TRADITION, CHANGE AND VARIATION
PAST AND PRESENT TRENDS
IN PUBLIC OLD-AGE CARE

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I dedicate this thesis to three, to me very dear, persons, who have taught me things of importance for writing a doctoral dissertation:

My late father, Ernst Bredin, who encouraged my eagerness to learn. I remember his “Let’s find out!” –response to my perpetual Why-is-this-questions as a child;

my late mother, Elsa Bredin, who transferred to me the joy of telling a story;

my husband, Bo Trydegård, who made me aware of the necessity of diligence and hard work.
List of publications

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals.


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Abstract

The general aim of this dissertation is to describe and analyse how public old-age care has developed and changed in Sweden during the last century. The study applies a provider perspective on how care has been planned and professionally carried out over time. A broader social policy perspective, studying old-age care at central/national as well as local/municipal level, is also applied. The large local variations in care and services for the elderly are specially brought into focus. The empirical base is comprised of official documents and other public sources, survey data from interviews with elderly recipients of public old-age care, and official statistics on publicly financed and controlled old-age care and services.

Study I addresses the development of old-age care in Sweden during the twentieth century by studying an important occupation in this field – the supervisors and their professional roles, tasks and working conditions. Throughout, the roles of supervisors have followed the prevailing official policy on the proper way to provide care for elderly people in Sweden; from poor relief at the beginning of the 1900s, via a generous level of services in the 1960s and 1970s, to today’s restricted and economy-controlled mode of operation.

Study II describes and compares two main forms of public old-age care in Sweden today, home help services and institutional care. The care-load found in home-based care was comparable to and sometimes even larger than in service-homes and other institutions, indicating that large care needs among elderly people in Sweden today can be met in their homes as well as in institutional settings.

Studies III and IV analyse the local variation in public old-age care in Sweden. During the last decades there has been an overall decline in home help services. The coverage of home help for elderly people shows large differences between municipalities throughout this period, and the relative variation has increased. The local disparity seems to depend more on historical factors,
e.g., previous coverage rates, than on the present municipal situation in levels of need or local economy and politics.

In an introductory part the four papers are linked together by an outline of the demographic situation and the social policy model for old-age care in Sweden. Trends that have been apparent over time, e.g. professionalisation and market orientation, are traced and discussed. Conflicts between prevailing ideologies are analysed, in regards to for instance home-based and institution-based care, social and medical culture, and local and central levels of decision-making. ‘Welfare municipality’, ‘path dependency’, and ‘decentralisation’ are suggested as a conceptual framework for describing the large and increasing local variations in old-age care. Finally, implications of the four studies with regard to old-age care policy and further research are discussed.
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INTRODUCTION

A quarter of a century of teaching future old-age care supervisors and managers has given me special insights into this important domain of the welfare state; it has also given rise to many reflections and questions. How does the reality of old-age care in Sweden compare with the benevolent policy-declarations and the legislation that we teach our students? What is everyday life like for elderly care-recipient and their families, and for those who work with the daily care and services, or who organise and manage the work? What happens to elderly people in need of care when large-scale reorganisations of public old-age care are implemented?

Additional questions relate to how we in Sweden – compared to other countries – have arranged the care of dependent elderly people: how and when did the form of old-age care arise, which we regard as typically Swedish, and why has it developed the way it has? Further, how is it that the supply of care and services varies so much from one part of Sweden to another, in a welfare state characterised by values such as universality and equality?

A third category of questions concerns to the professional staff working in old-age care. In a project looking at the professional roles of supervisors/managers in old-age care I found that there were major differences not only between municipalities but also between individuals in how they viewed and carried out their job (Trydegård 1990). Why do the professionals working in this field appear to differ so greatly? And why does it seem so hard for this occupational group to achieve a solid professional status, competent and hard-working as they are? And, an essential question for an academic teacher in the field: how can students be prepared in the best possible way for their future jobs, and what will the nature of these jobs be in ten years, in twenty years?

As a doctoral student, I have had the opportunity to develop some of these rudimentary reflections into research issues in the field of gerontological social work, a discipline which was established at Stockholm University in the early 1990s.
The studies presented in this dissertation started in 1994 as a research project about the current state of old-age care in Sweden. The project was initiated and financed by the Research Council of the Swedish Association of Local Authorities (Svenska Kommunförbundet) within the framework of the research programme “Local authority activities and their importance for people, with a special focus on the consequences of current changes”. The empirical studies were carried out in four municipalities of varying size and structure, all of which organised their old-age care differently. However, since static descriptions often become out of date before they can be published and therefore are not appropriate for describing changes, I decided to broaden the outlook of my work and to carry out retrospective studies of the old-age care offered in Sweden’s municipalities, in order to trace tendencies and patterns in its development.

**Aims of the dissertation**

The general aim of this dissertation is to describe and analyse old-age care in Sweden and its development and changes over time from a variety of perspectives. I will approach the issue from the care provider’s perspective, addressing how care is planned and professionally carried out. I will also examine the issue from a broader social policy perspective, looking at old-age care at central/national as well as local/municipal level.

More specific aims of the studies are:

- to illustrate the patterns of radical change in the public care of elderly people by tracing and analysing the history of its supervisors or managers;
- to describe and compare home help services and the institutional care of elderly people with regard to the care-recipients, the care they receive and the care-givers;
- to describe and analyse the local variations in the present distribution of home help services for elderly people and also to investigate whether these variations are linked to
differences in structural and political conditions in the municipalities;
• to study local variation in home help services over time, and also to explore to what extent the present distribution of home help is related to the municipalities’ previous situation of old-age care.

In two of the articles (studies I and II) and in this summary of the thesis I consider the two main forms of public old-age care in Sweden: institutional care and home-based care. In two of the articles (studies III and IV), I concentrate, for a number of reasons, on the home help system. Home help is an essential element of the welfare provision for elderly people in Sweden and has undergone substantial change. Moreover, home help is flexible and might therefore be a good indicator of current trends in old-age care in a municipality.
DEMOGRAPHIC CHALLENGES
AND THE SYSTEM OF CARE

Figure 1, below, illustrates the somewhat dramatic development and the challenging present situation of public old-age care in Sweden.

Figure 1. The number of elderly people 80+ and of recipients of different forms of public old-age care in Sweden 1960-1998 (Source: Szebehely, 1999c).

The number of very old persons in the population has steadily increased for the last forty years. Sweden now has the world’s highest proportion of people aged 80 years and older in the
De demographic challenges and the system of care

population. During the same period, the two main forms of public care for the elderly in Sweden – home help and institutional care – have developed in different ways, with home help showing the most remarkable trend. From a low level (similar to that of institutional care) at the beginning of the 1960s, rates of home help increased rapidly and reached a peak at the end of the 1970s. The expansion was much faster than the increase in the elderly population, and the number of care recipients was double the size of residents in special housing. Since the beginning of the 1980s the number of home help recipients has gradually decreased. At the end of the 1990s it was at a level comparable to the mid-1960s, with the number of recipients being more or less the same as for those in special housing for elderly people.

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 almost parallel to the rise in numbers of the elderly population. However, since the beginning of the 1980s institution-based care has not kept pace with the increasing numbers of very old persons in the population. In 1960 the two forms of old-age care together covered 85 percent of all elderly people over 80 years of age, to be compared to 65 percent in 1998 (if we make the assumption that all home help is distributed to this age group). It should be mentioned here that most care outside families is publicly provided in Sweden – care provided by private for-profit companies or by non-profit organisations remains uncommon.

The demographic challenges and the development of the old-age care systems will be further outlined in this and the following sections of the thesis.
The demographic context

An ageing population

The growing number of elderly people in the population is a world-wide phenomenon. The proportion of the very old in the population is increasing not only in the industrialised world, but also in developing regions (Kosberg 1994). According to estimates, the proportion of the population aged 65 or over in the OECD-countries will, on average, have more than doubled between 1950 and 2050, from less than 10 to around 20 percent of the population. Within this overall shift in population balance, a second demographic change is taking place; a secondary ageing process, “the ageing of the aged”, i.e., a substantial increase in the numbers of people aged 80 years or over. Although the size of the 80+ population remains small in relative terms, it is growing at a considerably faster rate than the population as a whole, and faster than the 65+ population. Between 1960 and 2040 the central and northern European countries are projected to have experienced an increase in the numbers of 80+ of at least 200 percent, New Zealand 500 percent, the United States 800 percent, Australia and Canada over 900 percent, and Japan over 1 300 percent (OECD 1996).

Sweden, being a small country with barely 9 million inhabitants, is no exception from the overall demographic trends, but shows a somewhat different pattern; the “greying” of the population started earlier than in many other countries. Today, Sweden has the oldest population in the world; 17 percent of the population are 65 years or over, as compared to Great Britain and Japan 16, Denmark 15, the United States 13 and Canada 12 percent. In years to come, other European countries, like Germany, Italy, and Greece, are expected to exceed Sweden in this respect. For the time being, the number of persons over retirement age (65+) in Sweden is about 1.5 million. This number is expected to increase very slowly for another ten years, and then increase considerably,
resulting in this age group constituting one fourth of the population in 2030 (Lundström & Landgren Möller, 1999).

Where people over 80 years of age are concerned, Sweden is the first country in the world to have reached the 5 percent level in the year 2000, as compared to the United States and Canada with 3.5, Japan 3.6, Great Britain and Denmark 4.1 percent. While the proportion of those aged 80+ in other European countries will increase substantially in the course of the next decade, the growth in Sweden will be moderate. In Italy, for instance, there will be an 80 percent increase in those aged 80+ in the next twenty years, in Germany 70 percent and in Sweden about 20 percent (Eurostat, 2000; Lundström & Landgren Möller, 1999; OECD, 1996).

However, there are considerable differences in age structure within Sweden. In one out of ten municipalities the very old (80+) constitute more than 6 percent of the population, while less than 55 percent of the population are of working age. This can be compared to another tenth of the Swedish municipalities which have a population with less than 3 percent aged 80+ and more than 60 percent of working age (Martinelle, 1992).

**Living alone**

An additional feature associated with the growth of the very old in the population is the growth of elderly households and of elderly people living alone. In the United States today, 33 percent of elderly people (65+) live alone; in Germany and Sweden this proportion is over 40 percent, and in Denmark 50 percent (OECD, 1996). Of elderly people (65+) in the European Union on average 32 percent live alone and 51 percent with a partner. A further 13 percent of the elderly live with their children or other relatives/friends; only 4 percent live in a residential home or other kind of institution. In Scandinavia the proportion of the very old (80+) living with their next of kin is quite low; less than 5 percent in Sweden and Denmark, compared to 40 percent or more in Spain and Portugal (Eurostat, 2000).
Women in the majority

Women dominate the oldest age groups in all countries. In Sweden, women constitute 58 percent of all retired people (65+) and 65 percent of those aged 80+. At 90 years of age 3 out of 4 are women, and of the centenarians 4 out of 5. Life expectancy at birth is 81.9 years for women and 76.8 for men, and at 80 years of age 8.3 for women and 6.6 for men (Heggemann, 1999; OECD 1996; Thorslund, 1998). Women’s longer life expectancy also makes them more likely to experience life alone (Korpi, 1995). Where 7 out of 10 men are married or living with someone when they die, the opposite is true for women: 7 out of 10 women are living alone when they die (Sundström, 1996).

A care gap?

What consequences does the increase in the elderly population have for health care and social care? In the early 1980s it was hypothesised that a natural life span of around 85 years would emerge, and that better health throughout life should result in delays in the onset of disability. This would lead to a ‘compression of morbidity’ into fewer years at the end of life (Fries, 1980) and consequently less pressure on the care system. Demographic and health data from the last ten years have not fully supported this hypothesis and the theory has been contested (Korpi, 1995; Lagergren & Batljan, 2000; OECD, 1996). The opposing hypothesis of the ‘expansion of morbidity’ (Olshansky, Rudberg, Carnes, Cassel, & Brody, 1991) suggests that, as a result of medical intervention for the elderly, a higher proportion of people with health problems will survive to an advanced age, and that the number of years of ill-health will increase. Other scholars have stressed the fact that, even if substantially more people now have reached an advanced age, chronic diseases like rheumatism and dementia have not been prevented (Parker, Thorslund & Ahacic, 1996; see also Sundström, 1999a). A third hypothesis, the ‘postponement of morbidity’ (Manton, Stallard, & Corder, 1995) proposes that the
active-life expectancy will rise at the same time as the total life expectancy, and that the number of years of ill-health will remain unchanged.

Thus, in what ways the shifting age-composition of the population will affect needs and demands for health and social care is a somewhat controversial question. On the other hand it is a well-known fact that care needs are not evenly divided among age groups in the population. The average length of stay in hospital rises sharply with age, as do the proportions of home help recipients and residents in special housing for the elderly (Korpi, 1995; Lagergren & Batljan, 2000).

Figure 2. Estimated needs and resources in old-age care in Sweden 1994 – 2010. Index: 1994 = 100 (each percentage point corresponds to approx. 500 million SEK)
(Source: Government Report 1996:103, p. 23.).

It is likely that the changing demographics in combination with a higher proportion of women in paid employment will increase the demands for formal services to provide support and care for frail elderly people, even in countries with a tradition of family-based
care of the elderly (Gori, 2000). If societies maintain (or even reduce) programmes for old people that are based on the calculation of the elderly constituting less than 10 percent of the population and the rate of old people in fact is doubled, there will be a widening gap between needs and resources in relation to the current situation (Government Report 1996:103; Thorslund, 1991).

The Swedish Minister of Social Affairs demonstrated an awareness of the problem when the latest Elderly Bill was presented to the parliament:

The eldercare policy is facing a range of challenges. In the long term the requirement is nothing less than a matter of adjusting all of society to a different demographic structure with a considerably larger proportion of the people aged 65 and over... (Government Bill 1997/98:113, p. 14).

One important prerequisite for the public provision of care for elderly people is the supply of manpower providing the care. Old-age care, like child-care and nursing, is mainly women’s work – both in the form of gainful employment and as unpaid, informal caring within families. Women dominate the public sector in most service occupations – the welfare state as well as the elderly need women’s work and their rationality of caring (Eliasson, 1995; Waerness & Ringen, 1987). The comprehensive child-care and elderly-care sector in Scandinavia is of double importance to women – it has enabled them to combine gainful employment with care within the family, and it has also offered an extensive labour market (Szebehely 1998a). In Sweden, 75 percent of women, highly educated as well as unskilled, are gainfully employed, compared to an average in the European Union (EU) of 53 percent. Szebehely stresses the fact that many women with small children are in gainful employment in Sweden – 81 percent compared to 53 percent in the EU. Similarly, large numbers of women in the age group 45-64, whose parents may be in need of help, are gainfully employed – 75 percent in Sweden compared to
42 percent in the EU. Swedish women have had the opportunity to be ‘working mothers and working daughters’ (op.cit., p 259; see also Korpi, 1995).

Lagergren and Batljan (2000) have estimated the impact of the demographic changes on care costs and on the number of employees in the care sector in Sweden with alternative scenarios. For the next thirty years an increase of between 17 and 32 percent in the care sector’s number of staff will be required, depending on whether expected health and mortality trends are taken into account or not. According to the Swedish Association of Local Authorities (1999a), municipalities need to extend their staff recruitment substantially, not only among young people entering the labour market, but also among the middle-aged in other fields of employment.

The social policy context

The first steps towards the development of a social policy discourse in Sweden were taken in the late 19th century. In 1884 the first comprehensive social insurance bill was passed by the Parliament. The Bill aimed chiefly at preventing and reducing consequences of work accidents and work injuries. Later followed a basic pension scheme, employment programmes, and state subsidies to voluntary sickness and unemployment benefits among other things. Poor relief nevertheless continued to play a major role up until the 1950s (Olsson, 1993) – the Swedish and Scandinavian welfare states are mainly a post-war phenomenon (Esping-Andersen & Korpi, 1987; Olsson, op.cit). A large number of provisions to counteract poverty and social inequalities were introduced during the post war years. These were based on the view that full employment was the very foundation of the welfare state and essential as a preventive social policy. The social protection of citizens was to be achieved through a combination of labour market policies, social insurance, social services and an efficient
economy able to compete on international export markets (Korpi, 1990).

Also the social care services part of the Scandinavian welfare state dates mostly from the years immediately after World War II (Sipilä, 1997). In Sweden, a social policy programme aimed especially at the care of elderly people was established during the late 1940s, when the Parliament decided on several reforms and guiding principles concerning the elderly. With reasonable pension benefits, housing allowances, and an improved housing standard, healthy old people were to be able to remain in their homes; chronically ill and mentally disturbed persons were to be cared for in the medical sector. For those elderly persons who needed attendance and care rather than medical services, modern old people’s homes were to be available. As elderly people would be able to pay for their board and lodging out of their pensions, the poor-relief character of the services should be removed (Government Bill 1947:243).

Issues concerning the care of the elderly have regularly been on the political agenda ever since. In 1957, the policy programme stated that, as a consequence of increasing urbanisation and changes in the household and labour market structure, it was now increasingly a responsibility of society to ensure that elderly people were taken care of when they could no longer manage on their own. For the first time alternatives to residential care were considered and it was seen as an important municipal issue to support the development of home help services (Government Bill 1957:38). In the policy programme of 1964 prominence was given to the fact that elderly people have a whole variety of needs. These can be summarised as ‘food, shelter and care’, that is, economic independence, good housing and, when necessary, personal care and attendance (Government Bill 1964:85).

Present policy vis-à-vis the care of elderly people is based on legislation from the early 1980s – the Social Services Act and the Health Care Act – and policy programmes from 1987/88 and 1997/98. The former programme introduced an extensive administrative reorganisation of the care of the elderly in the shape of the ‘ÅDEL-reform’ (Government Bill 1987/88:176), while the latter
presented a ‘National plan of action for the care of elderly people’ (Government Bill 1997/98:113). All these documents stress elderly people’s rights to self-determination, autonomy, integrity and freedom of choice. Giving recognition to the extensive care provided by families, the programmes establish society’s responsibility for ensuring that elderly people have access to a variety of good quality care and services.

