

# Welfare services for the Elderly in Sweden at the Beginning of the 21<sup>st</sup> Century – Still in Line with the Nordic Welfare State Model?

**Gun-Britt Trydegård, PhD<sup>1</sup>**

## **Abstract**

The Nordic welfare state is not merely a “social insurance state” but to a great extent also a “social service state”, and elderly care has a central place in the Nordic welfare model. Public services and care for elderly people have been broadly accepted, used by all classes in society and have had wide public support. In recent years it has been said that Sweden has moved from this idealized ‘caring state’. The 1990s was a turbulent decade for welfare services on the whole, and for services and care for elderly people in particular. The aim of this paper is to describe these changes and try to identify some general trends and tendencies in the development, and also discuss if Swedish elderly care is still universal, extensive, equal, and equitable – and in line with the traditional view of the Nordic welfare state model.

Although national policy and legislation have remained rather unchanged the last twenty years, old age-care has undergone substantial reorganization and reconstruction. The access to home-help services has been dramatically reduced, and institutional care has not kept pace with the growing elderly population. The resources have been concentrated on fewer and more care-demanding groups who receive personal care and home nursing care, sometimes all around the clock. Elderly persons with minor needs have been excluded, while others exit the services which they find too expensive or of poor quality.

A salient feature of Swedish welfare is that the operative responsibility for service provision rests with fairly independent and, to a large degree, financially self-sufficient local authorities. Like many other countries, Sweden experienced increased decentralization in many areas in the 1980s and most of the 1990s, not least in the care of the elderly and the disabled. A consequence of this scope is that local variation is extensive, and that what kind of elderly care a citizen may expect will vary according to where in Sweden he or she lives – it seems accurate to talk of geographical inequality in elderly care.

Another distinct tendency is different forms of privatization: management of municipal activities have become market-influenced; the former public provision of services have increasingly been handed over to private companies; costs and responsibility of care have more and more become a private business; and informal care from family, friends and voluntary organizations has increased.

Despite the substantial changes of the old-age care, very little is known about the consequences for the elderly, their next of kin and the staff. A deeper and more detailed understanding of the character of these changes is essential for perceiving the ongoing changes of the character of the Nordic welfare state model.

## **Welfare services – an important part of the Nordic welfare model**

How medical care and the care of the elderly as well as school, childcare and other social services function is important for most people’s welfare and daily life. To have access to welfare services of good quality is important not only for the people who are

presently making use of the services, but also for others for whom access to welfare services can be insurance coverage for possible future needs. Furthermore, the welfare services can also constitute a resource for everyone who has a family member in need of assistance, for instance in the care of the elderly (Welfare Commission 2002). Welfare services constitute an important part of the Nordic welfare state model – it is not only a ‘social insurance state’ but also a ‘social service state’ (Anttonen 1990).

According to the traditional view of the Nordic Welfare State Model, the social services are widely available and of high quality; they are publicly funded and mostly publicly provided. The same services are directed to and used by all social groups, without means testing and without demands for labour market affiliation. When it comes to elderly care, there is an articulated preference for home-based rather than institution-based care. Swedish home care for elderly people has provided help and support in everyday life for large numbers of senior citizens. Since its start in the 1950s, home care has made it possible for elderly people to be assisted with both household duties and personal care without having to move to a nursing home or depend on their next of kin. Public home care has been highly appreciated – several studies have shown that elderly people in the Nordic countries prefer to receive care from public home care rather than from their families, voluntary organizations or private firms (see for example Andersson 1993; Sundström & Hassing 2000). The comprehensive childcare and elderly-care sector in Scandinavia is of special importance to women; it has enabled them to combine gainful employment with care within the family, and it has opened up an extensive labour market for them. Swedish women have had the opportunity to be both ‘working mothers and working daughters’ (Anttonen 1990, p. 18).<sup>2</sup>

In Sweden, however, the 1990s was a turbulent decade for welfare services in general and for services to and the care of elderly people in particular. Although few legal reforms were implemented in this field, there have been many changes, and new phenomena have emerged. In this paper I will describe the most apparent changes in the care of the elderly in Sweden at the dawn of the twenty-first century, and try to identify some general trends and tendencies in the development. I will also discuss if

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<sup>1</sup> *Center for Health Equity Studies (CHESS), Stockholm University, Sweden*

<sup>2</sup> In Sweden, 75 per cent of the women, both the highly educated as well as the unskilled, are gainfully employed, compared with an average of 53 per cent in the European Union (EU). Many women with young children are in gainful employment in Sweden – 81 per cent compared with 53 per cent in the EU. Also, large numbers of women in the age group 45-64, whose parents are at the age when they might be in need of help, are gainfully employed – 75 per cent in Sweden compared with 42 per cent in the EU (Szebehely 1998).

the Swedish eldercare still can be looked upon as universal and available on equal conditions and thus in line with the Nordic welfare state model.

### **Structural reorganization and reductions**

#### *Reorganizing care for the elderly – the ‘ÄDEL-reform’ in 1992*

In 1992 a comprehensive organizational change was implemented for the care of the elderly, called the ‘ÄDEL-reform’. One aim was to gather all public care for elderly people under one authority, the municipalities; another aim was to strengthen the social service culture and de-medicalize care of the elderly. Responsibility for long-term medical care for elderly people was transferred from the regional county councils to the local authorities, except for attendance from physicians. The reform also comprised a strong financial incentive for the municipalities to find care outside hospital for so-called ‘bed-blockers’, that is hospital patients who are medically ready for discharge but cannot manage on their own at home. The municipalities were obliged to reimburse the county councils for the costs of care for bed-blockers who remained in hospital. This increased the pressure on home care and other parts of the care continuum as well as on family carers (NBHW 2000a). However, as late as ten years after the reform problems remain in the co-ordination between in-patient care, primary healthcare and the municipal care of the elderly (NBHW 2001). This has resulted in considerable difficulties for the increasing number of elderly people with wide-ranging medical and social needs who are being cared for in the home or in municipal accommodation for the elderly (Gurner & Thorslund 2003). As we will see, the reform has also had other consequences, intended or not, for elderly people in need of care.

