services?

In all Nordic countries, family legislation states that children and other family members do not have responsibility for the care of adults, and a social service or care act obliges local authorities to provide home-based and residential care to older people and other adults who are formally assessed as needing such services. There is, then, a right to eldercare in all countries. However, this right is weaker than, for example, the right to childcare, which is offered without needs assessment to all children in a certain age group – at least those with an employed parent (Eydal and Rostgaard, 2011). In eldercare, because an intervening process of needs assessment determines who will

receive what services, the legal obligation for local authorities to *provide* care does not automatically translate into a strong right for individuals to *receive* it. Given the strong principle of municipal self-government, local authorities determine what counts as need (eligibility) and how that need will be met (the scope and extent of service provided).

Evidence shows that, on the rights dimension, eldercare provision has moved in a de-universalising direction in all four countries in recent decades. Legislation granting the right to care has not changed, but the eligibility criteria for accessing eldercare services have been tightened, in response to actual or anticipated fiscal pressures caused by financial crises, population ageing and resource competition with programs for social groups with stronger legal protection such as pre-school children or disabled persons below retirement age (Gautun and Grødem, 2015; Jensen and Lolle, 2013; Kröger and Leinonen, 2012; Szebehely and Trydegård, 2012). In Finland and Sweden, recession raised needs thresholds in the early 1990s (Kautto, 2000) while in Norway, resource competition drove this process a decade later (Gautun and Grødem, 2015). The right to care has been argued to be more unconditional in the Danish legislation than in the other Nordic countries (Henriksson and Wrede, 2008; Rauch, 2007). However, more recently Danish municipalities have also started to interpret the (unchanged) legislation in a more restrictive way: in 2011 the Danish Appeals Board (Ankestyrelsen) decided in a binding test case that the municipality had the right to stop providing home care to an elderly couple, whose needs had not changed but the local guidelines had tightened.²

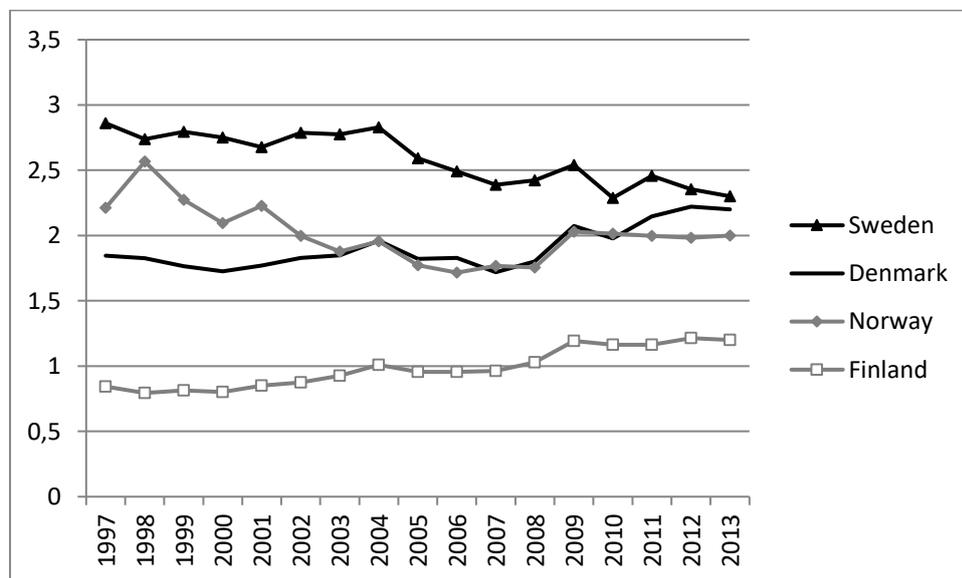
Same rules for all citizens?

On the question of whether the same rules of access apply to all citizens, the case of Nordic eldercare is not straightforward. On one hand, there are not different rules for different social groups and there is no means-testing. On the other hand, Nordic municipalities are highly autonomous and, as discussed above, tightened local policy guidelines have affected access to services. Thus, despite national legislation, there are stark differences between municipalities in eligibility thresholds, service coverage and spending on eldercare in all countries (Forma et al., 2011; Jensen and Lolle, 2013; Otnes, 2012; Trydegård and Thorslund, 2010). Since municipal variation cannot be explained by local variation in needs, researchers have raised concerns about geographical equality and fairness in all the Nordic countries. This is another respect in which universalism in eldercare is weaker than in tax-funded childcare, to which the legal right applies in *all* municipalities in all countries (Eydal and Rostgaard, 2011).