The Scandinavian welfare state

An often used classification of different types of welfare state regimes is that proposed by Esping-Andersen. He identifies three types of welfare state regimes, depending on the way in which welfare production is allocated between state, market and households (Esping-Andersen, 1990; 1999). One type of regime is the ‘liberal welfare state’, such as Australia, Canada and the United States, where means-tested assistance and modest social-insurance plans predominate, and market solutions are encouraged. Another is the ‘conservative welfare state’ such as Austria, France and Germany, where the preservation of status differentials predominate, and the principle of subsidiarity emphasises that the state will only intervene when the family’s resources are exhausted. Finally there is the Scandinavian ‘social democratic welfare state’, in which all citizens – also the middle classes – are incorporated under one universal insurance system. Another main principal is to minimise dependence on families, with the state taking direct responsibility for the care of children, the aged, and those who cannot look after themselves (Esping-Andersen, 1990).

The Scandinavian welfare state model has been described in terms of three essential features: social policy is comprehensive, embraces an extensive range of social needs, and has the aim of ensuring a unified system of social protection. The social entitlement principle has been institutionalised, namely granting the citizens a basic right to a very broad range of services and benefits. This principle is intended to constitute a democratic right to a socially adequate level of living. The social legislation is of a soli-
laristic and universal nature, and includes the entire population, regardless of income and position in the labour market. Universality, equity, and equality have been presented as guiding principles of the Scandinavian welfare states (Esping-Andersen & Korpi, 1987).

The share of public social expenditure of the Gross National Product is high in Scandinavia (33 percent), and taxation is also high (Esping-Andersen, 1999). According to opinion polls, public support for the welfare state is high in all Nordic countries, in spite of the high taxes, and does not seem to have declined. Health care and old-age pensions are among the most popular welfare programmes, and the great majority of people prefer the public sector to take responsibility for the care of the elderly rather than the family or private for-profit agencies (Andersen, Pettersen, Svallfors & Uusitalo, 1999; Andersson, 1994; Korpi, 1995).

**The social service state**

Yet another key to the Scandinavian welfare state model is the extensive coverage of social care services, such as old-age care and child care, and their availability to everyone who needs them, irrespective of class. The services are financed, controlled and often delivered by the public sector and they help people to cope with their everyday lives and make provision for themselves or for their dependants (Sipilä, 1997). These services have been broadly accepted, are used by all classes in society, and have wide public support (Kautto, Heikkilä, Hvinden, Marklund & Plough, 1999; Szebehely 1998a). The Scandinavian countries are not merely “social insurance states” but to a great extent also “social service states”, something which has often been neglected in mainstream social policy research (Anttonen, 1990).
Welfare state models, traditions, and culture

Anttonen and Sipilä (1996) analyse four kinds of social care services in the old-age care and child care sectors. In a comparison of European countries they suggest different welfare state models: the Scandinavian model of public services, the family care model found mostly in Mediterranean countries, a British means-tested model, and a central European subsidiarity model.

On the contrary, in her analysis of home care in the European Union, Jamieson (1991) talks in terms of different national welfare traditions:

“Whatever the structure of existing systems, these are in many ways a manifestation of historically rooted, welfare ideologies. Thus service provision and policies in all countries are formulated within the context of long-established welfare traditions which pervade attitudes and expectations and which have resulted in particular arrangements regarding the role of the state and the extent and criteria of welfare provision… But policies are not solely ‘predetermined’ by such historical legacies. Within this context, policy measures can vary and welfare regimes can themselves be subject to change or modification. At any given point in time, economic and political factors are powerful in affecting policies (Jamieson, op.cit., pp. 286-287).

Hugman (1994a) also argues that welfare responses to elderly people differ between countries as a result of the social and political context in which they are located, and he includes historical as well as cultural aspects in his comparative framework.

Baldock (1999a), in contrast, questions the assumption that a country’s social policy is a product of its culture, defined as the “shared beliefs, values and behavioural norms of a community” (op.cit., p. 461). Baldock’s conclusion is that the mass culture of a society is “neither a likely cause nor a supportive context for the welfare state” (p. 472). Once constructed, welfare systems depend
on popular acceptance and voters’ willingness to pay taxes to fund them.

Daatland (1997b) finds that established traditions and policies influence national policies for the care of the elderly and traces ‘path dependence’ in the ways different countries respond to the demands of the moment. Derived from historical institutionalism, the concept of path dependency suggests that institutions in society continue to evolve in response to changing environmental conditions and ongoing political manoeuvring, but in ways that are constrained by past trajectories (Thelen, 1999).

Welfare municipalities

As indicated above, there have been quite a few comparative studies in the field of social care services, which have compared different countries with regard to the extent and shape of the services as well as how they are organised and financed. These studies have not taken into consideration the fact that welfare services may vary within a country, and that a variety of traditions or historically rooted local cultures can exist. However, a number of Scandinavian researchers have indeed drawn attention to the large variation within the countries and the significant role of local governments in the making of social policy in Scandinavia (see for instance Berg, Branch, Doyle & Sundström, 1993; Daatland & Sundström, 1985; 1997; Hansen, 1997; Kröger, 1997; Naess & Waerness, 1996).

One of the distinctive traits of the Scandinavian model is that main responsibility for the social services rests with local governments – the municipalities. Legislation constitutes a framework without detailed regulations, and state subsidies are of a general nature. The municipalities enjoy great freedom to decide on the scope and quality of their services, and at individual level, to determine eligibility criteria as well as the amount and kind of help to be delivered. The municipalities also levy their own taxes – even though their freedom in this respect has been restricted in recent years – and set the charges for the services provided.
'Welfare municipality' is the term which has been used to describe the significant role of local governments in the social care services in Scandinavia and the strong autonomy that they enjoy (Grønlie, 1991; Kröger, 1997).

Furthermore, recent years have seen a noticeable trend towards greater decentralisation of responsibility and decision-making ‘down-wards’ in the organisation, and from central government to local authorities (Baldock and Evers, 1992; Parker, in press; Thorslund, Bergmark, & Parker, 1997). The trend of decentralisation is an international phenomenon in welfare states (Olsson, 1993), as well as in developing countries (see for example Hentic & Bernier, 1999).

The long tradition of strong local autonomy in Sweden, as in the rest of Scandinavia, together with the recent increase in decentralisation, has led to large local variations in the distribution of services, especially in the care of the elderly, a phenomenon that challenges the welfare state concepts of universality and equality.

The old-age care system

Formal and informal care

The basic principles governing responsibility for the care of older people (illustrated in Figure 3, below) vary from one country to another.

In some countries care is mainly of an informal character. Families have the main responsibility and the duty of caring for family-members is founded in religion, culture and the law, and is only marginally effected by the state or local or regional authorities. Voluntary organisations can have an important function in the provision of care and services, as for instance in Germany, Great Britain, and France, or their contributions can merely be a minor supplement to the care provided by public authorities, as in Sweden (Fölster 1996, Jeppsson-Grassman, 1994, 1999; Tinker, McCreadie, Wright & Salvage, 1994).
Internationally, old-age care has also increasingly become a market issue. This is due in part to the creation of ‘internal markets’ within the public sector, that is, the division between purchasing and providing functions within public authorities. It is also due in part to the ‘contracting out’ of services and care to private for-profit agencies outside the state sector (Baldock, 1999b). In Sweden, most care provided by ‘market producers’ is still publicly financed and controlled – in 1999, about 9 percent of municipal old-age care was provided by private entrepreneurs (NBHW, 2000a). Yet there is a growing “care- and service-market”, to which elderly people can (or have to) turn to purchase such services as cleaning, washing and shopping, or residence in “apartments for senior citizens”.

Sweden is representing those countries where the basic principle is formal care and where the state (in a broad sense) bears the main responsibility. According to official policy, old-age care
is a public responsibility, and is largely professionally provided by publicly funded care workers, relieving (usually female) family members from the daily caring duties and allowing for more personal and independent relationships between the elderly and their families (Blackman, 2000). However, even in this formal kind of system the amount of informal care can be extensive, although more invisible. 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 (Johansson, 1991; Szebehely 1998b). According to the latest Elderly Bill on the care of the elderly (Government Bill 1997/98: 113) municipalities are urged to develop their support for those who are caring for a dependent family member.

Szebehely (1999a) stresses the ambiguity of the concepts ‘formal and informal care’ and suggests a widened typology that takes into consideration who provides the care on the one hand, and who pays for the care on the other. Care-work in all four caregiving sectors – the family, the voluntary, the market and the public sector – can be unpaid, publicly financed, or financed within either the formal or the informal economy. The distribution amongst the suggested sub-categories can vary between different countries, at different periods of time, or among different groups of elderly people.

The studies upon which this thesis is based are mainly concerned with the care provided and financed by the public sector, i.e. formal care. Informal care is only considered briefly (see Study II).

The ‘welfare mix’

The basic principles of the responsibility for care for the elderly are certainly not absolute. Each country has developed what has been called ‘a welfare mix’ for services and care and a special balance in the division of roles and responsibilities between the state, the market, voluntary organisations, and family, including friends and neighbours (Evers, 1992).
Daatland (1992) discusses this public-private mix in welfare states, and describes three forms of shared responsibility for the dependent elderly: The state can be a substitute for or replace the family for those who lack families to provide for them. Responsibility can be shared over time and transferred from the family to the state, for instance when an old person is admitted to an institution. State and family can also care in partnership, for example, when old people receive care from the family while also receiving supportive home help from the municipality.

Johansson (1991) discusses this kind of interaction in terms of task-sharing at the individual level. His findings from a Swedish study of elderly people, who live in their own homes, indicated that task-sharing depends on individual circumstances more than on a planned division of work. Szebehely (1998b) found (also in Sweden) that how the caring is divided up between public home-helpers, spouses, and non-cohabiting kin depends on how often a task must be performed and the amount of physical strength needed to perform it.

Dempsey and Pruchno (1993) describe how caring tasks were shared between staff and family in institutional settings in the U.S. Families viewed tasks like bathing, dressing, cleaning, and giving medication as primarily a staff responsibility and viewed managing money, shopping, writing letters, and the like primarily as a family responsibility. Work by Bowers (1988) suggests that family involvement in the care of elderly relatives in nursing homes is much more complex and extensive than is indicated by the visible tasks they perform. On the whole, very little is known about the informal care contributions to elderly people in institutional care. Research on family care seem to have stopped at the threshold of the institution (Lingsom, 1997).

The social care services

The services and care provided for older people vary in kind and character. Hugman (1994a) suggests a typological approach that distinguishes different aspects of services as delivered, in addition
to the way in which they are organised. There is divergence in the location, which relates to the extent of home-based and institution-based responses to the needs of older people. The duration, that is, the period of time over which care is provided – long term or short term, the number of hours per day, days per week etc – and the formation, that is, how care and services are structured and organised, can vary and influence the use of services and care. The latter concept also includes whether care is oriented towards health care or social care. The boundary between these two can be blurred and differ between countries; it can also be a source of problems (see for instance Berg, 1994). Hugman (op.cit.) also suggests that the range of services available to older people has two dimensions: residence and care. The residence dimension ranges between the older people’s own home, in which they may have lived for many years, at one extreme, and the traditional nursing-home where older people live communally and to which they move late in life solely because they need care, at the other extreme. It is not always the case that a high level of communality in residence corresponds to a high level of care, and vice versa. For example, living in one’s own home can be combined with a low, medium, or high level of care.

In this thesis, two additional quantitative concepts of care have been used, the coverage, that is the percentage of the population in a certain age group receiving services or care at a given time, and the intensity, measured by the number of home help-hours per recipient per month.

Old-age care in Sweden

For decades, official Swedish policy has placed a strong emphasis on home-based care. It states that older people should be able to live in their own homes as long as possible. The dependence on institutional care should be reduced for economic and humanitarian reasons (Government Bill, 1987/88:176). Public home help services (hemtjänst) should make this possible by means of a flexible range of services and care – domestic as well as personal.
Home help (*hemhjälp*) can be combined with home health care, alarm systems, meals-on-wheels, daytime activities, short-term care, transport services, etc. A care manager (*biståndsbedömare, hemtjänstassistent*) makes an assessment of needs, and is delegated by the social welfare committee to decide on what kind of help and assistance the old person will receive, how much and how often. Home helpers (*vårdbiträden och undersköterskor i hemtjänsten*) may assist elderly people with domestic tasks, such as cleaning, washing, shopping, preparing food etc, as well as with personal care, for instance help getting in and out of bed, using the toilet, showering or bathing, dressing, eating, and with social contacts, recreation or shopping.

Domestic and social duties dominated at the start of the program, but in more recent years home help has become more occupied with personal care issues, and can also be delivered around the clock. The services have essentially become concentrated on those with the greatest needs.

At the end of 1999, 8.2 percent of all elderly people (65+) and 19.5 percent of the oldest (80+) received public home help in their ordinary housing (NBHW, 2000c).

The amount of help from professional home helpers may vary: from one or a few hours per month to 24-hour care for persons with extensive needs. During one month (November 1999), 35 percent of home help recipients received less than 10 hours, about 45 percent received between 10 and 49 hours, and 20 percent received 50 hours of help or more (NBHW, 2000a).

When institutional residence becomes the only option, Swedish official policy states that all institutions for elderly people should be as home-like as possible and should also be considered as the residents’ own housing. After a needs assessment, a social worker (care manager) decides on admission. The residents sign contracts for their rooms, and they are supposed to bring their own furniture and clothes. They pay rent and fees for room, board, and care. But so far, not all institutions have been rebuilt to provide single rooms or apartments. Six percent of residents share rooms with people who are not family, and about 35 percent live in accommodation with no cooking facilities (NBHW, 2000b).
Special housing for elderly people (särskilda boendeformor för äldre) is the official term for all public institutions for old people, but they are of different character, and they offer care services that vary in scope and intensity. About one third of special housing accommodations is made up of so-called service-homes or service-flats (servicehus, servicelägenheter), where residents may rent a one or two bedroom apartment and also receive municipal home help services, based on need. Tenants are supposed to use the restaurant and other service facilities in the building. Service-homes are intended to facilitate independent living and to serve as meeting places; they should also provide personal care when needed. However, they have also been regarded as somewhat miscalculated, medium-level institutions, where residents’ needs often exceed the range of services available (Korpi, 1995; Monk and Cox, 1995).

For elderly people in need of constant supervision and care, there are traditional old people’s homes (ålderdomshem), with a higher level of communality in residence. They offer small, single rooms with toilets, and common day rooms and dining rooms. A regular staff provides 24-hour care, and meals are served communally at set times.

In 1992, responsibility for nursing homes (sjukhem) was transferred from the medical system to the municipalities. They offer extensive nursing care for elderly persons with high medical needs, dementia, terminal illnesses, etc. Trained nurses provide the medical care. Physicians may be consulted but are not on the permanent staff, which has turned out to be a problem since the 1992 reform (NBHW, 2000a).

Over the last decade, group homes (gruppbostad) have become an alternative institution, mostly for cognitively impaired persons. Group homes usually have around six residents. Each resident has a room, shares communal areas, and has access to service and 24-hour care, which is provided by specially selected resident staff.

In December 1999, about 8 percent of elderly people (65+) and 20 percent of the oldest (80+) lived in some kind of special housing accommodation (NBHW, 2000c).
Even though public old-age care is heavily subsidised, users are charged a fee for both home-based and institution-based care. The municipalities are free to set the charges, and there are large and increasing variations between the municipalities, with no two municipalities applying the same scale of fees (NBHW, 2000a). For old people living in their ordinary housing most municipalities apply a system where the charge varies according to both income and the scope of the intervention. Residents in special housing for elderly people often pay separately for accommodation, meals, services and nursing, and charges are set either according to income or a combination of care needs and income. According to the Social Service Act (Socialtjänstlagen) municipalities must ensure that recipients of municipal care have funds left for their personal expenses when their fees have been paid, and that the financial situation of the wife or husband of an institutionalised old person does not deteriorate unreasonably. However, the NBHW (op.cit.) has demonstrated that most municipalities do not observe these directives. During the 1990s municipalities raised the fees for care services, and there are reports that the level of fees causes many elderly persons to refrain from applying for home help services, or to withdraw from help they actually need (Government Report 2000:3).

The Swedish municipalities

The smallest units of local government in Sweden, the (in November 2000) 289 municipalities (kommuner), are responsible for providing social services to their inhabitants, including home help services and institutional care of the elderly. Since the legislative reform in 1992, the municipalities are also responsible for most of the long-term health care provided for elderly people. The municipalities vary greatly in population and in character, from big cities to sparsely populated rural areas. In terms of population size, the municipalities vary between 2 800 and 740 000 inhabitants, with an average of 15 500. The population density varies between 1 and 3 900 inhabitants per square-kilometre, with an average of 27 (NBHW, Swedish Association of
Local Authorities & Statistics Sweden, 1999). The total number of municipalities in Sweden has changed considerably over the years: at the beginning of the last century there were about 2,500 municipal districts in Sweden, but after a series of boundary reforms (most of them between 1952 and 1974), the number is now 289. A considerable urbanisation took place during the twentieth century: at the end of the nineteenth century about 33 percent of the population were urban, 50 percent in 1930, and 80 percent in 1998 (Swedish Institute, 1999b).

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 (kommunfullmäktige) and committees (kommunala nämnder och styrelser) establish goals and guidelines for local government operations. They also approve the budget, set the local income tax rate and decide on the size of the fees charged for local services. For old-age care and other social services there are local social welfare committees. Some municipalities have a separate senior services committee (äldreomsorgsnämnd), while others prefer to handle care of the elderly within the framework of a more traditional social services committee (socialnämnd) (Swedish Institute, 1999b).