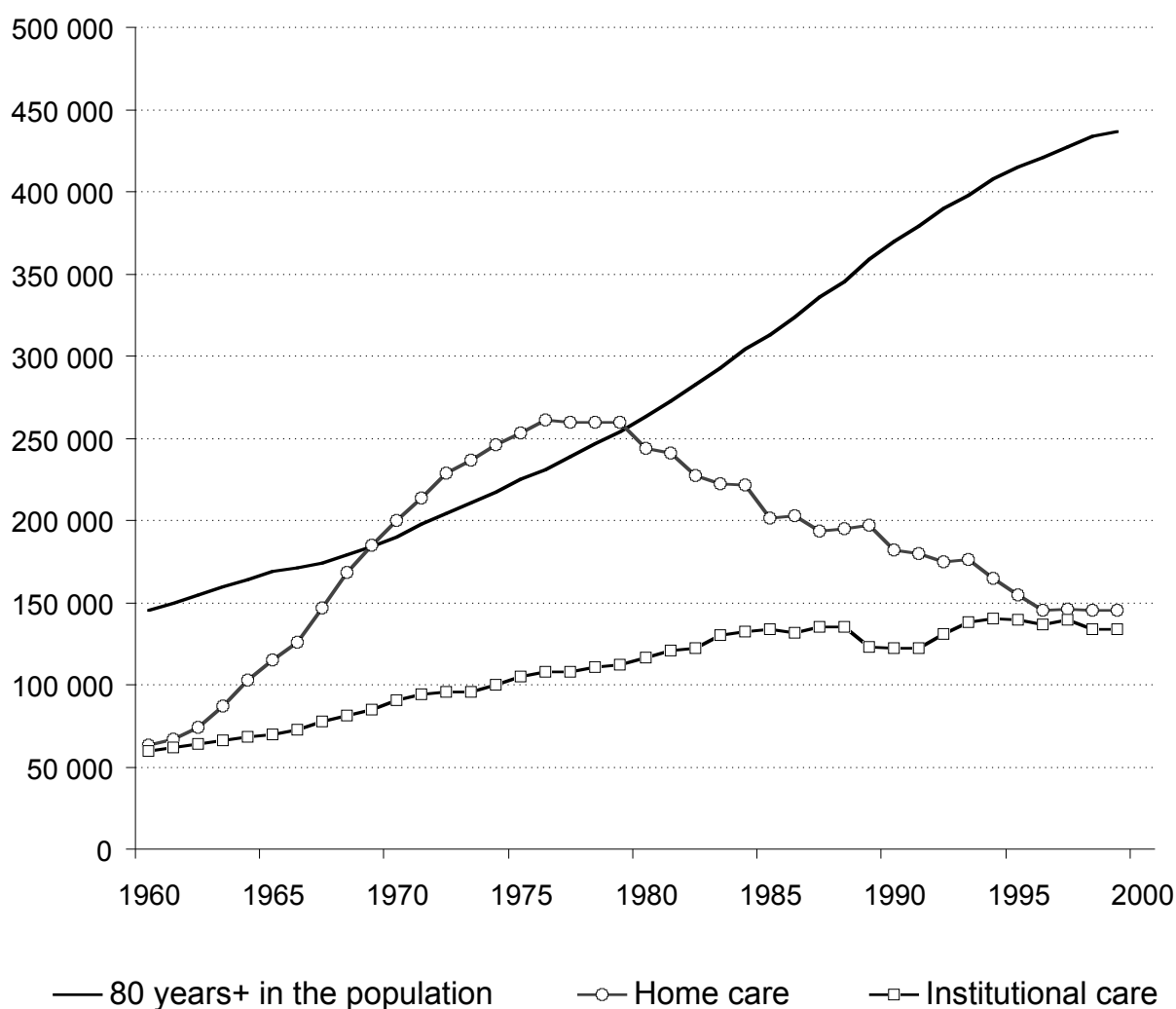
#### *Unchanged national policy – substantial changes in practice*

Apart from this reorganization, the Swedish national policy for the care of elderly people has remained unchanged for at least the last twenty years. The latest Government Bill, the ‘National plan of action for the care of elderly people’, was passed in parliament in 1998, and confirmed the overall aims stipulated in earlier legislation and policy documents. The national principles state that the care of the elderly is to be organized in a democratic form, be publicly funded and available as needed and not based on the individual’s purchasing power. Elderly people are to be able to age in security with maintained independence and have access to care and services of good quality (Government Bill 1997/98:113). The newly revised Social Services Act (SFS 2001:453) states, in conformity with the Act from 1982, that

everyone is entitled to help and assistance according to need, if he/she cannot manage on his/her own and his/her needs cannot be met in any other way. Local authorities have a mandatory responsibility to provide domiciliary services to elderly people, and the assistance should be given in ways that strengthen integrity and ensure a reasonable standard of living.

Despite the unaltered goals, Swedish care for the elderly has in reality undergone substantial changes during the last decades, both in extent and character.

Figure 1. *The number of elderly people 80+, and of recipients of different forms of public care for the elderly in Sweden 1960-1999* (Source: Szebehely, 1999).