Services publicly funded?

In all countries, eldercare is largely funded from general taxes (in particular municipal income tax) and total public spending is more generous than in most other countries (Rodrigues et al., 2012:98). Nevertheless, there are clear differences between the countries. Measured as a proportion of GDP, public spending on eldercare is lowest in Finland (1.2%) and highest in Sweden (2.3%), followed by Denmark (2.2%) and Norway (2.0%) (Nososco, 2015: 239). As shown in Figure 1, this proportion has declined in Sweden and Norway while it has increased in Denmark and Finland. However, there has been a much more dramatic increase of the oldest old (80+) in Finland than elsewhere³ and the increase in spending disappears once we adjust for the ageing population. On this basis, Denmark stands out as the most generous country and Finland falls further behind.

Figure 1. Spending on eldercare services as share of GDP, 1997-2013



Source: NOWBASE, Table SOCEXP01

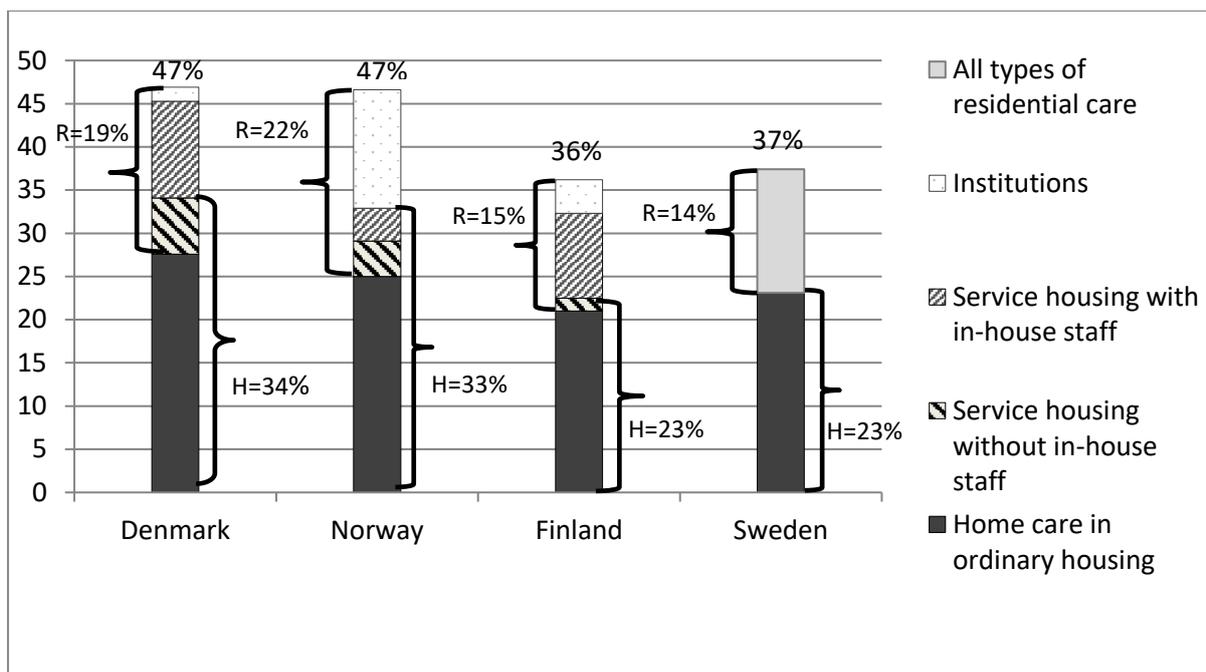
The share of user charges, a related measure of universalism, is also highest in Finland (21% of total expenditure on residential care and 15% of home care expenditure), followed by Norway (15% in residential care; personal care is free of charge in home care while there is an income-related fee for practical help). The smallest user contribution is reported for Denmark, at 4% of total expenditure on eldercare; home care is entirely free of charge for the user (Nososco 2015, p. 164-169). User charges are also low in Sweden (at around 5% of total costs) but, in contrast to Denmark, there are income-related user fees for all services up to a nationally-determined maximum monthly charge (Johansson et al., 2011).