The administration of the social service in the Swedish municipalities can be organised in a variety of ways. One is a ‘traditional’ organisation 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 home help auxiliaries. An alternative, which has lately become common, is a ‘purchaser-provider-model’, with special municipal officials administering needs-assessment and purchasing the services and care from special care-providers. These can be either municipal home help teams, regarded as ‘business units’ (resultatenheter), or private entrepreneurs. In both cases the services provided are still publicly financed and controlled. One conception behind this model is to introduce market mechanisms by exposing public sector activities to competition.
A number of new economic management methods were established in Swedish municipalities during the 1990s, based on the assumption that competition and economic incentives will increase productivity and efficiency in the public organisation (Gustafsson & Szebehely, in press).

A comprehensive organisational change in the care of the elderly was the ÄDEL-reform in 1992. Responsibility for long-term medical care for elderly people, except for acute hospital care and attendance from physicians, was transferred from the county councils to the municipalities with the aim of gathering all public old-age care under the auspices of one authority, the municipalities. The reform resulted in a strong economic incentive for the municipalities to find care outside hospital for the so-called 'bed-blockers' (medicinskt färdigbehandlade), that is, hospital patients who are medically ready for discharge but cannot manage on their own at home. The municipalities must reimburse the county council the cost of care for bed-blockers remaining in hospital care. This has increased the pressure on home help services and other parts of the care continuum substantially (NBHW, 2000a, Styrborn, 1994). The 1990s have seen a decline in the number of hospital beds and an appreciable shortening of hospital stays, especially for geriatric patients – something that has further increased the care-burden borne by the municipal care services. Today, elderly persons receiving care in various forms of special housing are in a poorer physical and mental state than was the case before the 1992 reform (Government Report 2000:3).

Central government issues in the care of elderly people

In Sweden, the central government's instruments of control within the field of old-age care are legislation, state subsidies and national policy-declarations. The state also executes consultative supervision through the National Board of Health and Welfare (Socialstyrelsen) and through the regional state authorities, the county administrative boards (länsstyrelsen).

The institutional care of elderly people was established in legislation in 1918. According to the Poor Laws (Fattigvårds-
municipalities were obliged to provide access to institutions of various kinds, among them old people’s homes. Until the 1950s residential care was the only form of public old-age care that existed, and it was valued by influential groups in society (Edebalk, 1991). Home help services were not regulated in law until 1982, when the Social Services Act (Socialtjänstlagen) was passed. By that time, however, home help had already expanded considerably and it reached its highest distribution in the late 1970s and the early 1980s (see Figure 1, above, p. 15). Municipalities had, with the help of state subsidies and encouraged by the fact that it was greatly appreciated by elderly people, built a far-reaching home help system. The Social Services Act confirmed this development when it established home help as a right for elderly and handicapped people, “if their needs could not be provided for in any other way” (section 6). Clients also received the right to appeal against negative decisions. Even though the Act has been revised repeatedly, home help services have retained their legal status. However, it is now being reported that municipalities in recent years have interpreted the Act more strictly, trying in particular to find alternative ways of providing for old persons’ needs – which usually means help from next of kin (Szebehely 1998a).

The first state subsidies for home help services for elderly people were introduced in the mid-1960s to stimulate the expansion and reform of this kind of old-age care (Edebalk & Lindgren, 1996). The subsidies were ‘earmarked’ for specific services and, as a main principle, the size of the subsidies was based on the number of personnel and the amount of services produced (Thorslund, Bergmark & Parker, 1997). In 1993, and later in 1996, the state grants were radically changed such that the provision of care and services became irrelevant. The new, general, state subsidies are block grants, calculated on the basis of a municipality’s incomes and estimated costs, and taking into account structural factors such as the age, living conditions, and socio-economic status of the local population. The official intention of the change was to create equal economic conditions for the municipalities to perform their obligations (Government Bill 1997/98:113).
However this new system did away with state control of how the money is used, thereby giving the municipalities greater freedom – and potentially also leading to greater diversification.

In the Swedish Parliament, there has on the whole been political consensus about the principles of old-age care. The government has produced policy documents, which, without much debate, have been passed by parliament, most recently in 1998 (Government Bill 1997/98:113). According to the national principles, old-age care should be organised in democratic forms, should be jointly financed, and should be available according to need rather than purchasing power. Older people should be able to lead an active life, influence their day to day existence and play a role in society. The principles further state that older people must be treated with respect and be able to age in safety. They must also have access to care and services of good quality. Central government has increased state subsidies for the care of elderly people and enlarged investments in gerontological research and training. Yet, the responsibility for realising the good intentions of national policy still rests with the municipalities in co-operation with the county councils.
MATERIAL AND METHODS

Material and methods
used in the dissertation

Study I – documents and texts

In this paper, the aim of which was to illustrate one hundred years of old-age care in Sweden as reflected by the professional role of its supervisors, a variety of documentary and written sources were analysed. Different kind of material was used to get as broad and varied a description as possible of the care of the frail elderly over the past century. Government reports, legislation, public authority documents, and social policy literature were all scrutinised to trace public policy on the care of the elderly. Curricula and other educational documents, such as annual reports from training institutions, were analysed to trace the development of the professional training. First-hand descriptions of the function and tasks of the supervisors/managers of old-age care were taken mainly from a periodical issued since 1950 by a professional association for supervisors working in the care of the elderly. The periodical contains reports from annual conferences, articles and letters to the editor on the occupational role.

Study II – survey interviews

A project in four municipalities

Study II, and part of Study IV, in this dissertation are based on a project financed by the Research Council of the Swedish Association of Local Authorities (see Trydegård, 1996a). The aim of the project was to study the present state of municipal old-age care in
Sweden with a special emphasis on the consequences for the elderly of current changes in policy and practice. The project was conducted in 1994 in four Swedish municipalities of different size and character and with differently organised old-age care. The four municipalities were Falun, a town with a population of 55,000 in central Sweden, with a traditional (publicly run) organisation; Linköping, a major town (population 130,000) in the south-east of Sweden, where a purchaser – provider old-age care organisation was introduced in 1994. Sollentuna and Sundbyberg are both suburbs of Stockholm (with 60,000 and 30,000 inhabitants respectively). The former has had a purchaser – provider organisation since 1992, while the latter had a traditional form of old-age care organisation at the time of the study.

Information about the municipalities was obtained from policy documents and official statistics, as well as from interviews with municipal officials. To obtain information from the elderly care-recipients, face-to-face interviews were carried out with a random sample of 400 persons from the municipal care recipient lists. The questionnaire included questions about the respondents and their living conditions, health and functional ability, and their care situation. There were also questions – structured and open-ended – which asked the respondents to assess the quality of the care they received from a variety of aspects.

**Face-to-face interviews with care recipients**

Study II was based on the interviews with the eldercare recipients in the four municipalities in the above-mentioned project. The aim was to describe and compare the recipients of home help services and institutional care in terms of their living conditions, health and functional ability, the care they received, and also who was providing the care.

In each municipality, 100 persons (65+) were randomly sampled from the care-recipients list: 50 recipients of home help services and 50 residents in institutions for elderly people (service-homes, old age homes, nursing homes and group homes for
elderly people suffering from dementia). The total sample was 400 persons.

We approached the elderly care-recipients through the care-staff, who delivered a letter, which presented the research project and asked the elderly persons if they would agree to participate. In advance we had, via the media, publicised the research project to make it known and to encourage participation. People with experience of caring for elderly persons were recruited as interviewers. They were trained and given encouragement by the researchers behind the project. The face-to-face survey interviews were carried out in the respondents’ homes/housing, and lasted between one and two hours. When direct interviews were impossible because of severe mental impairment or poor health, proxy interviews were used (12 percent of recipients of home help and 53 percent of those in institutional care). Next of kin or, if necessary, the staff member who was most familiar with the respondent were chosen for the proxy interview. In this way the non-response rate could be restricted to 9 percent (10.5 percent of the home help recipients and 7 percent of the institutional-care residents).

Efforts were made to construct questionnaires (different for self-respondent and proxies), which were concrete and easy for the interviewers. There were structured as well as open-ended questions. Where appropriate, questions from earlier gerontological studies were used, for instance the SWEOLD study (Lundberg & Thorslund, 1996).

The data were analysed by the SPSS and Microsoft Excel programmes.

**Study III & IV – official statistics**

The aim of Study III was to describe and analyse current local variations in the distribution of home help services for elderly people in Sweden and also to explore whether these variations were linked to possible differences in municipal structural and political conditions. The object of Study IV was to study local variations in the home help services in Sweden over time and also
to explore to what extent the present distribution of home help was related to the earlier situation of old-age care in the municipalities. The analyses in these two studies are based on official statistical information about social services in the Swedish municipalities, published today by the National Board of Health and Welfare, and before 1994 by Statistics Sweden. For other demographic, structural, political and economic information about the Swedish municipalities we used the ‘KFAKTA99’ database, compiled from various official sources at the Department of Political Science, University of Lund. Information about the current organisation of old-age care in the Swedish municipalities was obtained from the National Board of Health and Welfare.

For several reasons, home help was the focus of both studies. Firstly, home help has, for many decades now, been an essential element of the welfare provisions for elderly people in Sweden, as in the rest of Scandinavia. Secondly, the home help system has undergone substantial changes, in particular in the last twenty years, which makes it an important subject for an over-time study. Thirdly, in contrast to institutional care, home help does not require investments in buildings, and can more easily be adjusted to care needs as well as to the economic situation in the municipalities. Consequently, home help may be a good indicator of trends in old-age care in a municipality.

In both studies the coverage rate of home help was examined, i.e. the percentage of municipal residents of a certain age receiving municipal home help (for some years also home nursing care) at a given time. This relative measure makes it possible to compare between municipalities of varying size and with differing proportions of elderly people in their population. It also makes it possible to compare years with different numbers of elderly persons in a municipal population. For analytic purposes we also studied the intensity of home help provision, measured by the number of home help-hours per recipient per month, and the coverage rate of special housing.

In Study III we studied the home help provided for the oldest age group (80 years of age and over) living in ordinary housing, because in this age-group we expected to find the frailest persons
whose needs are difficult to ignore. Living alone is also most common in the oldest age group, which makes elderly people most dependent on public services. In Study IV we were obliged to use the retirement age (65+) as the age limit, because information about the oldest (80+) was not available until 1982, and we intended to go further back than that. We studied the home help provided in ordinary housing and in service-homes/service-flats, as this was the only data available before 1993.

In order to be able to obtain comparable data reported by municipalities, 1976 was chosen as the starting point for our time-analyses in Study IV. We used 1997 as the final year of the study due to difficulties in obtaining good quality data from 1998 and 1999 – according to the NBHW some local reports on home help coverage in service-homes for these years are unreliable and a number of municipalities are missing. 1997 was chosen as the year for analysis in Study III for the same reasons.

In Study III, the independent variables used for the analyses were carefully selected on the basis of previous studies as well as our own considerations. Influenced by Hånsen (1997) and Hörstedt, Prütz, Wells, Edebalk, & Lindgren (1996), we used two kinds of variables: indicators of the demand for care and services among the elderly at municipal level (the structure of the population and of the municipality), and indicators of the supply of services (local-government economy and politics). The latter are instrumental factors which the municipality can influence, unlike the former, structural factors, which they cannot affect.

The first step of the concluding multivariate analyses in Study III was to examine each separate independent variable for bivariate correlation (Pearson’s correlation coefficient) with the home help coverage rate. To examine the combined effect of independent variables, we tested those significant in the bivariate analysis in multiple models (linear regression) to find as high an explained variance as possible. We also wanted to study the effects of each independent variable while controlling for the effects of others.

In Study IV, to assess the over-time variation of home help coverage rates in Swedish municipalities, we calculated the mean
and the *standard deviation* for each year. However, it is difficult to compare standard deviations in absolute magnitudes where the distributions compared have different means (Frankfort-Nachmaias, & Nachmaias, 1992). Therefore, we also calculated the *coefficient of variation*, i.e., the degree of dispersion relative to the mean. A high coefficient of variation reflects a low degree of homogeneity and vice versa.

To assess patterns of change in the municipal distribution of home help coverage we used a cross-tabulation which accounted for the relative position (in percentiles) of each municipality 1976 and 1997. We also followed a selection of municipalities and their coverage rate of home help compared to the national median and the 5th and 95th percentile. These cases were selected in an earlier project (see Study II), and are municipalities of varying size and character, and with different ways of organising their old-age care.

In Study IV, in order to assess the degree of path dependency or inertia, we calculated the correlation between, on the one hand, the coverage rate in 1976 and, on the other, the coverage rate in each successive year up to 1997. This calculation was also performed for the coverage rate of 1997 and each preceding year back to 1976. Pearson’s correlation coefficient (r) was calculated and also bivariate $r^2$ to measure the explained variance.

In both studies, the data were analysed by the SPSS and Microsoft Excel programmes, using bivariate and multivariate regression techniques.

### Methodological considerations

This thesis uses a range of methodological approaches appropriate for the different aims and depending on the various issues of each separate study. All methods and materials clearly have advantages as well as disadvantages, and it goes without saying that the researcher must be aware of their weaknesses and strengths and must not draw unfounded conclusions. There are however a
number of methodological problems peculiar to gerontological research, which I will outline and discuss in the section below.

Documents and texts as sources of information

Old-age care in Sweden has been the subject of a multitude of official texts over the last century: Government Reports and Bills, policy declarations, authority instructions, educational documents, etc. There are also other public text sources, for example the press, periodicals edited by client organisations or occupational associations, and, increasingly, reports arising from research into old-age care.

Silverman (1993) states that public records, despite their potential, have been neglected by researchers. A massive documentation of official business covering for instance legal proceedings and the work of parliaments and parliamentary committees, constitutes a “potential goldmine” (op.cit., p 68) for investigators. These public records are relevant to important issues, he argues, since they reveal how public and private agencies account for, and motivate their activities. They are also accessible to the researcher without having to negotiate for access. Educational documents such as curricula and syllabi are other institutional records, exponents of the prevailing educational ideology, and can well serve as the object of text- and discourse-analysis. ‘Utility texts’ such as political pamphlets, information sheets, journalistic articles, etc. can also be used in research not as reproductions but as social constructions and perspectivations of reality (Selander 1994).

The different character of texts is outlined in simplified form in figure 4, below.
Figure 4. Model of different types of text.

Texts can be more or less general or specific; a further consideration is whether they are descriptive or prescriptive. An example of a general and prescriptive document is the ‘National plan of action for the care of elderly people’ from 1998 (Government Bill 1997/98:113) – it conveys the present public rhetoric in the field – while instructions from the National Board of Health and Welfare, for instance concerning the handling of medication in special housing, are specific and prescriptive texts. A journalist article about mismanagement in an eldercare institution would be an example of a descriptive and specific text, a ‘voice from the field’. The written views of individual elderly persons and their next of kin, or articles and letters to the editor in a magazine for pensioners or in a professional journal would be other examples. Research reports are often descriptive and might be more or less general, depending on the design and method used.

Study I in this thesis is based entirely on a variety of text-materi-
to get as broad and varied a description as possible of the care of the frail elderly over the past hundred years.

**Survey techniques**

The survey technique used in Study II raised a number of methodological considerations. Particular care is necessary in the design and execution of studies which aim to gather information about elderly people, their living conditions, health and functional status and care situation. Mail questionnaires, face-to-face interviews, performance tests – all have their pros and cons. If the survey addresses very old people, especially those in residential care, it is important to take into account that some of the respondents may have poor vision or be cognitively impaired and may find it difficult to answer a mail-questionnaire. It is very important to formulate questions that can be understood and answered correctly without help; the risk of a high non-response rate is large (Thorslund & Wärneryd, 1990). Carrying out face-to-face interviews may be one way to tackle these problems, but this is much more expensive, especially if one wants to reach a large number of respondents on a nation-wide basis. Thorslund & Wärneryd (op.cit.) found inconsistencies in the answers obtained from two different methods of data collection (mail questionnaire and interview). A greater number of health problems were reported at interviews, while reduced functional ability was not reported as often in interviews as in questionnaires. Performance tests, whereby individuals are asked to actually perform an activity, are also expensive to carry out, but can provide useful information, since they are less influenced by culture and environment, for instance on functional ability (Parker 1994). Both of the latter methods need trained interviewers. Lundberg and Thorslund (1996) also stress the importance of motivated and personally-engaged interviewers – preferably old themselves – and a strong support from the researchers to deal with the practical problems which may be involved in finding and encouraging respondents to
take part. These activities have been successful in reducing the non-response rate substantially.

**Proxy interviews**

When surveying elderly care recipients, it is essential to be aware of the problems involved in obtaining information from the most frail and dependent elders, especially those who are suffering from dementia. However, they must not be excluded from investigations, and one way to reduce non-response is to allow proxy interviews (Lundberg & Thorslund, 1996). In Study II, 12 percent of the home help recipients and 53 percent of the elderly in institutional care were judged (by staff) to be unable to participate in an interview. Thus, proxy interviews were conducted with the family or staff member who was most familiar with the respondent. Proxy interviews are not without their problems, however. The amount and quality of data which can be obtained is limited – proxy interviews must exclude questions about value judgements such as the quality of care, as well as personal questions on existential matters. Studies have indicated that proxy respondents are more likely to overestimate levels of functional impairment, while elderly respondents themselves tend to deny or rationalise their deteriorating health (Little, et. al, 1986; Lundberg & Thorslund, 1996). Staff may also overestimate care needs (Styrborn, 1994; see also Lagergren & Batljan, 2000, for a discussion). Both staff and family members may also be unaware of certain information. However, according to Seeman (1994; see also Lawrence, 1995; Parker, 1994), data provided by proxy respondents do not seem to bias the results for specific, concrete questions. The experience gained from Study II was that the contribution of the proxy interviews provided a different picture of the elderly care recipients, especially of those living in institutions, than did the results which were based solely on direct interviews with the elderly respondents themselves.
Selections and samples

When choosing the elderly respondents to be used in a survey, strategic considerations such as geography (municipalities, districts, units?), age (65+, 75+, 80+?), care utilisation (user- or population-based sample?), and care form (home help, day care, institutions?), have to be addressed before randomised samples can be drawn. The age-limits vary in international and national studies; for instance the Euro-barometer (see for example Walker & Maltby, 1997) has chosen 60+, a Scandinavian comparative study 65+ and 80+ (Daatland ed., 1997), while the Swedish longitudinal study SWEOLD contains persons aged 77 and over (Lundberg & Thorslund, 1996). It is obvious that choosing the oldest respondents (75 years and over), will give a picture of more dependent and frail elderly persons in all likelihood with greater care and support needs than if one chooses the ‘younger elderly’ (60 or 65 and over), who are usually the target for studies of activities and attitudes in the elderly population. User-based studies give a different view of care-needs among the elderly than population-based studies do, and they also seem to underestimate the contributions of informal carers (see Study II).