As Figure 1 indicates, the number of very old persons in the Swedish population has steadily increased during the last forty years. Sweden now has the world's highest proportion of people aged 80 years and older in the population (5.2 per cent). During

the same period, the two main forms of public care – home care and institutional care – have developed in different ways, with home care showing the most divergent trend. From a low level (similar to that of institutional care) at the beginning of the 1960s, rates of home care increased rapidly and reached a peak at the end of the 1970s. The expansion was much faster than the increase of the elderly population, and there were twice as many home care recipients as there were residents in special housing. But since the beginning of the 1980s, the number of home care recipients has gradually decreased. At the end of the 1990s it was at a level comparable to that of the mid-1960s, with the number of home care recipients being more or less the same as the number of persons living in special housing for elderly people. According to the annual national statistics, 8.2 per cent of elderly people 65 years and over and 19.5 per cent of those 80 years and over were receiving home care at the end of 1999 (NBHW 2000b), compared with 16 and 38 per cent, respectively, at the beginning of the 1980s.

Institution-based care in special housing or in geriatric wards shows a steadier development. Except for a slight recession in the early 1990s, the number of residents in institutions has slowly increased – during the first half of the period it nearly paralleled the increase in the elderly population as a whole. However, since the beginning of the 1980s institution-based care has not kept pace with the increasing number of very old persons in the population (Szebehely 1999). At the end of 1999, 7.6 per cent of the people 65 years and over, and 20.3 per cent of those 80 years and over, were living in special housing for elderly people (NBHW 2000b).

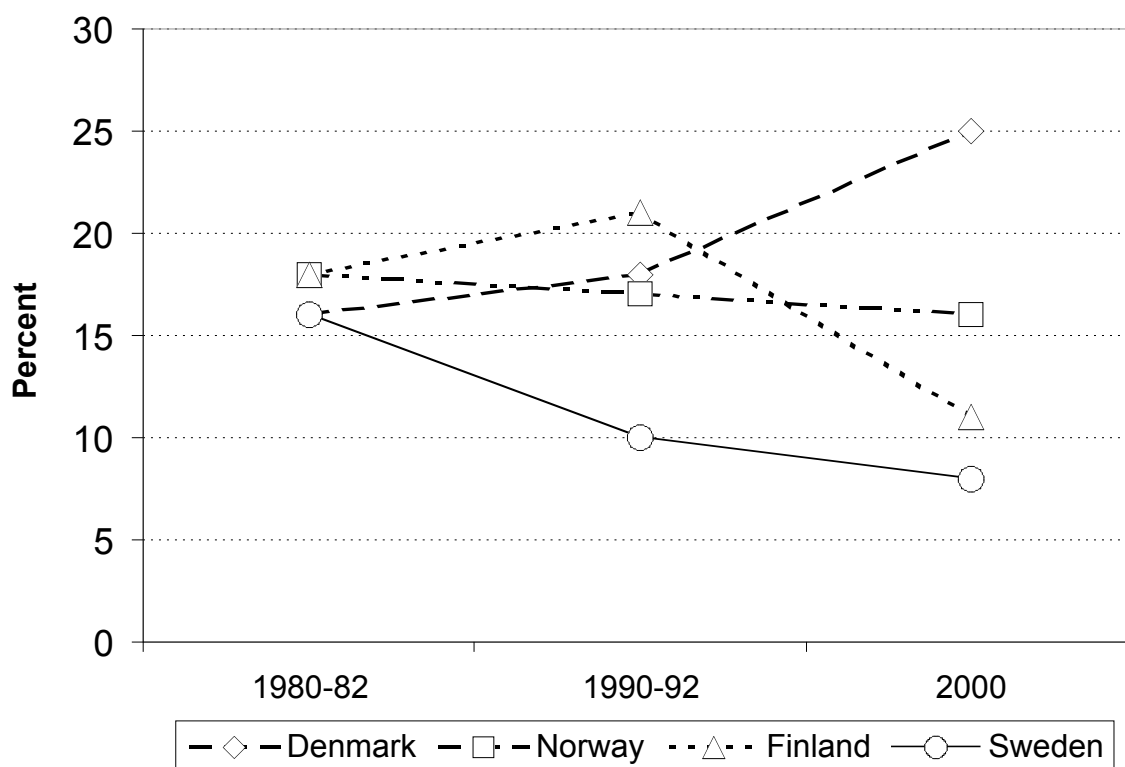
If we compare the development of home care coverage<sup>3</sup> in four Nordic countries (Figure 2), we find that twenty years ago there were only small differences between the countries; for example, approximately one pensioner of six received home care in all four countries. We could say that at that time there was a homogenous Nordic model of care for the elderly. Since then, home care has developed along rather disparate tracks in the four countries. In Denmark, home care coverage has increased substantially, whereas the development in Norway has been rather stable. In Finland the coverage has declined, especially since 1990, and in Sweden home care coverage has decreased the most – it has practically been cut in half. In proportion to the population, today three times as many Danish pensioners receive home care as do Swedish pensioners (NOSOSCO 2002). Denmark now seems to be “the most Nordic” country, when it comes to home help services – they are widely available, the services

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<sup>3</sup> I.e. the percentage of the population in a certain age group receiving home care at a given time.

are free of charge, and outreaching activities and preventive home-visits are mandatory (Szebehely 2003).

Figure 2. *Home care among elderly people 65/67 years and older in four Nordic countries.* (Source: NOSOSCO 2002; Szebehely 2003).