Thus, the Finnish welfare state stands out as the least universal on this dimension. Moreover, users' share of eldercare expenses has increased over time in Finland, partly as a consequence of a shift from nursing homes to service housing, in which users pay a larger share of the costs (Anttonen and Karsio 2016). Data on public opinion reflects this pattern. Two thirds of Finns are dissatisfied with the affordability of residential care compared to one third of Swedes and one sixth of Danes (Carrera et al., 2013:42; no information on Norway).

Services used by those who need them?

Service coverage is an outcome measure of universalism, as noted above; and change in the extent to which people who need services receive them is a good indicator of universalisation (increasing coverage) or de-universalisation (declining coverage). Coverage is difficult to compare within a country over time and between countries more generally, partly because services are organised and/or reported differently (Saraceno 2010; Nososco 2015). The major challenge in the Nordic context is that, except for Sweden, residential care can be provided in either institutions or service housing, and in some or all forms of the latter the help provided is reported as home care. Thus, older people living in service housing are double counted in the statistics as receiving both residential care and home care. Nevertheless, with care and persistence and noting any anomalies, we have managed to assemble a comparable snapshot of coverage in 2014 (Figure 2), and a relatively comparable overview of trends in residential care and home care from 1990 to 2014 (Figure 3). We focus on the oldest old (those aged 80 years and above) throughout, as a decline in service coverage in this age group cannot be explained by improved health (Chatterji et al., 2015; Parker and Thorslund, 2007).

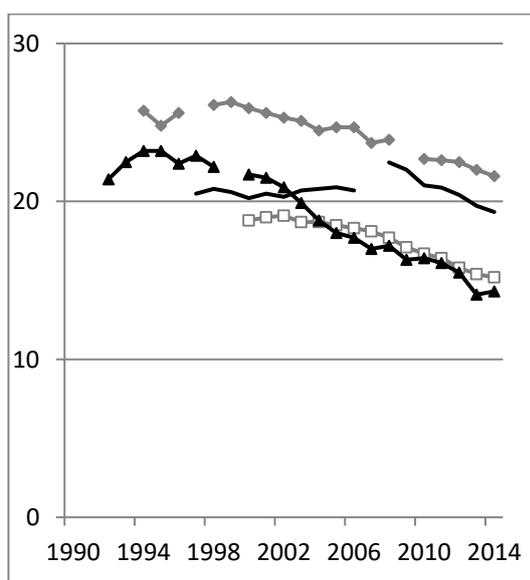
Figure 2. Residential and home care services. Users as proportion of the population 80 years and older, 2014 (H=home care; R=residential care)



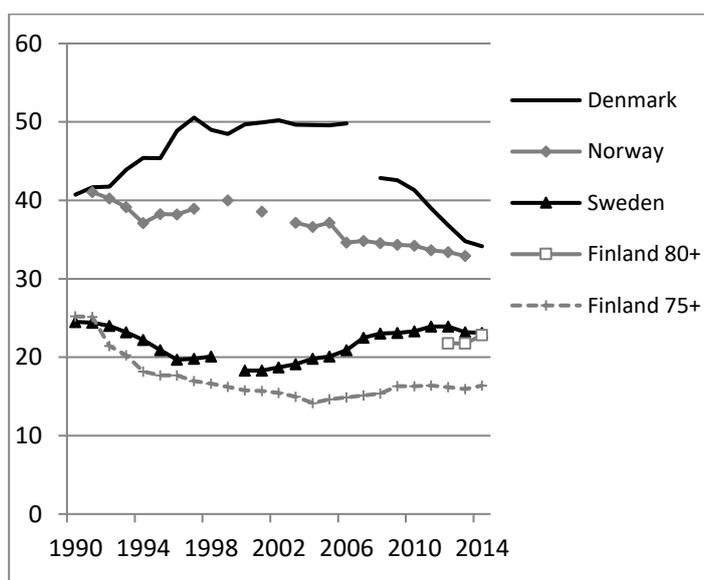
Sources: Denmark: StatBank Denmark, Tables AED06, RES101; Finland: Sotkanet, Tables 1049, 2485, 2486, 2489, 2490;⁴ Norway: Mørk 2015, Table 3.6 and Statistics Norway, Tables 04469, 06969; Sweden: NBHW 2016 p. 19.

Figure 3. Home care and residential care including service housing. Users as proportion of the population 80 years and older 1990-2014

Panel A: Residential care/service housing:
% of 80 years+ in population



Panel B: Home care: % of 80 years+ in population⁵



Sources: See Figure 1 plus Nordic Statistics Table SOCI22 ; Sotkanet, Table 1234; Ministry of Health and Welfare 2000, p. 41; NBHW 2014 and 2016; StatBank Denmark, Tables VH1B, VHPX.