Ethical considerations

Gerontological researchers share ethical rules and values with other social scientists: information, confidentiality, informed consent, and the responsible use of data are imperative (HSFR, 1990). In addition to this there is a number of special conditions which must be taken into consideration. Proxy interviews, when someone other than the respondent is going to decide whether information is going to be collected or not, give rise to ethical problems (Lundberg & Thorslund, 1996). Further, the role of the researcher may be unclear: an interviewer who visits an elderly person in his or her home for an interview and discovers unsatisfied help needs, may be seen as a promising care manager who can provide help and assistance. If the researcher is seen as a representative of the authorities, people who are dependent on help
may be submissive and may be anxious that they might lose the assistance they need, if they do not participate in the inquiry and express gratitude and satisfaction. Submissive gratitude has proved to be more common among elderly care recipients than among parents in receipt of child care (Möller, 1996).

Eliasson (1987) highlights a number of general, fundamental research principles, but also considers particular issues involved in research into vulnerable and dependent persons. The researcher must have the freedom to remain curious and inquiring, critical and sceptical, and ‘disloyal’ to established ideologies and rhetoric, but also make a conscious choice of sides and take the perspective of the weaker parties in his/her research.

**Official Statistics**

Studies III and IV are based on official statistics on the social services in Sweden. Information about publicly financed and controlled old-age care and services is delivered annually by the municipal administrations, and – after quality control – accounted for in statistical reports. Care provided by private entrepreneurs on commission from local authorities is included in these statistics. From 1965 until 1993 the authority responsible was Statistics Sweden and since 1994 the National Board of Health and Welfare. Since 1991 the annual statistics have also been published as a database: ‘Comparison Material for the Social Services’, edited by the National Board of Health and Welfare, Statistics Sweden and Swedish Association of Local Authorities in co-operation.

The quality of the public statistics on social services in Sweden is judged to be satisfactory, although there are some ambiguities, for instance how the category of ‘special housing’ has been defined (Swedish Association of Local Authorities, 1999b). The authorities behind the annual statistics endeavour to check data to minimise local errors, and to produce statistics of good quality. Carsjö, Thorslund & Wärneryd (1994) studied the validity of administrative registers of service utilisation and concluded that registers that are also used for service charges – such as the home
help register and the special housing register – seem to be largely accurate, since it is an economic incentive for municipalities to maintain accurate registers.

However, there are certain limitations in the data categorising old-age care in Sweden. One major problem is that the statistical information focuses on the elderly population as a whole, not on individuals. For example, we do not know whether home help recipients also have access to other services, such as meals-on-wheels, day care, safety alarms, etc. None of these other services, essential in the old-age care system, are accounted for in the annual statistics. There is no data about the care recipients’ health status, functional ability, or use of medical care, nor is there any information on social networks or family circumstances, all of which are essential in studies of care-needs and care utilisation in the elderly population. In Studies III and IV, we used indirect indicators available in public databases as a source for this kind of information.

To compare Swedish home help statistics over time calls for awareness of changes in data collection and in statistical methods. Firstly, home help figures up to and including 1992 refer to all elderly persons who had received home help at least once during the year, while data from 1993 refer to persons receiving home help on a given day at the end of the year (the 31 December, and from 1998 the 1 November). The year-measure has been calculated to correspond to 124 percent of the day-measure (Daatland 1997b), and in some of the analyses in Study IV data were adjusted in accordance with this formula.

Secondly, as a consequence of the ÄDEL-reform in 1992, home help data from 1993 to 1997 also included individuals receiving medical services delivered in the home by municipal staff, which means that the results from these years probably to some extent overestimate the actual amount of home help given.

Thirdly, up to and including 1992 home help statistics referred to home help provided by the municipality in ordinary housing as well as in service-homes. From 1993 home help in these two kinds of accommodations was reported separately in the statistics, but the annual reports for 1994, 1998 and 1999 accounted for
home help in ordinary housing only, because of poor local information. Supplementary information was obtained for 1993 from NBHW, but as the quality of data from 1998 and 1999 was judged to be unsatisfactory, these years were dropped in Studies III and IV.
PRESENTATION AND RESULT OF STUDIES

Study I


Aims

The main aim of this article was to describe and analyse the development of the professional role of old-age care supervisors or managers in Sweden, exploring what their tasks have been, what kind of knowledge and skills have been demanded of them, and the nature of their training at different times. Another object of the article was to illustrate the radical patterns of change in the public care of elderly people in general, by tracing and analysing the history of its supervisors or managers.

Material and methods

A variety of public documents and other written material was used. Government reports, legislation, the documents of public authorities, and social policy literature were all scrutinised to trace public policy on the care of the elderly. Curricula and other educational documents were analysed to look at the development of professional training and research reports on the professional role were examined. First-hand descriptions of the managerial functions and tasks were taken chiefly from fifty annual volumes of the occupation’s professional journal.
Results

The article describes the different phases in the development of old-age care and in the role of its supervisors. In the first decades of the last century, the elderly poor were admitted to strictly disciplined poor relief institutions where supervisors had a controlling function. The period 1920 – 1950 was dominated by a strong belief in institution-based old-age care, and the supervisor’s role had a variety of profiles, e.g., matrons of home-like institutions, geriatric nurses, and manageresses of increasing numbers of care-staff. The decades 1950–1980 were characterised by expansion and new fields of work, chiefly within the home help services, which after initial doubts became a new occupational arena for the supervisors. In the 1990s, with a strained public economy and increasing pressure on managers to maintain a tight budget, financial control became a central feature of the work of the managers, and old-age care became increasingly market oriented.

Conclusions

The twentieth century saw radical changes and a transformation of the principles in old-age care: There was a development from poor relief to general welfare; from care ‘in homes’ (e.g. institutions in the form of old people’s homes) to home care in people’s ordinary housing even for very frail and sick elderly. A development also took place in the role of care-givers: from being the work of amateurs to being that of professionals. Some periods have been dominated by social values, other have had a medical dominance. In later years, a market-oriented ideology was introduced in the municipalities in general and in old-age care in particular, which brought with it new aims for managers, such as target efficiency, budget control, cost effectiveness and quality assurance. Throughout, the professional role of supervisors has developed parallel prevailing official conception about the proper way to provide care for elderly people. Several reasons are put forward for this lack of professional independence: it is a female and a caring profession, dealing with the every-day needs of
elderly people which gives it a weak position in relation to higher-status professions such as medicine, the economy or technology.

Study II


Aims

The aim of this study was to describe and compare public home help services and institutional care of elderly people in Sweden with regard to the care-recipients, the care they receive and their caregivers. The following were some of the questions addressed: What are the characteristics of home help recipients in terms of age, health, functional ability, and need for assistance, compared to elderly people living in institutional settings? What kind of help and assistance do they receive, and who performs the various services in the two forms of care – staff, next of kin or voluntary organisations?

Methods

The study was based on a research project carried out in four municipalities of different size and character and with different old-age care organisation. Trained interviewers carried out face-to-face survey interviews. The questionnaire included questions about the respondents and their living conditions, health and functional ability, and their care situation.

In total, 400 persons were randomly sampled from the local authorities’ lists of care-recipients: in each municipality 50 persons receiving home help and 50 living in various forms of special housing for elderly people. When direct interviews were impossible because of severe mental impairment or poor health
(according to staff judgement), proxy interviews were used (12 percent in home help services and 53 percent in institutional care). We preferred to use the next of kin, otherwise the staff member who was most familiar with the respondent. The non-response rate was 9 percent (10.5 percent of the home help recipients and 7 percent of the institutional-care residents).

**Results**

Most recipients of public old-age care were very old and living alone, and the majority were women. About one third of them stated their health to be poor, and about half of the respondents reported a worsening during the previous twelve months. Respondents living in institutions were older and more likely to be functionally disabled, especially cognitively impaired. They received more care and a greater variety of care than respondents living in the community, for instance, help getting dressed, bathing or showering, managing medication, going for a walk, etc. However, the picture was not entirely unambiguous. The occurrence of health problems and the daily use of medication were fairly similar in the two types of care. Half the home help recipients received a great deal of help frequently, and sometimes even around the clock. There were many similarities between the recipients of ‘extensive home help’ and the residents of service-homes, in terms of health status and function, and the care they received. Elderly persons in more traditional forms of institution (old peoples’ homes, nursing-homes, etc.) were more likely to suffer from memory loss and were more likely to receive help with daily functions. The care-givers in institutions were mainly professional staff, while in home-based care it was more common for family and friends to contribute some of the care. There were very few private service providers or volunteers in either form of care.
Conclusions

It is not always the case that a high level of communality in residence corresponds to a high level of care and vice versa. In our study home-based care (with a low degree of communality) could be combined with high levels of care, while institution-based care (with a higher degree of communality) could have low levels of care, for instance in service-homes. The greater amounts of help and assistance people receive in institutions could be explained by a greater degree of poor health and functional limitations, but might, at least in part, be a consequence of “acquired incompetence” and the “service package solution” that tends to go with institutional care. Equally, the finding that family and friends contributed only rarely in institution-based care is chiefly explained by the fact that many elderly persons move to institutions because they lack families. It may also be explained to some extent by the traditional view of institutions as an arena for professional performance by staff where family members are not expected to take an active part.

The proxy interviews provided a different picture of the elderly care recipients than the direct interviews with self-respondents. The data indicate – as might be expected – that those who were directly interviewed in institutions to a minor extent suffer from poor health, poor vision, and poor memory. There were relatively few proxy interviews in home-based care (12 percent), and the main reason for these was poor memory.

Study III

Aims

The aim of this article was to describe and analyse current local variation in services and care for elderly people (80+), using Sweden as a case. Are the variations linked to differences in structural or political conditions in the municipalities? Are there any compensating factors which even out the local variations in the care of the elderly?

Material and methods

The analyses were based on official statistical information about the social services in Sweden’s 288 municipalities in 1997, and on the ”KFAKTA99” database of demographic, structural, political and economic information about the municipalities.

The current distribution of coverage for home help and special housing and the intensity of home help provision were explored univariately and bivariately, and were presented in numerical and graphic form. To examine the combined effect of independent variables, we tested those significant in the bivariate analysis in multiple models (linear regression) with the aim of finding as high an explained variance as possible and of studying the effects of each independent variable while controlling for the effects of others.

Results

The local variation was substantial: the municipal coverage rate of home help for elderly people (80+) ranged between 5 and 52 percent, with an average of 19 percent. Municipalities did not seem to even out low coverage by giving more hours of help per recipient, and only to some extent by providing institutional care. The overall finding of the bivariate analyses was that most relations with structure and policy were weak or non-existent. The final multivariate model explained only 15 percent of the variance.
Conclusions

The great variation in coverage rates for home help indicates that a variety of local social policies co-exists in Sweden with regard to care and services for elderly people. It seems more appropriate to talk about a multitude of welfare municipalities rather than a single welfare state. The article concludes that the municipal disparity constitutes a greater threat to the principle of equality in old-age care than gender and socio-economic differences.

Study IV


Aims

The aim of this article was to study municipal variations in the home help services for elderly people (65+) in Sweden over time and to explore to what extent the present provision of home help is related to municipal provision of old-age care in previous years.

Material and Methods

The analyses were based on annual official statistics. The coverage rate of home help for elderly people (65+) in the Swedish municipalities in the period 1976 – 1997 was studied by mean, standard deviation and coefficient of variation. A number of municipalities were examined in relation to the national median and 5th and 95th percentiles. Cross-tabulation giving the relative position (in percentiles) of each municipality was performed in order to assess patterns of change between 1976 and 1997. The correlations between past and present coverage were compared within and across municipalities to assess the impact of 'local history' in services for elderly people.
Results

The local variation was substantial during the twenty-year period looked at here, and had increased in relation to the declining coverage rates. Most municipalities seemed to follow their own coverage trajectories over time, more or less parallel to the national average. There was inertia in the home help coverage in the municipalities, very strong during the late 1970s and the early 1980s and weaker but not unimportant in the turbulent 1990s. The situation of preceding years seemed to be a stronger predictor of today’s home help coverage than is the present structural or political situation.

Conclusions

The results support the thesis that there is historical continuity – path dependency – in the individual municipalities as regards care and services to elderly people. The local autonomy is very strong, and neither the establishment of compulsory legislation nor the introduction of levelling state grants seems to have reduced the cross-municipal variation. Municipalities have differed in their welfare services to elderly people for more than twenty years, and this heterogeneous tendency has, relatively speaking, increased rather than decreased. In a universal welfare state like Sweden, with equal and equitable access to social care services as a main goal, it is remarkable to find that the probability of receiving care and services in old age seems to depend very much on one’s residential location.

Summing up the four studies: development and present situation

Two of the articles in this thesis, articles I and IV, have focused on the development of public old-age care in Sweden over time, while the other two (II and III), have dealt with the current situa-
tion. In brief, we saw radical and accelerating changes during the 20th century, especially in the last fifty years. Yet, it is also evident that many things are more or less unchanged, and that there seem to be strong traditions in the municipal care of and services for elderly people in Sweden. Some of these tendencies will be outlined and analysed further in the following commented summary of the four articles.

*From poor relief via general welfare to needs-tested help*

Three pictures, taken from Study I, of different epochs of public old-age care in Sweden can give an idea of how the basic traits of policies for the elderly have changed. The first picture is from the beginning of the century, when public assistance in old age was restricted to the poorest in society, those without means and without a family to provide for them. Local poor relief was highly restricted; ‘outdoor relief’ was given in kind at a very low level, often as board and lodging with farmers or smallholders in the parish. ‘Indoor relief’ consisted of lodging in poorhouses where a mix of poor people were housed – the frail, the chronically ill, the insane, etc. Poor relief was seen as an act of mercy, and local politicians wanted to restrict the cost to the utmost (Edebalk, 1991). The ‘paupers’ were not allowed to complain or show their discontent; they were to obey and show respect towards the superintendent, at the risk of being punished for misbehaviour.

The second picture I choose to give is from the late 1970s, when there was an extensive supply of resources: ‘outdoor relief’ in the form of home help services had expanded to a top level, and ‘indoor relief’, i.e. the institutional care of elderly people, was growing in old and new shapes. Outreaching and case-finding activities had become compulsory, and “old-age care for all” had very nearly been achieved – in 1975 nearly two thirds of all old persons (80+) either received home help services or lived in an institution (Sundström, 1999b). The home help supervisor became the mediator of common social benefits, and public old-age care –
especially the home help services – was accepted and appreciated by all groups in society. Elderly care recipients became users of general welfare contributions, and their care needs were not stringently tested – as a rule, those who applied also received help.

The third picture, from the end of the 1990s, is rather different. Both the outdoor and the indoor relief have diminished in relatives terms, and home help has declined most of all. In the oldest age group, 80+, the percentage receiving home help has decreased by one-third, and the percentage receiving institutional care by one-fourth (Szebehely, 1998b). According to the legislation, it is now a statutory duty to provide a variety of forms of old-age care to those people whose needs cannot be met in any other way. The new national goals for policy on the care of older people underline that elderly people must be treated with respect and must be able to influence their day to day existence. Officially, the recipients of old-age care have become clients, entitled to be treated in a formally correct manner and entitled to have their right of self-determination respected; they also have the right to appeal against negative decisions. However, municipalities are applying the Act more strictly, and public care has more or less become restricted to the oldest and frailest who are in greatest need of care. Those who apply for help with domestic tasks only are often obliged to resort to buying these services on the market – to become consumers or customers of services – or to rely on help from their next of kin (Szebehely, 1998a).

**Market orientation**

During the 1990s, an increasing market orientation became evident in public old-age care in Sweden, just as in other countries, such as the United Kingdom (Baldock, 1999b). “The legion of economists have marched with great success into the welfare arena as dominant experts” (Eliasson-Lappalainen & Motevasel, 1997, p. 192). The municipalities have reorganised and introduced a market-oriented terminology and organisation, stressing economic incentives, productivity, efficiency and quality control. In
order to open up for competition and for private for-profit companies to provide care for the elderly on commission, many municipalities have introduced the so-called purchaser-provider model, separating needs-assessment and the purchasing of services and care from the provision. These special care-providers can be either municipal home help teams or institutions, regarded as ‘business units’, or private entrepreneurs.

As shown in Study I, the managers working in the care services have been very much affected by this new ideology and their professional role has been divided into two separate occupational categories with either purchasing or providing tasks. Either they may be responsible for budget and quality control, and their new professional titles show the new times: purchasers can be called care managers, quality controllers, purchaser consultants, etc., while managers of the providing units go under the name of business unit managers, productions managers, etc. Managers have spoken of the ethical dilemma they experience in times of public cutbacks, when their obligation to stay on budget must be prioritised at the expense of the dependent elderly people in the area.

What is more, in some municipalities help for elderly people has been split up and defined as various types of ‘care products’. Standardised techniques for ‘measuring and securing the quality of care’ have come into fashion in the municipalities along the lines of those used in manufacturing industry, the service sector and the medical services (Eliasson-Lappalainen & Motevasel, 1997). To measure and value the ‘outcome’ of social care services in old people’s day-to-day lives is a quite different matter, because individual differences, varying from person to person and across time and place, will affect the outcome and the quality or value of the intervention (Baldock, 1997).