*Home-care service to fewer but more care-demanding elderly persons*

Although the coverage rates for home care in Sweden have declined substantially during the 1990s, the number of home care hours has instead increased. Resources have been concentrated on fewer and more care-demanding groups of elderly people, which is partly a consequence of the 1992 ÄDEL-reform, but also of the considerable cut-backs in the healthcare sector that have occurred during the decade. The number of hospital beds and the length of stays in hospital have been drastically reduced – both have almost been cut in half – and patients are sent home ‘quicker and sicker’ (Welfare Commission 2002). Elderly persons with extensive care needs, who previously were taken care of within healthcare, today consume an increasing proportion of the municipal resources. Home care now puts the main emphasis on personal care and home nursing care, including 24-hour care, whereas domestic services such as cleaning, laundry, shopping and social commitments such as ‘walks and talks’ are increasingly beyond the municipal undertakings. One could say that

social care services rather have become medicalized, contrary to the intentions of the ÄDEL-reform.

### *Exclusion and exit from services*

The restructuring of Swedish home care to fewer but more frail recipients is – as mentioned – not a result of legal reforms or a change of policy. Instead, changes in the surrounding world – shrinking financial resources combined with a growing elderly population as well as the reduced number of hospital beds and length of treatment – have been the driving forces (NBHW 2000c). In order to meet the increasing demands in an already strained economy, the municipalities have implemented more restrictive guidelines for the needs-assessment process. According to the Social Services Act, the individual has the right to receive care if ‘the needs cannot be met in any other way’. The municipalities have initiated both stricter interpretations of ‘needs’ – there is a higher threshold into the home care system – and wider interpretations of ‘other way’, that is, more demands on family and relatives to provide care. In particular, older married women who take care of their frail elderly husbands are increasingly left alone with the care responsibility; home care to relieve the pressure is nowadays a rare occurrence (Szebehely 1999). A great many municipalities have defined exactly the boundary lines of their undertakings, and elderly people, primarily needing help with household duties such as cleaning, doing laundry or buying food, have been directed to purchase these services from private firms, thereby putting them outside the range of municipal services for the elderly.

The reduction of home care is, accordingly, a result of *excluding* users with minor needs and prioritizing those with extensive care needs. However, there are also reports of users more or less voluntarily *exiting* from services. There are few formal rejections of applications for assistance and very few appeals against negative decisions (NBHW 2000c). It is likely that elderly people learn about the municipality’s rules and attitudes and therefore refrain from applying for assistance that they would probably not have received anyway. Many municipalities have rationalized and standardized their services and changed the services’ content and quality. There has been a decline in staff continuity, a restricted allotment of home care hours in relation to actual need and a thinning out of domestic support, which has most likely had an impact on the demand and made elderly people refrain from even applying for public home care (Trydegård 2003).

The fee system has also been used as an instrument to reduce services. By raising user fees for persons with minor help needs, municipalities have tried to deflect some

of the demands for public home care. Furthermore, many elderly persons – roughly one of six help-needing persons 75 years and older, foremost women with low pensions – have foregone municipal services for financial reasons (NBHW 2001).

#### *Increase of resources and staff*

Despite the reduced access, public resources for the care of the elderly increased in real terms during the latter half of the 1990s, i.e. with consideration given to the increase in the number of elderly persons in the population<sup>4</sup> (Welfare Commission 2002). Also, the number of persons employed to care for the elderly showed a tendency to rise. During the latter half of the decade, care staff increased by 13 per cent, while the number of managers and supervisors decreased by the same percentage, which has meant larger working teams and less supervision and guidance for the staff (Swedish Association of Local Authorities 2002).

#### *Decentralization*

The 1990s were on the whole characterized by a tendency toward decentralization – in several different ways. The ÄDEL-reform was an example of the *decentralization of authority* from regional to local level. Equivalent legal reforms have also been implemented within the support and services for persons with disabilities. Another form of decentralization concerns the *financing of care* for elderly and disabled people. During the decade state grants were radically changed such that the amount of care and services provided by the municipality became unimportant. The new general state subsidies are instead *block grants*, calculated on the basis of a municipality's revenues and estimated costs, and taking into account structural factors such as age, living conditions and socio-economic status of the local population. This new system did away with state control of how the money is used, giving the municipalities greater freedom – and potentially also leading to greater diversification (Bergmark 2001).

When it comes to care of the elderly, there are large differences across municipalities in terms of coverage, costs and accessibility, both in home-based and in institution-based care. According to studies of home care over time, these local variations have continued to increase in the 1990s (Trydegård 2000). Today, the most 'generous' municipalities provide home care to almost four times as many persons 80 years and over than do the municipalities at 'the bottom of the league' (30 per cent

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<sup>4</sup> At the end of the decade, the aggregate public funding for the care of the elderly was estimated at more than SEK 55 billions (equivalent to about 7 billion US dollars). This represents a rise in fixed rates of more than 20 per cent between 1993 and 1999, while the number of persons 80 years and older in the population rose by 10 per cent during the same period.

compared with 8 per cent). Studies by Trydegård & Thorslund (2000) of the variation in home care coverage for the oldest age group (80+) in all Swedish municipalities showed that municipalities did not even out low coverage by higher intensity, i.e. by giving more hours of help per recipient. Neither did they compensate for low home care coverage by providing institutional care or vice versa. Statistical analyses demonstrated that the great variation could only to a very small extent be explained by differing needs in the elderly population, or by structural, political or financial factors (ibid.). A final multivariate model explained only 15 percent of the variance. The history and the traditions behind the provision of home care in the municipalities seemed to be of greater importance (Trydegård 2000). There seems to be a path dependency (Thelen, 1999) in the sense that established traditions and earlier municipal policies influence the present supply of care for the elderly. This is also true of home care, although it does not have the inertia of buildings or other fixed assets. It seems more appropriate to talk of 'welfare municipalities' than one uniform welfare state when it comes to services for elderly people in Sweden (Trydegård & Thorslund 2000).