Figure 2 shows that both residential care (taking nursing homes and service housing together) and home care coverage was considerably higher in Denmark and Norway than in Sweden and Finland in 2014.⁶

Panel A of Figure 3 shows that the coverage of residential care (in traditional institutions or in various forms of service housing) has been declining in all countries. The trends in the coverage of home care vary more (Panel B of Figure 3). Comparing home care coverage is complicated, mainly because care provided in various forms of service housing is not treated in the same way in all countries (see Figure 2).⁷ However measured, though, Figure 3 shows that home care coverage has been higher in Denmark and Norway than in Sweden and Finland during the entire period covered, even when accounting for a wider definition of home care in the two former countries.

In line with the ideal of Nordic universalism, home care coverage in the four countries was similar, and considerably higher than in the rest of the world, in the early 1980s (Sipilä, 1997) and remains comparatively high (Rodrigues et al., 2012:84). Panel B of Figure 3 shows that, in all countries apart from Sweden, the coverage of home care was higher in 1990 than in 2014. Coverage had already begun to fall in Sweden during the 1980s (not shown in Figure 3), and both in Finland and Sweden coverage was falling during the recession of the early 1990s (Kautto, 2000). In Norway, home care coverage has drifted slowly down since the late 1990s. In Denmark, coverage rose in the first half of the 1990s, stabilised for a decade or so, and has fallen precipitously in recent years.

Overall, proportion of the population aged 80 years and over who received either residential or home-based care declined in Sweden from 62% in 1980 to 37% in 2014; in Norway from 58% in 1994 to 47% in 2014 and in Denmark from 57% in 2008 to 47% in 2014 (it is not possible to report a similar comparison over time for Finland).⁸

In all countries, as a goal of eligibility tightening discussed above, home care has become more targeted to those with the largest needs, and focused on personal care rather than domestic services. Nevertheless the pattern varies between the countries: many Finnish local authorities no longer offer any domestic help (Kröger and Leinonen, 2012), while in Denmark a stable 44% of older home care users (80 years+) receive domestic help only, as does a fairly large (20%), but declining, proportion of Norwegian home care users in that age group.⁹ That Denmark and Norway continue to offer small amounts of help to a relatively large proportion of older people seems to keep them closer to the ideal type of universalism. However, their higher coverage is a result of spreading the jam more thinly: on average, in 2014, an older home care user in Denmark received 3.7 hours per week, in Norway 4.5 hours (in both countries including those living in service housing), compared to 8 hours per week in Sweden in 2012. In Sweden and Norway, homecare intensity has increased in

recent years, while in Denmark, both coverage *and* intensity have fallen.¹⁰ No comparable figure is available for Finland, but expenditure levels and other evidence suggest that, despite an increase, average hours are considerably lower than in Sweden; see Kröger and Leinonen (2012).

Yet, not even in Sweden, the only country where the home care coverage has increased in recent years and with a comparatively high and slightly increasing intensity, has home care compensated for the reduction in residential care – hardly any home care users receive the same amount of care as in a nursing home (Ulmanen and Szebehely, 2015:84). This is even more true in the other countries with declining home care coverage and lower home care intensity.

Thus, in all countries, eldercare services are used by a diminishing proportion of older people, amounting to de-universalisation on this measure.

Services of good quality?

For a good part of their history, Nordic eldercare services have more or less lived up to the universalistic ideal that they be of high enough quality to attract all social groups. In residential care, the humanising redevelopment of traditional institutions began in the early 1980s in Denmark and a decade later in Sweden. Since then, residents in Danish and Swedish nursing homes typically live in apartments with private bathrooms and a kitchen or kitchenette, with comparatively high staffing ratios and strong focus on individualised care and social activities. This shift from a medical to a social care model happened later in Norway, where traditional institutions still have an important role and are popular among the general public (Daatland et al., 2015). In Finland the shift from traditional institutions to service housing is happening at present. This has led to improved housing standards but also to much higher financial costs for service users and has been criticised as an aspect of ‘responsibilisation’ in a time of austerity policies (Anttonen and Karsio, 2016).

Nevertheless, in its various forms, residential care retains strong public support all the Nordic countries today; for example, a recent survey found that a majority of Swedes would prefer residential to home care if they need help more than twice daily (Vårdanalys, 2015).