The care-recipients’ freedom of choice is a heavy argument in the rhetoric. However, it has proved difficult for newly-disabled older people to choose their own care. Especially, elderly people who are frail and vulnerable and in need of care, are not in a good position to ‘shop around’ or to be effective managers and purchasers of care, and they do not have a realistic prospect of
‘market exit’, i.e., they cannot do without help and they have no alternative care-provider to turn to (Baldock, 1997; Baldock & Ungerson, 1994; Walker & Warren, 1994).

**Professionalisation**

Study I has demonstrated the professionalisation of old-age care during the twentieth century. At the beginning of the century caring for old people was amateurs’ work. Elderly people were taken care of by their own families, or by other families in the parish. In the poorhouses, the “caring” and the “supervisory” tasks were performed by other, somewhat younger and healthier paupers. Poorhouse superintendents were some of the first to be employed in the municipal poor relief, and little by little, they were also able to appoint assistants to carry out the care tasks. The public care of elderly people had begun to be professionalised, in terms of it becoming paid vocational work (Freidson, 1994). One of the guiding principles of policies for the care of the elderly today is that it should be provided by trained and qualified staff, and the age-care sector is one of the largest fields of gainful employment for women in Sweden (Statistics Sweden 1997). The trend is not wholly straightforward though; elderly people still receive a great deal of care from families, neighbours and friends, something which even seems to be on the increase (Szebehely, 1998a).

The process of professionalisation can also involve establishing professional skills on a scientific and educational basis, in particular academic studies, and the authorisation of professionals (Freidson, 1994). In the institutional care of elderly people, the aspiration for education and special skills became apparent at an early stage, whereas the early home help services had a more amateur-like profile from the start. There were no demands for the organisers of these services to have special skills or training, and the women recruited as part-time home helpers were housewives with experience of caring for their own families (Korpi, 1995). Today, the demands for training have increased considerably both in institutional and non-institutional old-age care,
and the differences between the two branches have levelled out. Supervisors/managers are now trained at university level and many of the care workers are qualified nurse’s aids or assistant nurses – all of which demonstrates the increasing professionalisation, in this latter sense, of old-age care in Sweden.

**A women’s issue**

Old-age care remains a female domain. As Study II illustrated, women are in a big majority among care recipients, in home-based as well as institution-based care. This not only reflects the fact that there are more women than men in the highest age ranges; women are also more likely than older men to receive public home help and to become institutionalised, because women are less likely to be living with and cared for by a spouse late in life (Korpi, 1995).

Paid care-givers are also predominantly women: in Sweden, about 90 percent of the staff in municipal care of the elderly and 95 percent of the supervisors/managers are women. Again, it is worth pointing out that the extensive public care sector in Sweden has been of double importance to women. As a major part of reproduction work has been moved out to be performed by the public sector, most women have been able to go out to work (Montanari, 2000), and the public sector has also offered women a large labour market. Swedish women, including those with a low level of education, are gainfully employed to a very high extent, in comparison with other countries in the European Union (Szebehely, 1998a). However, as most of the jobs in old-age care, especially in home help services, are part-time, women have a weaker position on the labour market than most men, and are therefore disadvantaged when it comes to social insurance, for instance pensions and health insurance.

Women also dominate in the comprehensive, but more invisible, informal care sector. Daughters, daughters-in-law, and not least spouses, often frail themselves, carry out most of the unpaid care work within families, sometimes in partnership with
the public care sector (Gustafsson & Szebehely, in press). It is obvious that changes – positive as well as negative – in the system of care for the elderly have greater consequences for women than for men.

**Outdoor or indoor relief?**

During the first half part of the twentieth century, public care of elderly people was solely in the form of ‘indoor relief’, that is, institution-based. As shown in Study I, the authorities gave prominence to old people’s homes, and planned for a high demand for institutional care in the elderly population (see also Edebalk, 1991; Korpi, 1995). In the mid-1950s, home help services for old people gained a foothold in Sweden, as in other countries (Land, 1991), and developed fast. Swedish policy has favoured home-based care – ‘outdoor relief’ – ever since, and it reached a peak at the end of the 1970s. Despite policy declarations, the current cut-backs have affected home help services in particular, and there has been a shift in the balance between the two forms of care, in favour of institution-based care.

However, the results of Study II indicate that in Sweden today there is no clear distinction between home-based and institution-based care when it comes to the care-recipients and their care-needs. People can be in very poor health and still receive extensive home help – many hours of assistance many times a day, often around the clock. On the other hand, residents of service-homes can be self-reliant and in fairly good health. There are also ‘mixed forms’ of care: elderly people who live in ordinary housing can also receive treatment and rehabilitation during the day in a day-care centre, or short-term care in the form of temporary accommodation in an institution.

The special feature of the home help services – one that has been emphasised ever since their introduction in the 1950s – is that they are performed in people’s own home, in the private sphere, and that they therefore allow for more autonomy and integrity than institutional care. Now, however, with home help
services increasingly being directed at those with extensive, even round-the-clock, care needs, this feature has been threatened. An institutional wind is said to be blowing through the home help services as their staff enters with hospital beds, hygiene equipment, and specialised staff. Their working hours, timetables and routines tend to steer the daily lives of the care recipients; the home runs the risk of becoming institution-like (Berg, 1996) – another example of the blurred borders between home-based and institution-based care.

The idea of “the home-like institution” was established as far back as in the early decades of the twentieth century, when matrons were commissioned to create a home-like atmosphere in old people’s homes. Current policy emphasises that all institutions for elderly people should be home-like and regarded as the residents’ own housing. Reality was far removed from the ideals of policy in the 1930s – as it is at the beginning of the new century. Barely half of all institutions for old people can be regarded as “real housing”, and there are still more than 8 000 residents sharing rooms with people who are not family (NBHW, 2000b).

**Medical or social character of old-age care?**

Whether care of old people is a social or a medical concern varies between countries and over time. Which of the two ‘cultures’ is the prevailing one is often evident from the kind of skills and qualifications demanded of those working in the field. The way in which the occupation is viewed is thus a good mirror of the ruling opinion, and the development of the historical role of the supervisor in the care of the elderly may well reveal the changes in opinion over time in Sweden.

As we could see from Study I, supervising old-age care was right from the start a social rather than a medical occupation. Philanthropic organisations with strong social ambitions influenced legislation, policy, and training in this direction (Edebalk, 1991). In the middle of the century the social basis of the occupation (and of the training) gave way to a more medical profile;
partly because of the residents’ needs for medical care, partly under the influences of the developing medical field of geriatrics. During the 1970s and 1980s, the medical aspects of the work were transferred to the county councils’ visiting nurse organisation and to long-term geriatric care. Municipal old-age care was now ‘a social affair’, with its legal base in the Social Service Act. The supervisor role was de-medicalised, and the training concentrated exclusively on social issues. Since the ÄDEL-reform in 1992, when responsibility for long term medical care for elderly people was transferred to the municipalities, there has been an influx of nurses and other medical professionals into municipal old-age care, including the supervisory positions. Because many home help recipients and residents of institutions are in poor health and need medical attention, there is a demand for medical skills, and today the supervisor/manager training, although based in the social sciences, includes the study of geriatrics. The pendulum seems to some extent to be swinging back.

**Local variation and local traditions**

One of the central issues of this thesis is the great variation across municipalities that is characteristic of old-age care in Sweden. Studies III and IV demonstrate that the coverage rate of home help and of special housing varies greatly in all age groups, and that the variations have increased rather than decreased in relation to the national average. Only to a limited extent do the two main forms of old-age care compensate for each other, and it has not been convincingly demonstrated that supplementary home-based services have succeeded in making up for a deteriorating home help. Only some of the variation in coverage can be explained by structural or economic factors in the municipalities; it thus seems accurate to talk in terms of geographical inequality and welfare municipalities rather than one equal and uniform welfare state, when it comes to services and care for elderly people in Sweden today. Within the framework of a goal-oriented legislation the municipalities can themselves decide the scope and the quality of
their social care services, how these are organised, and the size of user-fees. Local variations can be related to the fact that Swedish municipalities have a long history of strong local autonomy. For instance, a study from 1829 of poor relief in rural Sweden, reports great differences not only between geographical regions but also between parishes in the same region – poor relief in two neighbouring parishes could look quite different from each other (Skoglund, 1992).

Given this strong local autonomy, it seems contradictory that municipalities follow the national average to such a great extent – results of Study IV indicate almost parallel paths, but on different levels. The theoretical concept of ‘path dependency’ suggests that societal institutions evolve in response to changing conditions, but in ways that are constrained by past trajectories. Applied to municipal old-age care, the parallel distributions of coverage rates might be consequences of the demographic and economic situation as well as local history and tradition. However, this hypothesis remains to be empirically researched at the local level.
CONCLUDING DISCUSSION

The object of this thesis was to describe and analyse the development of old-age care in Sweden over time from a variety of perspectives. The studies have dealt with different aspects of old-age care, its history and character, and in this section I will summarise and discuss the main results and their possible implications. I will also raise some possible issues for future research.

The choice of material and methods

To start with the issue of methodology, a variety of methods and material have been used in this thesis – survey interviews, official statistics, public documents and other written sources. The advantages of this approach are obvious – it is possible to illustrate more aspects and obtain a broader picture of the matters at issue. As was demonstrated earlier, however, each choice of method and material also gives rise to problems and difficulties in the field of social gerontology research.

On the basis of what I know now, I might well have made different methodological choices. For instance, in Study II, it no longer seems so wise to combine the four municipalities in the analyses of the care situation, bearing in mind the large variations that exist between municipalities. Also the four cases in the study turned out to have fairly different coverage rates and formation of care. It is also difficult to draw general conclusions from as few as four municipalities, but these were given in the project, as case studies to explore. In future studies of care-recipients and family care-givers the local social policy conditions must be taken into consideration in the study design and in the data analyses. It would also be of interest to look further at the professional role of old-age care supervisors/managers and how this has developed in local social policy conditions.

Another methodological reflection concerns the approach in Study I, namely letting the development of an occupation illustrate
Concluding discussion

public policy. The idea of going back into the history of the old-age care supervisor arose from a doctoral course on the “Care for the elderly: Conditions and everyday realities” (see Eliasson, 1996). It became clear that professions arise and evolve in a historical and structural context (Freidson, 1994) out of the interaction between the state, training and the professionals and their organisations (Thorstendahl, 1989). My conclusion was that a description of how the job of the supervisor has developed could be useful as a tool for describing and understanding changes in old-age care as a whole, giving more than just the rhetoric of the policy documents. However, this approach only gives one side of the picture – it does not tell what everyday life in old-age care is like for elderly care-recipients in different forms of care with different kind of supervisors – and again – in different local contexts.

Care formation and localisation

According to Study II, there are few obvious differences between different forms of care in terms of needs and use of care. Home-based and institution-based care, for example, are not necessarily two extremes of a care-chain, where elderly people needing least care receive home help, and those needing extensive round-the-clock help are in institutions. Instead, in the home help services today, elderly people can suffer from very poor health and receive extensive help – many hours of assistance and many times a day, sometimes around the clock. On the other hand, many elderly residents in service-homes can be in fairly good health and self-reliant. Indeed, the majority of residents in the traditional forms of institution, old people’s homes and nursing-homes, reported good or fairly good health – roughly the same proportion as those living in their own homes and receiving extensive home help.

These results are somewhat surprising. High levels of care in home help services and fairly low levels in some of the institutions – how should we interpret this? To what extent is it a sign of a conscious policy on the part of the municipalities to take elderly
people’s choice and self-determination into consideration? Some elderly people definitely want to ‘age in place’, in their own homes, irrespective of their care-needs, while others, even with very low levels of needs, want to move to the safety of a sheltered housing with staff in reach around the clock. A different interpretation is that there is inadequate care planning of individual cases, with some care recipients receiving too little care and supervision and others receiving too much in relation to their needs. In the former case the implications for the individual are serious; in the latter, the economic implications for the municipalities are considerable.

Study II was conducted in 1994 in the light of previous research into the characteristics of elderly persons using different types of care. Internationally, there seemed to be fairly distinct reasons for using one type of care rather than another: IADL-limitations for users of home help; ADL-limitations for those who had moved to sheltered housing or service-homes; cognitive impairment and a high level of physical and social disability for those who had been admitted to residential homes or nursing homes. A local study (Thorslund, 2000) has shown an increased care-load in all kinds of institutions in Sweden in recent years (Government Report 2000:3). For example, elderly people who moved to service-homes in 1999 represented, on average, a heavier care-load than the residents of nursing-homes twenty years earlier. In the home help services too there is an obvious increase in the number of very frail elderly people needing large amounts of care and a decrease in the number of people receiving few hours of help (NBHW, 2000a; Szebehely, 1998b; 1999b). The implications of these changes for staff as well as for care-recipients are important issues for further studies. Equally, the wider consequences of the new policy of not granting home help to people in need of help with household tasks only should be empirically investigated (for a discussion, see NBHW, 2000a; Sundström 1999b; Szebehely 1999b).
Social policy change?

Public old-age care in Sweden has had a changing and dramatic development, especially in the fifty years since the introduction of home help services. Having originally been a restricted, chiefly institution-based, poor relief measure for the very needy, public old-age care became universal and, at its peak in the late 1970s, reached about two thirds of the elderly population, 80 years and older. The home help services became a form of public assistance that was not stigmatising or perceived as poor relief; it has been broadly accepted and used by all classes (Sundström, 1984; Sunesson, 1990). The last twenty years have seen a considerable decline, and old-age care today is again restricted, not to the poorest, but to elderly people who are very frail. Among those elderly people who are outside the formal care system, Szebehely (1999a) traces an increasing dualisation of the informal care they receive: market-solutions for the better-off and increased family care for the less well-off. One important question for future research is how these changes affect the widespread public support for the public care system and people’s willingness to pay taxes for a system that is no longer able to keep its earlier standard.

A contested professional role

Although the social care of the elderly is a highly regarded and prioritised section of Swedish social policy – “a cornerstone” – and one of the biggest items of public expenditure, it has been difficult for the professionals in managerial positions to build a strong and self-reliant profession. They are today public officials with advanced decision-making on their agenda, in charge of large numbers of staff and extensive public expenditure, and yet, they are unknown and very little recognised as a professional group. Several studies have confirmed this picture of these professionals, or semi-professionals (see for instance Berg, 1994; Gynnerstedt,
and the literature suggests a variety of explanations for why this is the case: that work with old people and daily domestic tasks is discriminated against, as are female-dominated occupations generally (Hugman 1994b, Lymberly, 1998; Macdonald, 1995; Davies, 1996). Very little is known about the consequences for the professionals of having such a contested professional role and at the same time such a responsible and demanding position in the public care system. We also lack knowledge of what the new economy-orientation of the profession means to women and men who have preferred to work as care professionals. This calls for work environment studies as well as research into the situation of middle-managers in public care organisations at a time of strain.

Local variation and geographical inequality

Studies III and IV indicated that there is no homogeneous ‘Swedish model’ of old-age care. The coverage and the formation of services – whether home-based or institution-based – vary considerably between municipalities. Only a small part of these variations can be explained by local structural or political factors. To use a term from Kröger (1997), it seems more appropriate to talk about ‘welfare municipalities’ than one uniform welfare state when it comes to services for elderly people in Sweden. Our results here were in line with earlier studies of local variations in Sweden and in the other Scandinavian countries (see for instance Berg, Branch, Doyle & Sundström, 1993; Boll Hansen & Platz, 1995; Kröger, 1997; NBHW, 1996; Naess & Waerness, 1996). However, most studies are based on data on the home help, and one immediate issue is also to look at institutional municipal old-age care in a similar way, both the present situation and variation over time. Do the coverage rates of institutional care, or special housing accommodation as it is now formally called, also vary and
fluctuate over time, since they are limited by investments in physical buildings and can therefore hardly be as flexible as home help?

Further questions for research concern the implications of the extensive local variations – for the elderly and their families, for the staff, for the politicians. When the fact that municipalities have highly varying rates of coverage of services and care for their elderly residents becomes more widely-known, are people going to move to ‘high-coverage municipalities’ in their old age? What are the implications for care-staff and care-managers, of working in a high-coverage or low-coverage municipality? These questions call for further study.

Powerful traditions

Study IV has demonstrated that the local variations have a long history in Sweden, and are linked to a tradition of strong local autonomy. When it comes to home help coverage, past municipal traditions seem to have a greater influence than present conditions. There seems to be a path dependency (Daatland, 1997b; Thelen, 1999) in the sense that established traditions and earlier municipal policies influence the present supply of old-age care, even in the home help services which do not have the inertia of buildings or other fixed assets. The inheritance from the past is obvious. But how can this be? How and when does this local path first become established? What are the crucial factors and critical incidents in the local development – is it the work of policy makers, local ideologists, influential professionals, opinion-makers such as authors and journalists, or strong local pensioner’s organisations? How do policy programmes, once constructed, retain the acceptance of local inhabitants/taxpayers? This is indeed a rich field for study.
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From Poorhouse Overseer to Production Manager: One hundred years of old-age care in Sweden, reflected in the development of an occupation.

Gun-Britt Trydegård


Abstract

The aim of this article is to illustrate the changes in the Swedish system of old-age care during the twentieth century by tracing and analysing the history of the job of supervisor or manager of this care. The main sources that have been researched are public and educational documents as well as articles from the occupation’s professional journal. A development in periods of different character is described. During the first decades of the century, supervisors had a controlling function in strictly disciplined poor-relief institutions. The period 1920 – 1950 was dominated by a strong belief in institution-based old-age care, and the supervisor’s role had a variety of profiles, e.g. matrons of home-like institutions, geriatric nurses, and managers over increasing numbers of care-staff. The decades 1950 - 1980, were characterised by expansion and new arenas, chiefly the home help services. In the 1990s, with a strained public economy, the financial control has become a central feature of the work of the managers. Finally, some of the changes and trends are analysed and discussed.