#### *Also signs of re-centralization*

In some respects, however, there are also signs today of the opposite trend: re-centralization (Bergmark 2001). One example is a central government decision from July 1st 2002 on a reform for elderly care, the so-called 'max-fee-reform'<sup>5</sup>, which restricts the municipalities' freedom to set the charges for local services. The reform aimed at lowering the fees for approximately half of today's help recipients, but also at leveling out the wide and increasing variations between the municipalities with no two municipalities applying the same scale of fees before the max-fee-reform was introduced (NBHW, 2000a). An initial evaluation of the reform showed that an increased proportion of care recipients has been exempted from fees (34 per cent compared with 14 per cent before the reform), and that the variation in fees has decreased, but not the variation in how charges are set (NBHW 2003). What effect the reform might have on the demand for home care is still too early to say.

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<sup>5</sup> A single person should be able, according to this reform, to keep at least SEK 4,870 (approx. 675 US dollars) per month (housing costs exempted) after the fee for elderly care is paid, and no one should have to pay more than SEK 1,516 (210 US dollars) per month for care (Government Bill 2000/01:149).

### **Privatization in various forms**

In Sweden the 1990s are said to be the *decade of the market and privatization* in welfare services in general, and in the care of the elderly in particular (Welfare Commission 2002). In this section I discuss some of the forms of privatization of care (cp. Armstrong 2002) that have appeared in Sweden during the last decades. For instance, we have seen a private-market influence of considerable proportions within the organization and management as well as in the ‘production’ of care for the elderly. Further, the costs and responsibility for care have more and more become a private concern. We have also seen privatization in the form of increased informal care from families, but also, in a new form, from voluntary organizations.

#### *Privatization through management*

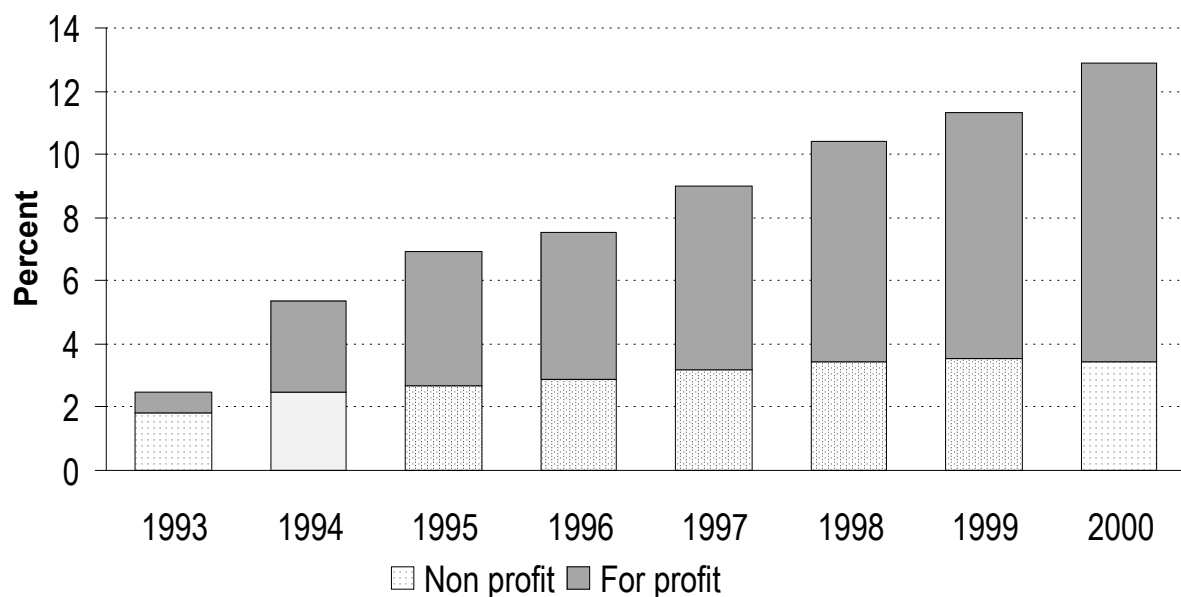
A market-inspired influence on public operations is an international phenomenon that has been more explicit in Sweden than in the other Nordic countries, but more restrained here than in certain other European countries, such as the UK. Already in the early 1980s ideas of ‘New Public Management’ were being introduced in the Swedish municipalities, and were intensified in the 1990s. As Eliasson-Lappalainen and Motevasel (1997, p. 192) put it: “The legion of economists have marched with great success into the welfare arena as dominant experts”. The municipalities reorganized and introduced a market-oriented terminology and organization, stressing financial incentives, productivity, efficiency and quality control. The majority of the municipalities have introduced the so-called purchaser-provider model, separating needs-assessment and purchasing of services and care from the provision. They have opened up for competitive tendering and introduced consumer-choice models (Welfare Commission 2002). By these means home care teams and residential homes for the elderly have become ‘business units’ with greater financial responsibility for their activities, and they are now obliged to compete with private entrepreneurs for contracts. The professional role of earlier home care supervisors has been split up and job titles have been changed. Supervisors with purchasing tasks are now called care managers, quality controllers, purchaser consultants etc.; and those in charge of ‘providing units’ now have the title of production manager or business-unit manager (Trydegård 2000).

What is more, in some municipalities care for elderly people has been split up and redefined as various kinds of ‘care products’. Standardized techniques and systems for measuring and securing the quality of care have come into fashion along lines similar to those used in the private sector in the manufacturing industry and the service sector.