In home care, history shows that, in their early years, services were attractive because care workers were able to adapt their help to individuals’ changing needs. The necessary organisational pre-conditions for this practice were high continuity of care, reasonably generous time frames and a low degree of detailed regulation, giving care workers considerable discretion (Dahl, 2004; Vabø and Szebehely, 2012). More recently, however, de-institutionalisation, rationalisation and market-inspired organisational changes have threatened the quality of home care. Services have become increasingly pre-defined, standardised and time-squeezed, various instruments have been developed to verify that the work performed complies with the order, and an increasing share of

work time is spent on documentation and quality measurement with a focus on the aspects of care that are measurable but not necessarily those most important for service users. These changes limit care workers' discretion and thus their ability to provide individually-adapted care (Dahl, 2009; Henrikson and Wrede, 2008; Trydegård, 2012; Vabø, 2006).

Services publicly provided?

The last dimension of universalism we discuss here is whether services are publicly *provided*. Religious and other non-profit organisations have historically had an important role in initiating, organising and providing care in all the Nordic countries. However, when eldercare services began to develop as part of the welfare state in the 1950s and 1960s, the vast majority of new services were publicly provided. This has begun to change in recent decades, as the impact of New Public Management reshaped the internal organisation of the public sector and promoted the development of the private sector in the Nordic countries through successive policies of marketisation (Szebehely and Meagher, 2013). Private, for-profit providers have increasingly moved into service provision, enabled by the introduction of market principles of competition and choice, which have been justified (as elsewhere in the world) with promises of reduced public spending, improved quality and empowered users.

For-profit providers of eldercare operate in all countries, but the size of the for-profit sector differs considerably between them. Finland and Sweden opened up for for-profit providers earlier and more intensively than Denmark and Norway. Since the beginning of 1990s, the share of for-profit provision has increased from virtually zero to 18-19% in Finland and Sweden and to around 4-6% in Denmark and Norway. In none of the countries has the non-profit sector grown (Szebehely and Meagher, 2013:244-245).

While declining service coverage occurred without political debate or changes in eldercare legislation, marketisation has been enabled by deliberate political decisions. Of the Nordic countries, Finland and Sweden were first to implement legislation that enabled *competitive tendering*, through which municipalities could outsource eldercare services to private providers, including for-profit companies. Similar legislation was introduced later in Denmark and Norway, although, significantly, both chose to protect the non-profit sector from competition. Differential rates of use of competitive tendering is one reason for the higher proportion of for-profit providers residential care in Finland and Sweden and for the much stronger position of large care corporations in these two countries compared to Denmark and Norway (Szebehely and Meagher, 2013:249-255). In recent years, these large care chains have been building their own facilities in Sweden and Finland, and offering places to municipalities instead of contracting to provide services in municipally-owned

buildings. This business strategy gives for-profit providers new advantages. When municipalities own facilities and outsource their operation, it is relatively easy to end a contract if quality is unsatisfactory, without discontinuing services to existing residents. When facilities are privately owned, the power relationship is reversed. If a municipality is unsatisfied with the quality of services in a privately owned facility, it faces the disincentive of finding new homes for residents, which is disruptive and may be difficult to arrange. Another business advantage is that for-profit providers are able to attract affluent residents to pay privately for premium services, through offering superior housing in their new facilities.

In home care, private providers, almost entirely for-profit, have mainly come onto the scene through consumer choice models, which were implemented during the 2000s in all countries except Norway, through specific legislation to promote competition (2003 in Denmark, 2004 in Finland and 2009 in Sweden). Increasing the share for-profit provision has been an explicit goal of choice policies, justified as increasing diversity of offerings to meet differentiated consumer preferences (Szebehely and Meagher, 2013:262).