Key words: Old-age care, manager, supervisor, caring profession, professionalisation, history, eldercare policy.
Introduction

How frail elderly people are taken care of when, through frailty and age, they can no longer manage on their own varies considerably between societies and over time. Each country has developed a special welfare mix of service and care and a special balance in the division of roles and responsibilities between the state, the market, voluntary organisations, and the informal sector: family, kin, friends and neighbours (Evers 1992, Daatland 1992, Kosberg 1994). There have always been variations in the location of services, i.e. home-based contra institution-based responses to the needs of older people, and in whether old-age care is considered to be a matter for the social or the medical services. The formation of services, that is their structure and organisation, also varies (Hugman 1994a), as well as the extent to which the care is given by trained, employed staff. Accessibility can differ; the public care of old persons may be selective – for instance directed only at the most needy, those who lack family-support, the poorest, those who can afford to pay, or those who have previously been in gainful employment – or it can take the form of a more general welfare provision for all elderly persons in need.

What many countries have in common is that care and services for older people have developed substantially during the last fifty years, and have become a central welfare issue and a point of pressure in the industrialised world. As a growing number of people live to an advanced age, and in most societies constitute a substantial proportion of the population, innovation and reform have become necessary, and radical patterns of change are described from different countries (Baldock & Evers 1992). Sweden is no exception here; indeed, with one of the world’s ‘greyest’ populations, it is often seen to be at the forefront of change (Thorslund & Parker 1994, Korpi 1995).

Organisation and management of old-age care in Sweden today

Meeting the service and health care needs of the elderly is one of the cornerstones of the Swedish welfare state, and an area that
continues to be given priority (Governmental Proposal 1997/98:113). Two fundamental principles guide the public elder-care policy today: old-age care is a public responsibility – even though informal care-contributions are extensive – and should be provided by trained and qualified staff (Sundström & Thorslund 1994). The Swedish municipalities\footnote{At the beginning of this century there were about 2 500 municipal districts in Sweden, but after a series of boundary reforms, there are now 289 municipalities (kommuner) in Sweden. The municipalities vary in population and in character; from big cities to sparsely populated rural areas. There was considerable urbanisation during the twentieth century: about 33 percent of the population was urban at the end of the nineteenth century, 50 percent in 1930 and 80 percent in 1998 (Swedish Institute 1999). There is also a regional organisation with 21 county councils (landsting) or equivalent.} have main responsibility for old-age care. There is a long tradition of autonomy of local government in Sweden; the municipalities levy their own taxes and enjoy great freedom to decide the quality and nature of the services they provide. The state defines social objectives through legislation and exerts its influence through supervising authorities and a system of state subsidies to the municipalities (Thorslund, Bergmark & Parker 1997).

At the local level, the municipalities provide services and care for elderly people, according to individual needs. Within the social services sector there is a wide spectrum of benefits, from domestic services and personal care within the home help system to care in institutions of various kinds. Since a legal reform in 1992, the municipalities are also responsible for the main bulk of long-term health care for elderly people, with district nurses in charge of home nursing care. County councils\footnote{At the beginning of this century there were about 2 500 municipal districts in Sweden, but after a series of boundary reforms, there are now 289 municipalities (kommuner) in Sweden. The municipalities vary in population and in character; from big cities to sparsely populated rural areas. There was considerable urbanisation during the twentieth century: about 33 percent of the population was urban at the end of the nineteenth century, 50 percent in 1930 and 80 percent in 1998 (Swedish Institute 1999). There is also a regional organisation with 21 county councils (landsting) or equivalent.} are responsible for emergency treatment, and for medical care carried out by physicians and other staff in health centres and hospitals.

The local social welfare committee takes the overarching decisions concerning old-age care, while care managers or supervisors are employed for assessing needs, for deciding care contributions, and for managing and co-ordinating care. How these jobs are structured and performed varies a great deal, between munici-
palities, between individual managers and also over time (Trydegård 1991; 1996). Also the title of their occupation has varied and varies today: superintendent, matron, supervisor, organiser, manager, needs’ assessment officer, etc, etc, which makes descriptions of the occupation rather indistinct.

Currently, the old-age care services have about 5 000 care managers or supervisors, and some 120 000 auxiliaries, of whom approximately half work with home-help services while the others work with institutional care. More than nine out of ten working with the care of the elderly are women (Swedish Institute 1999).

The managers/supervisors are trade-union members to a very great extent, and about half of them are also associated with an occupational society with links to one of the big trade-unions for municipal officers, ‘The Association for Social Care’ (Föreningen Social Omsorg)². The association organises local and national activities concerning occupational matters, arranges annual meetings on current themes, and also edits a periodical.

**Aims and methods**

A wide variety of studies of professions and professionalisation have been carried out in social science research. Some have sought to identify the attributes of ‘true professions’, and consequently also talk about ‘semi-professions’, others focus on the strategies and power used by occupational groups to claim and protect a professional territory. In a ‘state of the art essay’ on studies of professionalism, Freidson (1994) identifies the study of knowledge-based groups in their historical and structural context, and analysing and comparing the professionalisation processes of modern professions during the nineteenth and twentieth centuries as major current areas of interest. The active role of the state in this process is emphasised, as well as the interaction between the

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² This association started in 1920 for the students from the training courses with the object to arrange discussions on professional matters and to provide further training for the members. In 1950 the association started to produce a paper, which has developed – under various titles – into an edited periodical.
state, the education and the professionals and their organisations (Torstendahl 1989). Freidsson (op.cit) calls for studies of the work that professionals actually do, and what influence different kinds of knowledge and work can have on the process of professionalisation.

The diversified and sometimes ambiguous character of the occupational role of managers or supervisors in old-age care has been demonstrated in a number of studies (Trydegård 1990; Gynnerstedt 1993; Nordström 1998). The elder-care supervisor is described as being, simultaneously, a social worker in contact with elderly and disabled persons in need of assistance; a leader of staff; an officer in charge vis-à-vis local politicians; and a partner for collaboration with other welfare organisations. The supervisors’ workload is high, and they occupy a ‘buffer position’ in the organisation, and a boundary-spanning role, balancing demands from all directions. They are public officials, with advanced decision-making on their agenda, in charge of large numbers of staff and of extensive public expenditure, and yet, they are unknown and very little recognised as a professional group. Supervisors have, in conformity with nurses, teachers and social workers; been referred to as semi-professionals as their work does not rest on a firm theoretical knowledge base, and there is no public authorisation for the job. Semi-professionals cannot claim a monopoly of exclusive skills in the performance of their work, and they do not have the autonomy to influence the development of their professional field (Etzioni 1969; Toren 1972). On the contrary, they are influenced and ruled by shifts in public policy decisions and ideology. Consequently, a description of how eldercare supervisors’ job has developed could be useful as a tool for describing and understanding changes in old-age care as a whole.

The main aim of this article is to describe and analyse the development of the professional role of supervisors or managers of old-age care in Sweden, exploring what their tasks have been, what kind of knowledge and skills have been demanded of them, and the nature of their training at different times. This professional role has changed radically during the twentieth century, and
the change has run parallel with the development of public old-age care. Another object of the article is accordingly to illustrate the radical patterns of change in the public care of elderly people in general, by tracing and analysing the history of its supervisors or managers.

A variety of materials have been used. Government reports, legislation, the documents of public authorities, and social policy literature have all been scrutinised to trace public policy on the care of the elderly. Curricula and other educational documents, such as annual reports from the training institutions, have been used to look at the development of professional training. First-hand descriptions of the managers’ functions and tasks are taken chiefly from a periodical\(^3\) which has been edited by the professional body since 1950 and where reports from annual conferences and articles on the occupational role then and now can be found\(^4\).

**The first decades of the twentieth century: A controlling function in poor relief institutions**

Imagine a miserable little tumble-down, two-room cottage, where poor, old, worn-out people live together in a state of dirt, vermin, hunger and wretchedness - then you will know what a poorhouse is, or was... It was a horrible place to have to live in when poor people grew old and were no longer able to manage for themselves. (Lindgren 1966: 86)

In her books about the mischievous little boy Emil in Lönneberga, the Swedish author Astrid Lindgren paints the picture of the poorhouse and its inhabitants in the late nineteenth century. Although a children’s book, it gives us an idea of how the public ‘care’ of old people was arranged in rural Sweden at this time. She

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\(^3\) See the reference list for detailed information.

\(^4\) All original sources are written in Swedish. A complete reference list of these sources can be found in Trydegård, 1996.
also describes the horrid ‘overseer’ (*kommandoran*), who was in charge of the poorhouse:

She was a pauper herself, but she was the biggest and strongest and worst-tempered one, and so had been given charge of the poorhouse. (ibid: 87)

To be ‘in charge of’ the poorhouse was a commission of trust, like most of the poor relief work in the nineteenth century (Thullberg 1990). Sweden had no legislation and no public care directed specifically at the elderly. According to family law and long tradition, old people were taken care of by their families. Wealthy old people could employ private carers or buy lodging and care in so called ‘pious foundations’ in the cities. There were also special charitable homes for the ‘pauvres honteux’, i.e. old people, often widows, who had been better off, but were unable to support themselves in their last years (Odén 1985).

Poor elderly people, with no family to take care of them, were obliged to resort to the local poor relief. They could be auctioned off to the farmer or smallholder who bid the lowest price to take care of them, or they had to wander—or even be transported—from farm to farm in the parish. The last resort was lodging in small poorhouses, where they could get at least shelter, firewood and some food to cook for themselves. In the poorhouse there was a mix of the poor: the frail elderly, the chronically ill, the retarded and the insane, single mothers with small children, vagrants and the like. The only help available to the elderly was from the healthier paupers in the poorhouse. As we have seen, one of them was selected to ‘be in charge’—to keep order and to distribute the small portions of food (Skoglund 1992).

There were practically no employees within the poor relief system at this time. In rural Sweden it was mainly politically elected parish representatives or unpaid, voluntary workers—so called friendly visitors (*vårdare*)—who made the decisions concerning the running of poor relief (Swedner 1993). The existing Poor laws from 1871 were very restrictive, and the local politicians wanted to restrict the costs to the utmost. According to a government committee from 1907, poor relief was to be seen “as a token
of mercy, upon which the individual could not importunately insist” (Edebalk 1991: 5).

**The first paid poor relief staff**

Around the turn of the century, there were some 5 000 poor relief institutions of various kinds throughout Sweden. The ages of the inmates varied, but the old and the sick predominated. Beside the poorhouses, there were workhouses in the biggest cities, and so-called poor-estates (fattiggårdar) in the countryside. The latter were intended to be big municipal farms, where able-bodied paupers could be occupied with ‘honest work’ (Åman 1976). The inmates – including the old – were obliged by law to contribute to the farming work and the household: they did the cleaning, the washing, the cooking, the refuse collection and so on. Discipline was strict, and those who left the area without permission, or who misbehaved, were punished by the withdrawal of food, whipping, or imprisonment (Swedner 1993).

At this time, urban municipalities had begun to employ salaried officials to be in charge of the expanding poor relief institutions. They were often lower-ranking former military men, and they were appointed as guards or superintendents (föreståndare), to keep order and control and to maintain a master’s legal duties and rights towards the inmates (ibid.). In time, rural municipalities also started to employ superintendents for their poorhouses, sometimes a married couple. Besides the superintendents’ duties within the institution, they could take on a variety of tasks in the community which were to be performed by the inmates, such as refuse collection, street-sweeping, wood-chopping. The superintendents were obliged to take part in all kinds of work, inside and outside the institution.

According to regulations proposed by a government committee in 1915, the (most often male) superintendent was to "exercise supervision of the inmates” and ”ensure that orders were punctually carried out, and that cleanliness, order and morality was observed”. The duties of the (female) matron (husmor) were to do the housework ”with the assistance of spe-
cially appointed personnel and the inmates” – assistants might be appointed for temporary needs. She was also to ”take special care of women, sick persons and any children that might be admitted to the asylum”. The inmates were obliged to obey and to show respect for the superintendent and the matron, who could take disciplinary steps towards those who misbehaved, were disobedient or negligent in their work.

Below, a retired female matron (one of the very first to be trained) was interviewed about her duties in the early decades of the twentieth century. She and her husband had been working as superintendent and matron…

… for the most diverse clientele - women awaiting confinement, infants and people of all ages above, of whom some were imbecile. In one of the institutions there were 110 inmates to look after. The mothers were working as aids, and the only employees were kitchen staff. The matron was also supposed to deliver food and firewood to the needy in the community, and also to run the letting of a mangle to people in the neighbourhood. There was work to be done around the clock, and of course no free time to look forward to. (The Professional Journal, 1968)

**Start of the first training**

The National Association of Poor Relief (*Svenska Fattigvårdsförbundet*), a philanthropic organisation established in 1904, saw one of its objects as to recruit superintendents for the municipal institutions. As it proved difficult to find ”suitable and competent men and women for the poor relief work”, the Association started in 1908 a training course for male and female poor relief functionaries. One motive for this was the idea that working in poor relief, as in medical care and education, required the development of theoretical and practical knowledge and training. Another motive was that its practitioners needed to achieve a better social position.
It was a 6-month course consisting of practical training in various establishments for poor relief, the care of children and medical care. The students also visited the meetings of the local Poor relief-committees (*fattigvårdsstyrelsen*), and followed charity organisations and other social bodies. The theoretical training took place in the evening on the Association’s premises. The teachers were well-reputed members of the social and health policy establishment, and they taught poor relief and medical care, as well as bookkeeping and office work. Twelve women and ten men attended the first course. In the 1920s, as the demands for trained staff increased, 30 students were admitted each year.

From 1915 training was for women only. The Association had decided not to admit men as students, since it had been difficult to find employment for them, especially if they were unmarried. The wife of a married superintendent was supposed to work – without payment – as a matron or a cook at the institution. Unmarried men usually received a lower salary, and for the difference a cook could be employed (Gynnerstedt 1993).

**1920 - 1950:**

*Institution-based old-age care*

In 1918 the Poor Laws (*Fattigvårdslagen*) were revised, and the new legislation was influenced by the ideology of leading philanthropic organisations. It was established by law that people were entitled to poor relief in certain situations, and they also had a right to appeal against decisions. The auctioning off of poor people and letting them wander around the parish was prohibited. Institutional care was considered valuable, and the municipalities were obliged to have access to institutions of various kinds, among them “old people’s homes” (*ålderdomshem*). According to the law, the institutions should have a *supervisor, male or female* (*föreståndare eller föreståndarinna*), with “the qualifications needed to hold such a position” (The Poor Laws 1918, section 32). This was the start of a policy with a strong belief in the institutional care of elderly people.
A new professional profile was now emerging among the supervisors. The matrons of old people’s homes were charged with creating pleasant and home-like institutions for frail, poor elderly people in need of care and supervision, and with no family to take care of them. To overcome the troublesome ”mix of clientele” in the municipal institutions, the state and the county councils were to take care of insane, retarded, and chronically ill persons in the medical sector.

The policy was also reflected in the development of training. This was gradually lengthened, with more periods of vocational training and the addition of new theoretical subjects, for instance Swedish, domestic science, gardening and also weaving, mattress-sewing and other handicrafts. Even instruction from a nursery-school teacher in making paper-flowers and garlands was included, as ”it could be of great use to the matrons to be able to decorate the homes cheaply at festivals and feasts” (cite from the annual training report, 1929).

However, the real state of things was far from the ideal, and institutions differed considerably from one municipality to another. The matrons were struggling to live up to the vision of the good home. They still had to perform all kinds of care and household tasks, even though assistants now could be appointed on a more regular basis. The matron lived in the institution, she had to be on hand around the clock, and she could hardly even be relieved for holidays or vacations (Edebalk 1991). A letter from a newly qualified matron, can give us an idea of what their circumstances were like in the early 1930s:

Those who have been here before me have not in any way known how to do their work. Everything is worn out. The wallpaper is hanging loose and everything is mismanaged. The floors are dirty, like in a stable… The wash-house is situated in an old house on the yard, and we have to carry the water into the wash-house. And the amount of laundry is not small - we

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5 Supervisors of old people’s homes were called ‘matrons’ in conformity with hospital nurses with organisational responsibilities.
are 43 persons including the personnel. The old people were grimy with dirt and there were no spare clothes, so I had to sit down and mend what I could find to have something to put on, when I had bathed them… The old men are making compost, which I will sell for big money in the springtime. I will also sell a pig, which we can’t afford to eat, in my opinion. (The Professional Journal, 1970)

The government had given the municipalities ten years to implement the compulsory obligation to build or in other ways get access to Old people’s homes, but the time-limit was prolonged some five years. During the 1930s old people’s homes were built all over the country, and many existing homes were rebuilt and enlarged. In 1938, there were 1,400 homes with 42,000 beds, corresponding to five percent of the elderly population, 65+ (Edebalk 1991).

Even in the 1940s, the old people’s home was the only form of public old-age care that existed, and they were intended for elderly people without means. However, as the quality of the homes was improved, a new tendency began to appear. Frail elderly persons with financial resources began to apply for accommodation in old people’s homes, paying the full costs. At the end of the 1940s, every sixth person in an old people’s home was such a lodger. Thus, the old people’s home was no longer an institution only for the poor, but rather for elderly people in need of care (ibid.).

**New guiding principles and social policy reforms**

In the late 1930s a government committee was set up to revise the poor relief legislation and also to consider other social policy issues. At the suggestion of the committee, the Swedish Parliament decided on several reforms, which were important to the elderly. One was a reform in the National old-age pension-system (*folkpensionen*) in 1946, giving all citizens over 67 years of age the means to support themselves, albeit at a minimum level, without having to depend on the poor relief.
A further decision in 1947 was to lay down the following guiding principles for the care of the elderly: With reasonable pensions, higher housing allowances, and an improved housing-standard, healthy old people should be able to remain in their homes. Chronically ill and mentally disturbed persons should be cared for in the medical sector. For those elderly persons who did not need medical services, but rather attendance and care, modern old people’s homes should be available. Ten percent of the elderly population (65+) was estimated to need such institutions. As elderly people were now able to pay for their board and lodging out of their pensions, the poor relief character of the services should finally be removed. The National Board of Welfare organised architectural competitions and made concrete recommendations as to how the municipalities could build pleasant and homelike ‘homes’ for old people.