### *Privatization of provision*

The most obvious and visible privatization tendency of the welfare services in the 1990s was the transference of *the provision* (or with the new term *production*) of services from the public to the private sector – a firm, company, co-operative or non-profit organization.

Figure 3. *Private provision of publicly financed care for the elderly.* (Source: Trydegård, 2001).



Care of the elderly was the welfare sector in which privatization accelerated the most; publicly financed but privately provided care for the elderly quadrupled in the 1990s (Figure 3). The proportion of employees in private employment increased from 2.5 to 13 per cent (Trydegård 2001). The majority of the entrepreneurs were for-profit companies, in the care of the elderly mostly large international companies. In 1999 the four largest private actors accounted for half of the contracted operations – whereas the contributions from non-profit organizations were of a minor extent (NBHW 2000d). The competitive tendering of elderly care has recently been evaluated by the National Board of Health and Welfare. There is no evidence that privately run elder-care is cheaper or of higher quality – nor the opposite (NBHW 2004).

Privately operated care of the elderly is more common in larger population centers. In Stockholm, for instance, half of the special housing is contracted out to private providers. Privatization is also more common in municipalities with a high concentration of conservative voters (the Moderate Party), whereas it is lower in areas

that have a high concentration of residents with fewer educational qualifications (Trydegård 2001).

Stockholm and some other municipalities have also introduced a '*consumer-choice model*' for home care, with the care recipients' freedom of choice being a strong argument in the rhetoric. The municipal care manager still makes the needs-assessment and decides on how much home care an elderly person is entitled to. The 'consumer' then has to choose a care provider from among the companies or municipal providing units that have been approved by the municipality. So far, this new model has been evaluated from the politicians' and the officials' perspective (and they seem to be fairly satisfied) (Kastberg 2002), while the elderly consumers' opinion has not yet been systematically investigated. However, local studies as well as experiences from the UK have indicated difficulties for, among others, newly disabled older people in making well-informed choices about their own care. In particular, frail and vulnerable elderly people who are in need of care are in a poor position to 'shop around' or be effective managers and purchasers of care (see for instance Baldock 1997).

#### *The privatizing of costs and responsibility for care*

Yet another form of the privatization of care is the *privatizing of costs* in various respects. First, there has been an increase in the financing of welfare services by the users themselves. Higher user fees have been introduced in medical care as well as in social care services. Regarding medical care, the patients' costs increased by nearly a third between 1993 and 1998, especially in the form of larger personal contributions for medicines and dental care (Welfare Commission 2002). Elderly people also had to pay a greater part of the costs for home care and for residential care. It should be noted, however, that the earlier mentioned max-fee-reform for care for the elderly, which was introduced in 2002, might have broken this ongoing trend.

Another kind of privatization of costs, which we could call *privatization through de-institutionalisation* (Armstrong 2002), was an effect of the ÄDEL-reform. Before 1992 the some 35,000 nursing-home beds were seen as hospital care. The patients paid a minor flat rate fee for care, food and medication, as well as their housing costs. Through the reform these nursing-home beds were transferred to the social care sector and the municipalities. Administratively, they were thereby regarded as a form of housing for which the former long-term care patients were now obliged to pay rent (even if their so-called housing in some cases consisted of sharing a four-bed room with three other persons). The amount paid out of pocket by the elderly person

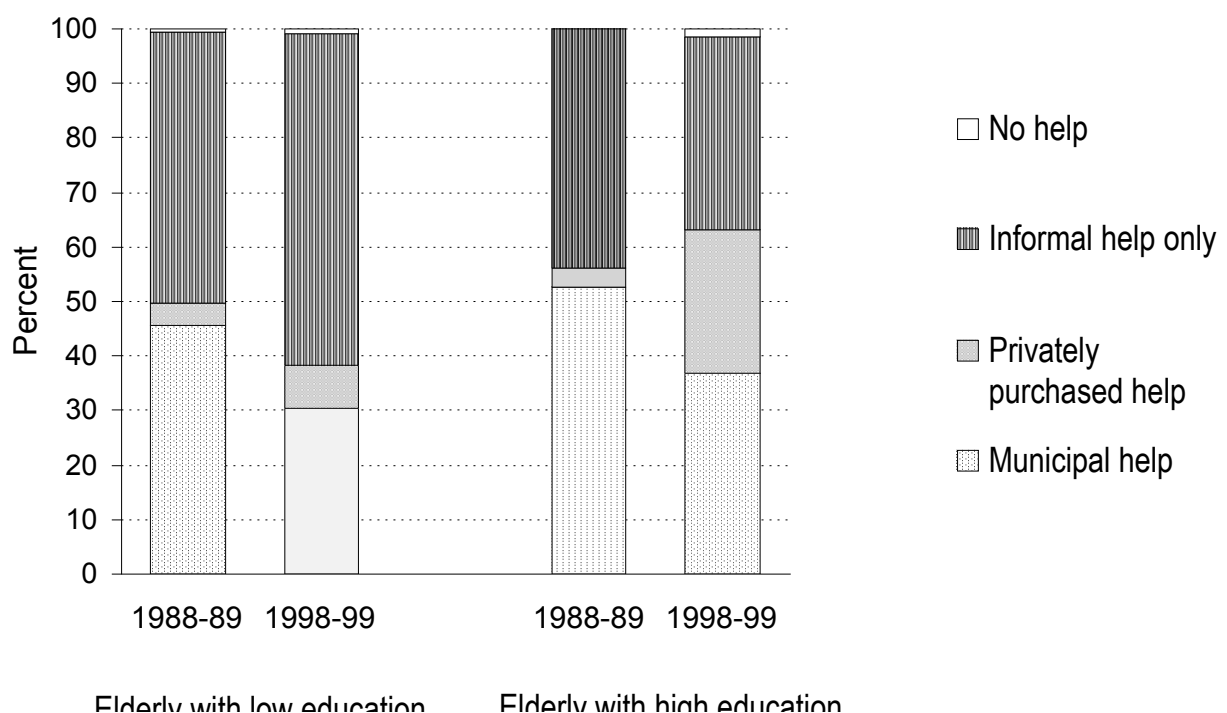
increased and the user fees became income-related and varied substantially between the municipalities.