Further, in Denmark, Finland and Sweden, user choice models include rules which allow private (but not public) providers to offer 'top-up' services, which older people can privately purchase in addition to their needs-assessed, publicly-subsidised services. Moreover, such purchases attract a *tax rebate*, which is another policy instrument that promotes private provision in three of the countries; again with Norway as the exception. The rebate applies to expenditure on household services and care, and was introduced in 1993 in Denmark, 1997 in Finland and 2007 in Sweden. The rebate is not a specific eldercare policy: taxpayers of all ages can use it. The Swedish scheme is the most generous: taxpayers pay half the price of services to ceiling of €5,700 per person per year, compared to 45% of the cost and a ceiling of €2,000 in Finland, and 33% of the cost and a ceiling of €2,000 in Denmark. Although detailed time series are available only for Sweden, uptake of the rebate seems to have increased in all the countries, especially among older people with higher incomes (Szebehely and Meagher, 2013: 262-265). These privately-purchased (and tax-subsidised) services are used both instead of needs-assessed home care service and to top up publicly-subsidised services provided by private companies only. The result is that, in these three countries, well-to-do older people with high care needs have a clear incentive to choose private home care providers (Szebehely and Trydegård, 2012). In Sweden and Finland, for well-to-do older people who have smaller care needs, the combination of income-related user fees for home care services and the tax rebate serves as an incentive to refrain entirely from use of formal home care services and buy private help instead. (In Denmark homecare services still are free of charge for the user).

To summarise, marketisation policies, which have introduced competition and choice, and encouraged for-profit provision, have reduced the extent of public provision and de-universalised eldercare in all countries. However, the extent of marketisation is considerably higher in Finland and Sweden, while Norway remains closest to the universal ideal type on this dimension.

Consequences of de-universalisation

We have presented evidence that de-universalisation has occurred in all four Nordic countries, but more in Finland and Sweden than in Denmark and (particularly) Norway. The causal drivers of these changes have been well-documented, although the precise mix and impact of various drivers vary between the countries.¹¹ They include the impact of New Public Management on service and system organisation and fiscal pressures related to economic recessions, resource competition from other social services, such as childcare and disability support, and the perceived pressure of population ageing.

As discussed above, universalisation of eldercare aims to reduce inequalities of class and gender through shifting the risks and costs of care from families and markets to public care systems. In this section, we seek to answer the questions: has de-universalisation shifted the distribution of care from public care systems to the family, through '*re-familialisation*' (Saraceno 2010), and/or to the market, through *privatisation*? And are older people from different social groups affected in different ways by declining service coverage and by marketisation, resulting in *dualisation* of care? As with the analysis in the previous section, we present the best available evidence, noting any gaps and disparities in the data.

Re-familialisation?

There are clear indications that declining eldercare coverage since the 1980s has been followed by an increase in family care in three Nordic countries. Re-familialisation has been evident in Sweden since the 1980s (Johansson et al., 2003; Szebehely and Trydegård, 2012; Ulmanen and Szebehely, 2015), where the share of population 75 and over in need of practical help care who received care from non-cohabiting relatives rose from 40% in 1988–89 to 65% in 2010 (Ulmanen 2015: 22). Data is patchier on the other countries, but available evidence points to similar trends in Finland, (Anttonen and Häikiö, 2011; Henriksson and Wrede, 2008; Kröger and Leinonen, 2011) and in Norway (Svalund 2005). We have not found any Danish studies on family care over time.

Our findings suggest that lower service coverage would have led to higher levels of family care in Sweden and Finland than in Denmark and Norway. Again, data are patchy, but available evidence supports this inference. One study comparing Denmark and Sweden found that the proportion of

older people receiving family care was much lower in the more generous Danish system than in Sweden (Rostgaard and Szebehely, 2012). Measured in terms of the impact of caring responsibilities on middle-aged women's employment, in 2007 Danish women were half as likely to be affected as Swedish and Finnish women by caring responsibilities (Naldini et al., 2016: 7).¹² Indeed, Swedish and Finnish women aged 55-64 years may be particularly vulnerable to the negative impact of re-familialisation, because their full-time equivalent (FTE) employment rates are high in comparative perspective at 0.64 and 0.54 respectively, compared to the OECD average of 0.37.¹³ Moreover, and critically important from the perspective of class inequality, is that the distribution of reliance on family care is uneven within the Nordic countries, as elsewhere. Family care is significantly more common among older people with shorter education in Denmark and Sweden (Rostgaard and Szebehely, 2012), a trend which has consolidated in Sweden over time (Szebehely and Trydegård, 2012; Ulmanen and Szebehely, 2015). This pattern has also been shown internationally (Saraceno, 2010), which suggests that re-familialisation increases both class and gender inequality.

Privatisation?