A student in vocational training at the end of the 1940s, wrote this report from an old people’s home, illustrating the transition that had occurred in the institutions during the period:

The Home, which is situated opposite the church, is built in three storeys and white-painted. On the balcony-rail HOME (HEM) is written in big, capital letters. The interior makes a nice, cosy impression. Painting and wallpaper are everywhere in bright and cheery colours. Curtains, furnishing fabric and rugs are all hand-woven by the matron herself. The pot plants in the large, modern windows enhance the cheerful atmosphere...The day before Christmas Eve, when the butchering, baking, and cleaning were done, we were sitting till midnight, preparing the Christmas presents—underwear, aprons, shaving soaps—from the Poor Relief Committee to the old folks. On Christmas morning the Christmas tree was decorated and Christmas tapestries were hang up...After coffee-time the vicar came for the Christmas Night service. (The Professional Journal, 1980)
**A more medical profile**

Only a few years after the announcement of the new eldercare policy, the authorities had to back down from their ideals. Other forms of care, such as long-term medical care, psychiatric care and the care of the mentally retarded, were in short supply and therefore many physically and mentally ill or disabled persons were still being looked after in old people’s homes (Edebalk 1991). In 1955 about 47 percent of residents were judged to be physically ill and 14 percent ‘mentally abnormal’. The Minister of Social Affairs stated that it was necessary to provide medical care in old people’s homes, although not at a very high level. The manageresses became responsible for medical care, and the occupation accordingly took on a much more medical profile. This image was further strengthened by their uniform, which was like a nurse’s blue and white dress with a brooch and a little starched cap. The manageresses were also addressed as ‘nurse’, although they were not trained as such, and in fun, they were called ‘granny-nurses’.

In 1955, when the professional role of the manageress of Old people’s homes (älderdomshemsförståndarinna) was analysed, it was described as diversified and varying from one home to another, in part because these varied in size. They had two chief categories of task: care-giving and management. The medical duties were considered the most important of the care-giving tasks. The manageress had to supervise and administer medicines, give injections, change dressings etc., all in accordance with directions from a doctor. She had to be on-call around the clock to attend residents, who were ill, worried, or in need of special attention. If a resident’s state of health deteriorated seriously, she should decide when it was necessary to call in the doctor, and also inform the family.

Training was gradually lengthened to three years, and medical care became a more central element. The curriculum dealt with diseases of old age, their causes, symptoms, treatment and prevention. Three-quarters of the course consisted of vocational training, and more than half of this was training in the medical services. During the 1950s and 1960s geriatrics evolved as a separate field of medical care and research (Odén 1997), and the
manageresses turned to these specialists for their further training. In 1965 the training was transferred from the National Association of Social Welfare to the county councils’ schools for medical-care professions, which strengthened the medical profile still further. From now on, men were again accepted as students.

A greater emphasis was now also placed on management duties: managers had to manage the home, its organisation, its economy and staff, and had also to represent the home in the community. The control function still played a part: maintaining discipline and ensuring that hygiene standards were maintained. Staff-management had become more demanding, as the daily tasks were now carried out by appointed personnel – the residents were no longer obliged to work, but should ”be assisted in finding something to do for their recreation” (The Professional Journal, 1954).

Protests against the self-sacrificing vocation

In the 1940s and the early 1950s the managers began to unionise, like other care professionals, such as nurses, kindergarten teachers and social workers (Hatje 1992). Members of the professional body began to protest against their conditions and the image of self-sacrificing vocation that went with their job:

Do you think that there is anyone in the municipality who considers how burdensome it is for a single person to master everything—the personnel and the old people—day and night?…We shall pluck up courage and let them know that also we have our own thoughts and opinions…Too many years have passed with depressed and too humble manageresses…We should not have to work as managers in daytime and as assistant nurses at night, which has been our position far too long. But to talk about remuneration for our work at night is to the authorities like a red rag to a bull. (The Professional Journal, 1955)
In the early 1950s the managers had become the third largest group in the trade union of municipal salaried employees (SKTF). They succeeded in securing a salary system, which meant they no longer had to “feel that obsequious gratitude that goes with the payments in kind, that were earlier offered by the municipalities”. During the 1950s, they achieved a regulated status as municipal managerial officers with set working hours, the right to free time and vacation, regulated pensions and a salary of about SEK 1000 per month. This was a tenfold increase in ten years and was on a level with corresponding posts in the medical care services and adjacent fields. The profession was described by the educators in attractive folders, as “unusual varying and interesting work,…a leading and independent position,…a high social status…a steady income from the start,…housing accommodation in the home or in the community” (from 1959, cited in Trydegård 1996).

The professional association campaigned for formal qualifications for the managers of old people’s homes, as an inquiry had shown that half the professional group lacked vocational training. In 1957, the Minister of Social Affairs rejected this proposal, stating that the qualifications for managing old people’s homes did not need to be statutory.

1950 - 1980:

Expansion and new arenas for the care of elderly people

In the early 1950s a different type of old-age care was beginning to take shape. "Home-care instead of care in a home" was a common slogan, or rather a battle cry, which was coined by the Swedish author Ivar Lo-Johansson for the reform of old-age care. Strongly committed to the cause of the old and powerless, he managed to persuade both public opinion and leading politicians

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6 SEK 1000 is approximately equivalent to GBP 72 or USD 115 today.
to change policy and to pave the way for home help services for elderly people (Edebalk 1990).

An important initiative was taken at the same time by The Red Cross, which, inspired by Great Britain, organised the first home help for old people in 1950. It was based on volunteers – middle-aged women, who received a small remuneration. It soon became clear that many elderly persons preferred to be cared for on their home ground, the demand for institutional care fell, and the development of home help services was rapid. After four years there was home help for elderly people, under public or voluntary management, in 43 percent of the rural municipalities and in 83 percent of the cities (ibid). In 1957, the Minister of Social Affairs made the following comment in a Governmental Bill:

Nowadays it is clear, that care in old people’s homes – although necessary and important – is only a relatively limited part of the public measures we have to take to create safety and comfort for the elderly.

The organisation of home help services varied, but in many municipalities a clerk or home-carer was appointed as home help administrator (hemvårdsassistent). As the name implies, these co-ordinated the help supplied, but could not really be said to be supervisors or managers. There were no demands for special training, in line with the more amateur-like profile of the home help services. The home-helpers carried out domestic tasks like they did in their own homes, and they were not supposed to need either supervision or support from colleagues.

To begin with, the professionally trained managers of old people’s homes did not seek admission to this new branch of eldercare. Not until some ten years later, in 1966, did the former head of the training suggest that there might be job opportunities in the home help services, declaring that ”education and training in the care of old people is an excellent basis for assessing care needs and for the instruction of assistants” (The Professional Journal, 1966).

Training was lagging behind the rapid development of the home help services. Not until 1970, did a new curriculum come
into force, called ”Education of supervisors for old people’s homes and for the non-institutional care of elderly people”. It was still dominated by the demands for medical knowledge, but social subjects such as psychology, sociology, administration and management were given more space than earlier. However, only a small part of the vocational training focused on the administration of the home help services.

The 1970s were a period of expansion in the care of elderly people. This was not only in answer to the rapid increase in the number of elderly people in the population\(^7\), but also the sign of a rising level of ambition. Through an additional clause to the Social Assistance Act (Socialhjälpslagen), the municipalities were obliged to arrange outreaching and case-finding activities, and to offer help and assistance to those in need. More than 40 percent of the municipal budgets were aimed at the care of the elderly, and the services were expanded by some five percent annually during the 1970s (Trydegård 1996).

The resources expanded in a variety of areas: the number of beds in somatic long-term care, the number of places in old people’s homes, and the number of households receiving public home help, which increased the most – they quadrupled between 1963 and 1975. The range of services was also widened, and home help could now be combined with transport services, meals-on-wheels, day-care, chiropody services, etc. So called service-homes with small apartments, and home help and other services within reach, were built in many municipalities. At its peak, in 1975, public old-age care was serving about two thirds of the oldest (80+) in the population, either with home help services or with residential care (Sundström 1997).

In the mid-1980s, about 165 000 persons, mostly women, were employed in the social and the medical long-term care of elderly people, most of them as home helpers, nurse’s aides and assistant nurses. This made great demands upon the then 5 000 supervisors working in old-age care (of whom 2 000 in home help services

\(^7\) During the period 1960 - 1975 old people (65+) in the population had increased from 888 000 to 1251 000, or +43,5%.
and 3,000 in old people’s homes), who were judged to be too few for the amount of work to be done. The authorities realised that they would need to recruit large numbers of staff, both for the care-work and for the supervisory tasks (Trydegård 1996).

**An integrated professional role; a “spider in the welfare web”**

During the later part of the 1970s the county councils expanded both nursing-home care and the home-nursing services. The visiting-nurse organisation was strengthened by the addition of assistant nurses and occupational therapists. According to an agreement between the county councils and the municipalities in 1978, the visiting nurse and her assistants were to deal with all medical care for elderly people, including the residents in old people’s homes. Thus, the medical profile of the supervisors was soon outdated. One supervisor wrote in the professional journal in the early 1980s:

> We have to let go our role as ‘amateur-nurses’ and make clear our real professional task as managers, leading and developing the personnel...In my opinion, managers should be converted into home care supervisors, as everything is home care, in fact. (The Professional Journal, 1982)

The division between the two types of supervisor, i.e. in old people’s homes or in the home help services, gradually disappeared, and the two roles became increasingly co-ordinated and integrated. In many municipalities a supervisor could be responsible for both, sometimes with the help of an assistant supervisor.

This new professional role was described in the professional journal as a key-position in the welfare state:

> The home help supervisor is a community worker with the goal of bringing about social change. She has a set of tools at her disposal: home help, transport services, meals on wheels, safety-alarm, housing
adaptation, personal support, contact with other welfare agencies, service houses. The supervisor is an administrator of needs, and – like a spider in a web – she will try to improve the living situation of individuals through a variety of activities. The work is mainly carried out by other people, which makes it still more difficult...The development of the municipal care of elderly people will without doubt make great demands upon the professional skill of the staff. A professional profile, with emphasis on social administration, is necessary to improve the work, for the benefit of those citizens who are in need of our services. (The Professional Journal, 1982)

1980 - 1990:  
Statutory right to old-age care but also reduction and control

In 1982 a new law, the Social Services Act (Socialtjänstlagen), came into force, with the aim of guaranteeing everybody personal security, equality, and an active social life, and emphasising everybody’s right to personal autonomy and integrity. There was a special section concerning the elderly, imposing an obligation on the municipal social welfare committees to work for good housing with service, assistance and support available in the home, and special housing for those in need. The Social Services Act also included a section which stated that ”the individual is entitled to assistance from the Social Welfare Committee towards his livelihood and other aspects of living, if his needs cannot be provided for in any other way” (section 6). This statutory right also included home help services, transport services, living in service houses or old people’s homes etc. In this way, old people officially became clients, entitled to be treated in a formally correct manner. They also received the right to appeal against negative decisions. This was a whole new field for supervisors to come to terms with.
Parallel with the revision of the legislation, training underwent a radical upheaval at this time. Through university reforms in 1977 and 1983, it became a college education, like many other study programmes in the medical and social services. *The study programme for social care of elderly or disabled people* was a two-year college course, offered at some twenty university colleges for the health and caring professions (*Vårdhögskolor*), run by the county councils all over Sweden. According to the new curriculum, the programme should have "exclusively social contents"; students could well have some previous medical knowledge, but this was only one of many possible suitable backgrounds.

However, at the end of the 1980s the training background of the just over 5,000 supervisors in the municipal social services still varied greatly. Only just over half of them had completed a training specially designed for the job. As there was no ‘licence to practice’ of the type required for doctors or nurses, supervisors could have any number of backgrounds: assistant nurses in somatic or psychiatric care, registered nurses, social workers, clerks or simply a long experience of old-age care (Statistics Sweden 1989).

**Cut-backs and economy orientation**

The late 1980s and the 1990s were characterised by a hard-pressed public economy with cut-backs, repeated saving packages, and demands for increased efficiency within the public sector – with old-age care no exception. Among the very oldest (80+), the percentage receiving home help has decreased by one-third, and the percentage receiving residential care by one-fourth over the last two decades. Public care has more or less become reserved for the most frail elderly, often living alone, who need extensive help and assistance, often around the clock (NBHW 1998a).

The 1990s have also been characterised by great changes in the organisation of public care in Sweden. One revision of the law transferred responsibility for a great number of clients from the county councils to the municipalities, for instance people with learning disabilities, the physically disabled, and long-term psy-
From poorhouse overseer to production manager

Article 1. From poorhouse overseer to production manager

chiastic patients. Through a reform in 1992 (ÄDEL-reformen), the long-term medical care of elderly people, in nursing homes and in ordinary housing, also became a municipal responsibility. The reform also included a strong economic incentive for the municipalities to arrange non-hospital care for so-called bed-blockers, that is, hospital patients who are ready for discharge but cannot manage on their own (Styrborn & Thorslund 1993). One important aim of the reform was to promote a more efficient use of society’s resources; another was to strengthen the home care and make it possible even for very frail elderly people to stay in their own homes. Where this proves impossible, a range of types of institutional care should be offered in ‘special housing’ (särskilda boendeformer), i.e. home-like institutions, where the residents have a rental contract for their rooms, and bring their own furniture and clothes.

The municipalities have reorganised and introduced a market-oriented terminology and organisation, stressing target efficiency and financial control. One particular organisation-model has gained currency, especially in the bigger cities, namely the so-called purchaser-provider model (beställar-utförarmodellen). This organisational split has paved the way for private contractors of old-age care. In 1997, the municipalities had awarded about 10 percent of the institutions and 3 percent of the home help to private entrepreneurs (NBHW & Statistics Sweden 1998). For managers, this organisation has meant a new division into two separate occupational categories with either purchasing or providing tasks.

The purchasers go by various names: needs assessment officer, care manager, quality controller, purchaser consultant, etc. They have the authority to decide who gets assistance, what kind and how much, and how the services and care are purchased. They are also responsible for following-up and assessing the care-contributions and their quality. The providers of old-age care are business unit managers, managers of home care services, local managers, production managers etc., and they are responsible for the economy and personnel within their ‘business unit’ (resultatenhet), i.e. a home care district or/and an eldercare institution. They may be employed by the municipalities, by care-
contractors or by client- or staff-co-operatives, or even be self-employed.

It should be noted that not all municipalities have chosen to split managerial functions in this way. As a consequence of this, three distinct occupational roles now exist within the profession, one integrated and two specialised.

A further apparent trend in municipal administration has been a tendency to decentralise decision-making and responsibility to lower levels in the organisation. Decisions on priorities between different needs and different individuals have been transferred from the political to the professional level (Thorslund et al 1997). The managers of old-age care services have been given total financial responsibility for their units. The dilemma that managers experience in times of public saving and cut-backs is described in the professional journal:

> The harsh economy of the 90s has meant a great change in working conditions among the officials in charge of the social care services. In many municipalities there has been one saving package after another. Step by step, this has led to a situation, where further cut-backs affect the fundamental objective of the activity. As managers of the operations we are in a difficult situation... In our ambition to represent the employer, we must not forget our ethical duty towards the people who are depending on the services. (The Professional Journal, 1994)

As a result of the 1992 reform, a large number of health care personnel were transferred from the county councils to the municipalities. The number of managers with medical training (e.g. registered nurses and occupational therapists) rose considerably in the municipalities, while the managers of social care fell by 12 percent, from 6 300 to 5 600 (NBHW & Statistics Sweden 1993). Later statistics have shown the same tendency: the number of social care managers is decreasing, while the number of managers with medical skills is increasing. The described concentration of public old-age care to the most sick and dependent elderly has
also lead to increased demands for medical skills in the organisation in favour of the medical professions.

In their journal the professionals have discussed the supposed threats to their existence. As some municipalities have preferred to employ nurses as managers in old-age care, there has been a keen debate about what the necessary skills should be for managing the care of elderly people. The professional society has called for managers to be formally authorised, but these demands have been rejected just as they were in the 1950s.

During the 1990s the training has repeatedly been reformed and discussed. Central and local authorities have pointed at the important work the professionals do, and the great amounts of money they are responsible for, and have demanded a solid academic education. The professional body, which is striving to raise the training levels and gain respect for social competence, has encouraged this development. A growing number of professionals are studying for Masters’ degrees or PhDs, and in 1999 the first representative of the professional group obtained her doctorate (Gustavsson 1999).

In 1997, the National Agency for Higher Education suggested that training should be transferred from the county councils’ colleges for health professions to the state universities, and that it should result in a Bachelor’s degree or equivalent in social sciences. This would give the students an internationally accepted level of university education, and qualifications for PhD-studies. The affiliation of such training programmes to appropriate university departments has been carried out in a variety of ways around the country. In Stockholm, for instance, the education has been integrated into the University as a parallel programme to the existing one in Social Work. Although located to a department of social sciences, the programme features basic courses in geriatrics in order to equip students to assess needs in a more comprehensive way, and to co-operate with health-care staff when an old person needs professional medical care.
Concluding discussion

As demonstrated in this article, the job of supervisor or manager of public old-age care in Sweden has changed radically during the twentieth century, corresponding to the vigorous development of the public care of elderly people. A variety of forms have appeared and then disappeared, depending on the demands raised by society. An overview of the development is shown in Table 1 below. In this final part of the paper I will give some more detailed comments on some of the changes and trends.

Table 1. The development of the profession of manager or supervisor of old-age care in Sweden.