Also the earlier mentioned decrease in the number of hospital beds and in the length of hospital stays for geriatric patients has led to the de-institutionalization of care. Elderly persons with extensive care needs are being cared for in their own homes or in residential care in the community with much more of private responsibility.

#### *Privatization as increased informal care*

Informal care of elderly people in the form of help from family, friends and neighbors has always been rather considerable in Sweden, even in times when formal care contributions were more extensive than they are today. Since the reduction of public care services in the 1990s, there has been an increase in care provided by family members, spouses or other close kin. An even greater increase took place in the amount of services that the elderly were directed to buy 'out of pocket' from companies on the private market, chiefly laundry and cleaning. These shifts, which can be characterized as '*informalization*' and '*marketization*', respectively, are unevenly distributed from a class perspective. Elderly people with a higher education tend to replace municipal home care with market help, whereas those with less education more often receive assistance from family members (Figure 4). These shifts in help patterns tend, therefore, to lead to a reinforced layering in the care of the elderly. It is important to note that the family members who have had to shoulder an increased responsibility for care are, in practice, usually women, foremost elderly wives and middle-aged daughters (Szebehely 2002).

Figure 4. *Sources of help to disabled elderly persons (75-84 years) in*



*need of practical assistance.* (Source: Szebehely 2002).

Contributions from *voluntary organizations* to elderly people in need of care have in Sweden mostly been a minor supplement to the care provided by public authorities and by the family. For instance, members of pensioners' organizations can make social visits to elderly people in residential care, including reading them the newspaper, taking them for walks etc. In recent years, however, the official policy has been to place increasing emphasis on the role of the voluntary sector. According to the latest Government Bill on the care of the elderly (Government Bill 1997/98:113), municipalities are urged to develop their support for persons who are caring for a dependent family member. The government has decided on a rather extensive state grant to stimulate these activities, *on condition that voluntary organizations are engaged* in the planning and implementation of the support. To link the voluntary organizations to the public care services in this way is a new phenomenon in Sweden, and seems to have been influenced by a more continental welfare tradition.

### **Summarizing and discussing the tendencies and trends in the development**

The 1990s have indeed been a turbulent period when it comes to the care of elderly persons in Sweden – especially home care for elderly people has changed radically. There has been a considerable *reduction* in access to municipal home care. Care and services have become *selective*, but have also been *reconstructed* and *intensified*. Fewer and fewer users receive more and more help in terms of many home care hours and assistance several times a day, and also round-the-clock, every day of the week, year around. Furthermore, home care has become *medikalized* during the 1990s, since elderly people, who earlier were cared for in hospital wards or in long term care, are now being discharged to municipal care with remaining extensive care needs. Personal care, combined with home nursing care, has been prioritized at the expense of traditional home-help chores of domestic and social character.

A general tendency within the welfare services is increased *decentralization*. This is also true in the care of the elderly, even though the government decision on the max-fee-reform in 2002 suggests the opposite trend. Local variations in home care have also increased, indicating an increased geographic inequality or a *diversification* of the Swedish care of the elderly. The prospects to receive care seem to depend very much on which side of the municipal border the elderly person lives.

*Privatization* in various forms is, as we have seen, another distinct tendency in Swedish care of the elderly. The mode of organizing and managing municipal operations is influenced by private business enterprises in a way that makes it appropriate to talk about a '*companization*' of public activities. Furthermore, the responsibility for assisting elderly people has shifted from the public sector to various private sectors: the family, voluntary organizations, the market sector. One evident shift has been from public to market provision of care, paid for by the public, a shift that we can call '*contractization*' or '*entreprenadization*'. We have also seen a growing *marketization*, when former publicly paid and provided services have to be bought on the market and paid for 'out of pocket'. There is also a tendency toward *informalization*; i.e., from publicly paid and provided care to unpaid carework by family members. It has been shown that these latter two shifts are unevenly distributed from a class perspective, and that they tend to lead to a reinforced layering in the care of the elderly (Szebehely 2002).

So, back to the initial question: Is Swedish elderly care still in line with the Nordic welfare state model? It is difficult to give a definite answer to such a question, even if there are signs of a "cracking welfare state". The far-reaching changes, which have been outlined in this paper, certainly constitute threats against several of the fundamental principles of the model. The extensive reductions of the home-care services have affected the idea of universalism and might undermine people's trust in the system. Insufficient public services of poor quality can reduce the citizens' support for the system and their willingness to pay high taxes to be assured services and care when they need. Also the increasing local variations in access to services suggest a geographical inequality, which is not in harmony with the principles of equality and equity. In the footsteps of the reductions we have also seen signs of inequality from a class perspective, when care-needing elderly people with low education have to rely on help from their families, while those with a higher education more often buy services on the market. The accelerating privatization (in the form of *entreprenadization* and *marketization*) is also a new phenomenon in the Nordic welfare model, which has been reported also from the other Nordic countries (Szebehely 2003).