The purchase of private care services from users' own funds is an alternative to family care when public eldercare services are not available. Several Swedish studies have found that both privately-purchased help and family care increased as the coverage of publicly-funded eldercare services declined. Not surprisingly, privately-purchased help shows the opposite class pattern to family care: it is most common among those with more resources in Sweden (Szebehely and Trydegård, 2012; Ulmanen and Szebehely, 2015), Denmark (Rostgaard and Szebehely, 2012) and Finland (Mathew Puthempambal et al., 2017). Swedish statistics on use of the tax rebate for domestic services and care confirm this picture: older people with higher incomes use the rebate at a much higher rate than those with lower incomes (Erlandsson et al., 2013).

While consumer choice justifications are common among policymakers keen to promote social service markets (Blomqvist 2004), evidence suggests the choice to purchase private services may be more forced than free for many users. A Finnish study found that four of ten older persons who turned to private providers did so because the municipality did not offer enough services; those who did *not* buy private help commonly cited lack of resources to purchase it (Mathew Puthempambal and Kröger 2016). Thus, it seems that what Ranci and Pavolini (2015: 282) note about Sweden and England is true also for Finland: 'cuts and restructuring [have] paved the way towards a hidden road of partial privatization'.

Dualisation of care?

There is a clear class pattern in the consequences of declining service coverage: family care is more common among older people with fewer resources, while help purchased in the market, paid for out-of-pocket by the user (more recently subsidised with a tax-rebate), is much more common among older people with more resources. Thus, there is clear evidence that re-familialisation and privatisation have diminished the class- and gender-equalising potential of Nordic welfare states, and contributed to the dualisation of care. Yet, despite developments in recent decades, a minority of eldercare users in the Nordic countries receive publicly-funded services from private providers or purchase services privately in a care market. This is true even in Sweden and Finland, where defamilialisation, marketisation and privatisation are most widespread.

Nevertheless, there is reason to be concerned about the *dynamic effects* of marketisation on the universality of Nordic eldercare. System design features are critically important here. As discussed above, choice models, implemented to varying degrees in all countries, have de-universalised the *supply* side of Nordic eldercare systems, particularly in Finland and Sweden. On the *demand* side, choice models position older people in the new role of ‘empowered consumer’. However, older people with care needs have limited capacity to act in the role thus assigned to them. Exiting an unsatisfactory provider is a primary presumptive means of quality control in choice systems, yet Swedish research has shown that the exit option is almost entirely non-existent for eldercare users, partly because continuity of care is so important to quality, and partly because of their poor health and frailty (Vamstad 2016). Moreover, choice models have an inherent class sorting effect because the skills required for making use of market information are not equally distributed. Research in the UK and Denmark has found that, unsurprisingly, those with higher education are most able to find the best providers (Glendinning, 2008; Rostgaard, 2012).

Class-based sorting between better and worse providers can be a distributional problem ‘internal’ to publicly-financed eldercare offered in a choice-driven mixed economy. However, system design features in Denmark, Sweden and Finland generate further ‘external’ risks to universal eldercare. They do so by offering incentives to those with more financial resources to opt out of public services entirely, via the combination of user choice systems in which for-profit providers have a market advantages in the exclusive opportunity to offer top up services for private purchase, subsidised through a tax rebate.

Finally, there is another mechanism through which marketisation has a dualising effect, through its impact on quality. Outsourcing of public services, whether via contracting or choice models, tends to increase the detailed regulation of services, as a precaution in the management of public funds and

public duty of care. Yet detailed regulation works against service quality in care, even as it seeks to assure it (Braithwaite et al., 2007). If care becomes routinised as a consequence of detailed regulation, its quality falls and it becomes less attractive. If publicly-subsidised and needs-assessed care services become less attractive, older people with more resources have another incentive to leave the publicly-funded eldercare system to find alternatives over which they have more control.

Conclusion

In their wide-ranging analysis of changes in long-term care (LTC) in six European countries in recent years, Ranci and Pavolini (2015) found that countries with less developed LTC systems have expanded their coverage and generosity – in other words, universalised – while countries with universalistic LTC models have moved in the opposite direction, towards what they call ‘restricted universalism’. Our systematic assessment of the trajectory of change in Nordic eldercare deepens their analysis. We show that de-universalisation has occurred in all four countries on several, if not all, the six dimensions we established at the outset, but considerably more in Finland and Sweden. Further, although comprehensive data are not available for all four countries, available evidence suggests that declining coverage – both a measure and an outcome of de-universalisation – has shifted some eldercare from public care systems to families (re-familialisation) and the market (privatisation). It is significant that these changes have occurred without an explicit attack on universalism or retrenchment of formal rights. Theories of institutional change assist us in understanding how this has happened, through incremental first and second order policy changes in the organisation and delivery of services (Ranci and Pavolini, 2015:271). Importantly, the trends we have identified in Nordic eldercare do not signal the ‘universal decline of universality’ (Béland et al. 2014) in these countries. As the coverage of eldercare has fallen, the coverage of childcare, for example, has reached towards 100% in Denmark, Norway and Sweden (Meagher and Szebehely, 2012). Complex patterns of service extension, retrenchment and redesign are underway within Nordic social service systems, as elsewhere, and these confound over-arching claims about a single direction of change.