However, the question mark can not yet be eliminated. There are still remaining questions and many knowledge gaps to fill in, which constitute a challenge to social policy researchers. We lack knowledge about the consequences of the changes – for the elderly, for their next of kin, and for all those who work in the elderly care

(Welfare Commission 2002). For instance, we have very limited knowledge about what consequences the reduction and reconstruction of home care have had for those elderly people who are still in the home care system – do they receive services and care according to their needs, and of good quality? Neither do we have knowledge about the situation of older persons outside the system – what implications do the cut-backs in public care have on their everyday lives and their welfare? And how have the lives of older husbands and wives, middle-aged daughters or sons and other family members with caring duties been affected? We also lack knowledge about how the changes in the welfare system have affected the citizens' support for and trust in the public care system, and their willingness to pay taxes for a system that can no longer maintain its earlier standard.

Although privatization of the provision of care for the elderly constitutes a considerable change in the Swedish welfare model, this issue has not yet been systematically evaluated (Welfare Commission 2002). For instance, we do not know what elderly people think about receiving help from private entrepreneurs or voluntary organizations, neither what they think about being seen as consumers or customers of care, who are supposed to make well-informed decisions when they are needy.

Another knowledge gap concerns the consequences that tightening budgets and the new forms for organizing and managing the care of the elderly have for the staff and their work conditions. An increased occurrence among care staff of physical discomfort, tiredness, exhaustion and a sharp increase of long-term sick leaves have been reported (Bäckman 2001; Swedish Association of Local Authorities 2004). It is very likely that the increased care load and the shortage of time for performing the caring tasks, together with new efficiency measures and reorganizations, have been of significance; yet many of these questions remain to be further investigated.

Indeed, the ongoing changes of the Swedish elderly care are worthy of our continued attention.

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## Appendix

### Care of the elderly the Swedish way – a background

According to the Swedish policy declaration, care of elderly people is a public responsibility. Care and services are largely provided by publicly funded professional careworkers, relieving or supporting (usually female) family members in the daily caring duties and allowing for more personal and independent relationships between elderly people and their families. It should be mentioned, however, that even in this formal kind of system there is a considerable amount of informal care. Studies have shown that in Sweden spouses and other family members contribute at least two to three times more care than the public care services for elderly people living outside institutions (Sundström, Johansson & Hassing 2002).

For decades, official Swedish policy has placed a strong emphasis on home-based care. Older people should be able to live in their own homes as long as possible and the dependence on institutional care should be reduced for humanitarian as well as economic reasons. To make this possible, public *home-care services* should provide a flexible range of services – domestic help as well as personal care. Home-care services can be combined with *home nursing care, alarm systems, meals-on-wheels, recreational activities, short-term care, transportation services* etc. However, the national legislation regulating the care of elderly persons provides only a framework and contains no detailed regulations, and it is interpreted in different ways by different local authorities. Professional assessments of needs are made by social workers (care managers) who are delegated by the social welfare committee to decide on what kind of help and assistance elderly persons in their constituency will receive, how much and how often. Employed careworkers assist elderly people with domestic tasks such as cleaning, doing laundry, purchasing and preparing food etc; as well as with personal care, for instance help in getting in and out of bed, using the toilet, showering or bathing, dressing, eating; and with social contacts, recreation and shopping. The care recipients are charged a fee, which is adjusted to their income and to the scope of assistance. The amount of help from professional home helps may vary: from one or a few hours per month to 24-hour care for persons with extensive needs.

When institutional residence becomes the only option, the Swedish official policy states that all institutions for elderly people should be as home-like as possible; they should also be regarded as the residents' own home. After a needs assessment, a social worker (care manager) decides on admission. The residents sign a contract for their rooms, and they are supposed to bring their own furniture and clothes. They pay rent and a fee for board and care. '*Special housing for elderly people*' is the official term for all public institutions, but they differ in character and offer care services that vary in scope and intensity. About a third of all special housing accommodations consists of so-called *service-homes or service-flats* where residents may rent a one or two bedroom apartment and receive municipal home care, depending on need. For elderly people in need of constant supervision and care, there are traditional *old people's homes* and *nursing homes* that provide comprehensive nursing care for elderly persons with extensive medical needs, dementia, terminal illness etc. In the last decade, *group homes* have become an alternative 'small-scale' institution, mostly for persons with cognitive impairments.

### **The Swedish municipalities**

The 290 municipalities in Sweden are the smallest units of local government. They have the responsibility for providing services and care to their elderly inhabitants, including homecare and institutional care as well as most of the long-term medical care. The municipalities vary greatly in population and character, from big cities to sparsely populated rural areas<sup>6</sup>. About 80 per cent of the population live in densely populated areas.

There is a long tradition of local government autonomy in Sweden. Locally elected politicians make all major decisions of principle for their areas. The municipal council and committees set goals and guidelines for local government operations. They also determine the budget, set the local income tax rate and decide on the size of the fees charged for local services. The local welfare committees are in charge of making provisions for the care of the elderly and other social services.

The administration of social services in the Swedish municipalities can be organized in various ways. One is a 'traditional' – and increasingly disappearing – organization with a head of social services and a district head, and under them case officers and supervisory staff who deal both with needs assessment and the administration of the

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<sup>6</sup> In terms of population size, the municipalities vary between 2,800 and 740,000 inhabitants, with an average of 15,500.

home care auxiliaries. An alternative, which has become rather common, is the 'purchaser-provider-model' whereby special municipal officials administer needs-assessment and purchase services and care from special care providers. These can be either municipal home care teams, regarded as 'profit centers', or private entrepreneurs. In both cases the services provided are publicly financed and controlled.

Regional authorities (the county councils) operate all *hospital care* and most of the *primary care* for elderly people as well as for citizens of all ages.

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