Nordic eldercare, however, does appear to be a universal model at a crossroads, and the equality consequences of de-universalisation require careful monitoring. Evidence from Sweden about class differences in use of family and purchased care, and from Denmark about recent rapid coverage declines, suggests concern is warranted about both the availability and quality of care for older people with care needs, and for the employment opportunities of their middle-aged daughters. Data development should also be a priority in all countries, but perhaps particularly in Finland, where extensive change has occurred, but available evidence on its impact remains thin. Further, changes

in delivery systems have altered the structure of interests in the eldercare field in Finland and Sweden, as for-profit care corporations have become powerful new actors. These corporations increasingly represent themselves as indispensable to the future provision of eldercare, and their evolving business models are extending and entrenching their position. This raises concern about a growing private sector that drives dualisation, by increasingly providing an alternative to formerly universal public services, which, in turn, face the risk of creeping residualisation.

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Databases (all visited July 2, 2016):

Nordic Statistics: www.dst.dk/nordicstatistics

NOWBASE: <http://nowbase.org/da/database>

OECD.stat :<http://stats.oecd.org/>

StatBank Denmark: www.statistikbanken.dk

Statistics Norway: www.ssb.no

Sotkanet: www.sotkanet.fi

¹ The smallest of the Nordic countries, Iceland, is not included in the analysis partly because there is less data available, and partly because of space limits within the article format.

²www.ast.dk, case 221-11.

³ In Finland the proportion 80+ in the population increased from 3.26 to 4.98 between 1997 and 2013; in Denmark from 3.90 to 4.15; in Norway from 4.14 to 4.35 and in Sweden from 4.80 to 5.47 (NOWBASE, Table POPU01).

⁴ The Finnish statistics report home care as proportion helped during the year; the other countries report the number of recipients at a certain point of time. To be more comparable the Finnish figure in the statistics (28.5%) is reduced by 20% (calculation of the difference between the two measures based on Daatland 1997: 61).

⁵ As the Finnish figures on home care refer to those receiving help during the year we have reduced the numbers by 20 % (see previous footnote). Further, the longer trend line refers to a younger age group (75+); the other countries to 80+. This limits the comparability between Finland and the other countries but not the interpretation of the Finnish trend.

⁶ Both health and social long-term care services are included in Figure 2 and 3.

⁷ Sweden has the strictest definition (only services in older people's ordinary homes are included in the home care statistics) while Norway reports services in all kinds of service housing as home care. Denmark had a similar wide definition of home care until 2006 and while the definition is more narrow from 2008 (explaining the break in the Danish line in Figure 3B), services in one form of needs assessed housing for older people ('ordinary elder dwellings') are still reported as home care. Also Finland includes home care provided in 'ordinary service housing' in the home care statistics.

⁸ For all the countries the information for 2014 is from Figure 1; for the early time point Government Bill 1997/98:113 p. 33 (Sweden); Otnes (2012:70) (Norway) and StatBank Denmark Tables AED06 and RES101 (Denmark).

⁹ StatBank Denmark Table AED06 and Statistics Norway Table 06969.

¹⁰ StatBank Denmark Table AED021; Statistics Norway Table 09933 and authors' calculation from NBHW 2013, Table 5 (Sweden).

¹¹ For accounts of Sweden and Denmark, see Rostgaard and Szebehely (2012) and chapters 3 and 4 respectively in Ranci and Pavolini (2013). On Finland, see Anttonen and Häikiö (2011) and Anttonen and Karsio (2016). On Norway, see Daatland et al. (2015), Vabø and Szebehely (2012) and Vabø et al. (2013).

¹² Whether the comparatively favourable situation of Danish women has changed with the more recent precipitous decline in home care coverage remains unknown.

¹³ OECD.stat Tables 'LFS by sex and age'; and 'FTPT employment based on a common definition'.