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<tbody>
<tr>
<td>Job title</td>
<td>Poor house overseer</td>
<td>Superintendent of poor relief institutions</td>
<td>Matron of old people's homes</td>
<td>Manageress of old people's home Home help organiser Home help supervisor</td>
<td>Manager of old age care Care manager Production manager</td>
</tr>
<tr>
<td>Training</td>
<td>None; a commission of trust</td>
<td>Various; Establishment of a training course</td>
<td>Gradually extended vocational training</td>
<td>2-3 years upper secondary training</td>
<td>Academic education 2-3.5 years</td>
</tr>
<tr>
<td>Job character</td>
<td>Control</td>
<td>Guardian of law and order; Master</td>
<td>Homemaker; Manageress; “Granny nurse”</td>
<td>Home help organiser; Supervisor of institutions and/or home help; Welfare distributor</td>
<td>Specialised or integrated professional roles; Control of quality and economy</td>
</tr>
<tr>
<td>Professional status</td>
<td>Amateur</td>
<td>Pre-professional</td>
<td>Professional ambitions</td>
<td>Professional ambitions within institutions; Home help services more amateur-status</td>
<td>Semi-professional Academic affiliation</td>
</tr>
<tr>
<td>Elder care policy</td>
<td>None Care by families; Poor relief in poorhouses or in the community</td>
<td>Poor relief in institutions</td>
<td>Old people's homes</td>
<td>A wide range of home help services and eldercare-institutions &quot;Old age care for all&quot;</td>
<td>Statutory right to care according to needs; Priority to the most frail; Reduction Economic orientation</td>
</tr>
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From poor relief to general welfare
– and to market-oriented eldercare

At the beginning of the twentieth century, public provision for the elderly was limited to the very poorest, those without means and without a family to provide for them. The supervisor was the controller of poor relief, acting as the extended arm of the authorities. However, by and by the stamp of poor relief was removed and at the end of the 1970s ‘old-age care for all’ almost became a fact. The home help supervisor became the mediator of the general welfare benefits during these ‘golden days’ of old-age care.

Now we are witnessing rather the opposite – public spending has been limited and old-age care has become more selective. This leads to difficult decisions about how care and services should be allocated, and about how different kinds of needs and individuals should be prioritised. Such decisions are increasingly decentralised to professionals at subordinate levels of the organisation – in old-age care to the managers and supervisors, who have to handle ‘the hot potato’ and often act as gate-keepers (Thorslund et al. 1997), a task to be compared to the controlling functions at the beginning of the century.

The introduction of a market-oriented ideology in the municipalities has also brought new ideals for the managers to try to live up to, such as target efficiency, budget control, cost effectiveness and quality assurance. Their professional titles have even been adjusted to the new terminology – it is now possible to be called production manager or quality controller in the public care of elderly people. The professionals describe the ethical dilemma they find themselves in, balancing the demands of being an efficient manager, responsible for the budget and, at the same time, a sympathetic care-giver.

Tension between medical and social care models and personnel

The supervisor was originally a social rather than a medical professional. Philanthropic organisations with strong social ambitions
influenced legislation, policy, and training in this direction (Edebalk 1991). In the middle of the twentieth century the under- 
lying social nature of the profession was transformed into a more 
medical one in old people’s homes. This was partly because of the 
residents’ need for medical care, partly because of the influence of 
the developing field of geriatrics. Supervisors and their training 
adapted to these demands, and for a long period around the 
middle of the century their professional role became that of the 
geriatric nurse, the “granny-nurse”. Then, however, in the 1970s 
and 1980s, the supervisory profession was de-medicalised, and 
training concentrated exclusively on social subjects. 

Today we can see tendencies to rivalry between the social and 
the medical professions in the field. When public funding is re-
stricted and public care increasingly is aimed at the most frail and 
dependent elderly, there is need for a comprehensive field of 
knowledge, based in social sciences but with complementary basic 
elements of geriatric medicine. For the future one can see a sce-
nario with a complex and fragmented old-age care system, a 
‘welfare mix’, provided by a variety of professionals and organised 
in various ways and by a range of providers, including voluntary 
organisations and, increasingly, families. This will require care co-
ordinators and managers to have an overarching view of needs 
and resources, and the social competence to co-operate across 
professional borders.

Care in a home or at home?

During the first half of the twentieth century, the public care of 
elderly people and its supervisors were solely institution-based. 
The authorities had a strong belief in the institutional care of 
elderly people, and the managers of these institutions gradually 
gained a fairly influential position. As a break to this policy home 
help services, with a quite different organisation and structure, 
were introduced in the early 1950s, and the managerial tasks 
changed substantially. Municipalities usually appointed clerks or 
home-carers to administer and co-ordinate home help. The 
managers of old people’s homes as well as the professional train-
ing were slow to accept this new variety of the professional role. However, by and by home-based and institutional care became regarded as necessary and complementary parts of the old-age care programme; the two professional roles were integrated, and are now seen as two sides of the same profession.

**Occupation and gender difference**

Even though old-age care, like child-care and nursing, mainly has been women’s work, supervisors have been both male and female over the years, depending upon the dominant demands of the time. In the early decades of the twentieth century the first superintendents to be appointed were men, often with a military background, which was appropriate for their primary tasks of maintaining discipline and controlling the inmates and their statutory obligation to work. The female matron at this time had duties of a more domestic and maternal nature, especially towards the ill and frail inmates and children, who at this time could be admitted to the same institutions as old people.

The first training courses had approximately the same proportion of men and women. However, as the poor relief institutions developed mainly into homes for frail and sick elderly people, caring and domestic skills were demanded, and men who did not have a wife to take care of these tasks, found it difficult to get employment as supervisors. Equally, the homemaker-profile, that of the creator of pleasant and home-like institutions for elderly people, suited a matron, who also had the female skills of sewing and weaving and who could be on duty around the clock, living (unmarried) in the institution. Consequently, men were not accepted onto the training courses for fifty years. Women dominate the occupation even today; only some five percent of care managers or supervisors are men. The current managerial profile, which has also been apparent in the UK, is said to have masculine characteristics (Davies 1995), with control of money and quality as an essential part of the work, and a more distanced position vis-à-vis

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8 between 1915 and 1965. Note that during the 1960s men began to enter traditionally female occupations, for instance nursing.
the care-users. Yet, the occupation does not seem to attract men to any increasing extent. The small proportion of men – some five percent – is constant, and the training courses often attract very few male students. Caring for elderly people remains a female domain.

**Professionalisation of old-age care**

The aim of this article has been to follow the development of two parallel phenomena: old-age care and the occupational role of manager and supervisor of this care. Professionalisation is a concept that applies to both. Professionalisation at societal level can mean that tasks that were earlier performed without payment, are transferred to the realm of paid work (Freidson, 1994). At the beginning of the twentieth century caring for old people was the work of amateurs. Elderly people were taken care of by their own families, or by families in the parish. For those who lived in poorhouses, both the ‘caring’ and the ‘supervisory’ tasks were performed by other, somewhat younger and healthier paupers. Poorhouse superintendents were some of the first to be employed in municipal poor relief, and little by little they were also allowed to appoint auxiliaries – public care of elderly people had begun to be professionalised in terms of being paid vocational work. Today, one of the guiding principals of age-care policy is that care should be provided by trained and qualified staff, and the age-care sector is one of the largest fields of gainful employment for women in Sweden (Statistics Sweden 1997). The trend is not wholly straightforward though; elderly people still receive a great deal of care from families, neighbours and friends, something which even seems to be on the increase (Szebehely 1998).

However, the primary focus of this article has been to trace the emergence and development of the occupation—the professionalisation – of supervisors or managers of old-age care. Professionalisation in this sense can mean the activities of occupational groups, in interaction with the state and the training institutions, to build up special professional skills, based on knowledge and education, in particular academic studies, and to achieve auto-
nomy in their work. This was especially visible in the period of institution-based care 1920 – 1950, with the training institution and the student association as instigators, but we have seen that there is no straight line in the development of the profession. The role has variously been one of social control, superintendent, paramedic, homemaker and carer, social worker, and budget manager. The professional role expected of the supervisors has reflected the prevailing official conception of the proper way to provide care for elderly people. As legislation and received policy wisdom have evolved, so the role of the supervisor has been repeatedly redefined.

Why is it that managers and supervisors of old-age care have such a contested profession? The literature offers various answers to this question. Experience from the UK (e.g. Hugman 1994b; Lymberly 1998) indicates, that discrimination against old age and work with elderly people – ‘ageism’ – is evident in the practices and organisation of caring professions, and that social work with older people has been of a markedly lower status than social work with children and families, and has been much less successful in establishing its professionalising claims. Another answer is that this is a public sector profession, and has been so from the start, and is as such subordinated to state bureaucracy and local authorities (Brante 1990). Other scholars point out that caring professions such as nursing, midwifery and social work, usually meet with resistance in their professional striving (Macdonald 1995). These are female professions, and according to Davies (1996) women are often by routine included in ill-defined support roles. Nordström (1998) refers to the special knowledge and context of the home help services and old-age care; the professionals within this domain are specialists in helping people with their daily lives and daily duties, a field that is difficult to professionalise in the traditional sense.

The changes that have been characteristic of old-age care over the last century, not only in Sweden, but in most countries in the industrialised world, have been radical. They have not merely been caused by the demographic situation, but also by the transformation of the principles of care: from poor relief to general welfare
and back again to a more selective contribution; from informal care to formal, and then on to more of a ‘welfare mix’; from institution-based to home-based care even for the very sick and dependent elderly, etc. It goes without saying that it is difficult to build a strong and distinct profession in such a turbulent field. For old-age care this might imply obstacles to gain respect and attention for the need of resources and space in the political field in competition with other strong professions in medicine, economy or technology. Considering the substantial growth of the elderly population that can be foreseen, in all probability accompanied by growing demands for service and care, this constitutes a serious threat to an essential object of the Swedish welfare state, the care of the elderly.

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**The Professional Journal has been edited under various titles:**

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Public Long Term Care in Sweden: Differences and Similarities between Home-Based and Institution-Based Care of Elderly People

Gun-Britt Trydegård

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Abstract

This article describes and compares public home-help services and institutional care of the elderly in Sweden, regarding the care-recipients, the care they receive and their care-givers. Interviews were carried out on 364 elderly (65+) care receivers, living in the community or in different institutions. Proxy interviews were used when direct interviews were impossible because of mental impairment or poor health. The institutionalized elderly were older and more often functionally disabled, especially cognitively impaired. They received more care and in more different forms than the elderly living in the community. However, the picture was not unambiguous. The occurrence of health problems, and the daily use of medication was rather similar in the two types of care. Half the home-help recipients received a great deal of help frequently, and sometimes even around the clock. There were many similarities between the recipients of high-extent home help, and the residents in service houses, concerning their health status and functions, and the care they received. Elders in other institutions suffered more often from poor memory, and they received help with daily functions to a much larger extent. The caregivers in institutions were primarily employed staff. In home-based care family and friends more often contributed in some of the tasks. Private service providers or volunteers were very sparse in both forms of care. [Article copies available for a fee from

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Introduction

Many studies in the fields of social and health policy have described the characteristics of elderly persons using different types of care. Some researchers have taken an interest in the targeting of home-help services, and effects that different risk factors can have on the use of these services (for example, Tennstedt et al., 1990; Thorslund et al., 1991; Bebington and Davies, 1993; Spector and Kemper, 1994; Ginn and Arber, 1995). Others have examined factors or characteristics that predict admission to different forms of institutional care for elders (for example, Kane and Kane, 1980; Sinclair et al., 1988; Clapham and Munro, 1990; Waerness, 1990; Jette et al., 1992; Higgs and Victor, 1993; Victor, 1995, Noro and Aro, 1996).

Although it is hazardous to compare studies from different systems for organizing service and care, the studies could be summarized like this: the most typical home-help receiver is a woman, very old (80+) and living alone – with difficulties in managing daily activities such as cooking, cleaning, washing, and so on (IADL limitations).

For those who move into sheltered housing or service houses, the criteria are rather vague. Studies mention those who live with a frail partner in poor housing conditions, with limitations primarily in functions such as eating, bathing, and using the toilet (ADL limitations).

For admissions to residential homes or nursing homes, cognitive impairment, such as dementia, seems to be a main reason – as well as high level of physical and social disability, and poor health. Failure of current domiciliary caring systems and absence of
family caregivers are also mentioned as main factors for institutional care.

The way in which an individual’s needs are met is not only a matter of individual characteristics, but of the social and caring context that they find themselves in. Higgs and Victor (1993) stress the importance of the existing health and social policy for service and care distribution.

Different countries have a range of mechanisms for the care of elders and an array of eligibility criteria for these resources (Kosberg, 1994). There is divergence in the location of services, which relates to the extent of home-based and institution-based responses to the needs of older people. Also the formation of services, that is, structure and organization, can vary (Hugman, 1994), and influence the use of services and care, as indicated by Wagner (1994).

Each country has developed a special welfare mix for services and care and a special balance in the division of roles and responsibilities between the state, the market, voluntary organizations, and the informal sector, that is, family, kin, friends, and neighbors (Evers, 1992). Daatland (1992) discusses this public-private mix in welfare states, and describes three forms of shared responsibility for dependent elders: The state can substitute for or replace the family, for those who lack families to provide for them. Responsibility can be shared over time and transferred from the family to the state, for instance when an elder is admitted to an institution. State and family can also be caring in partnership, for example, when an elder receives care from the family and at the same time, receives supportive home-help from the municipality.

Johansson (1991) discusses this kind of interaction in terms of task-sharing at the individual level. His findings from a Swedish study of elders, who live in their homes, indicated that task sharing depends on individual circumstances more than on a planned division of work. Szebehely (in press) found (also in Sweden) that the division of the caring work among public home-helpers, spouses, and non-cohabiting kin depends on how often a
task must be performed and the required amount of physical strength needed to perform it.

Dempsey and Pruchno (1993) describes how caring tasks were shared among staff and family in institutional settings in the U.S. Families viewed technical tasks (bathing, dressing, cleaning, medicating) primarily as a staff responsibility and viewed non-technical tasks (managing money, shopping, writing letters) primarily as a family responsibility. Work by Bowers (1988) suggests that family involvement in the care of elderly relatives in nursing homes is much more complex and extensive than is indicated by the visible tasks they perform.

**Care of elders in Sweden**

In Sweden, it is a fundamental principle that it is the society as a whole which is responsible for the care of elders. Public care should be professionally provided; it is heavily subsidized (Governmental Proposal 1987/88:176). Yet, informal care is extensive; studies have shown that spouses and next of kin contribute at least two to three times as much as public care for elders, who live outside institutions (Johansson, 1991; Szebehely, in press).

So far, the private for-profit sector has played a very small role in the Swedish system. In 1995, private interests accounted for about 5 percent of all elderly care. As a rule, the municipality finances and controls their activities (Swedish Institute, 1996). According to recent studies, voluntary organizations and their activities in Sweden are quite extensive. But in the social sector, they are seen more as a minor supplement to statutory services (Jeppsson Grassman, 1994).

For decades, there has been a strong emphasis on home care in the official Swedish policy, which states that older people should be able to live in their own homes as long as possible. For economic and humanitarian reasons, the dependence on institutional care should be reduced (Governmental Proposal, 1987/88:176). The public home-help services should make this
possible through a flexible range of services and care – domestic as well as personal – often combined with home health care, alarm systems, and so on.

At the end of 1995, 9 percent of elders (65+) and 21 percent (80 +) who lived in ordinary housing, received public home-help services (National Board of Health and Welfare, 1996a).

The amount of help from professional home helpers can vary – from one or a few hours per month to 24-hour care for persons with extensive needs. During one month (November 1995), 40 percent of the home-help recipients received less than 10 hours, 40 percent received between 10 and 49 hours, and 20 percent received 50 hours of help or more.

When institutional residence becomes the only option, the policy states that all institutions for elders should be as home-like as possible and should also be considered as the residents’ own housing. Elders hold contracts on their rooms, and they are supposed to bring their own furniture and clothes. They pay rent and fees for room, board, and care. But so far, not all institutions have been rebuilt to single rooms or apartments. Twelve percent of the residents share rooms with people who are not family (op. cit.).

Special housing is the official term for all public institutions for the care of elders, but they are traditionally of different character, and they offer care services that vary in scope and intensity (Swedish Institute, 1996).

In service houses, residents may, after a needs assessment, rent a one or two bedroom apartment and may also receive municipal home-help services – based on need. The tenants are supposed to use the restaurant and other service facilities in the building. The service houses are intended to enable independent living and to serve as a gathering place. But they have also been regarded as rather miscalculated, medium-level institutions, where residents’ needs often exceed the range of available services (Monk and Cox, 1995).

For elders in need of constant supervision and care, there are traditional old-age homes, with a higher level of communality in
residence. They offer small, single rooms with toilets, and also common day rooms and dining rooms. A regular staff provides 24-hour care. Meals are served communally at set times.

In 1992, responsibility for nursing homes was transferred to the municipalities from the medical system. They offer extensive nursing care to elders with severe medical needs, dementia, terminal illnesses, and so on. Physicians are not on the permanent staff.

During the last decade, group homes have become an alternative institution, mostly for cognitively impaired persons. Group homes have about six persons. Each resident has a room, shares communal areas, and has access to service and 24-hour care, which is provided by a specially selected resident staff (Swedish Institute, 1996).

In December 1995, about 8 percent of elders (65+) and 23 percent (80+) lived in some kind of long-term care institution (National Board of Health and Welfare, 1996a).

The smallest units of local government (284 municipalities) are responsible for social services, which include home-help services and institutional care of elders. Since a legal reform in 1992, the municipalities are also responsible for the main bulk of long-term health care for elderly people.

According to the Social Services Act (1982), everyone, whose needs cannot be met in any other way, is entitled to help and support from the municipalities – to be able to live independently with a reasonable quality of life. Municipal social workers (for example, home-help supervisors or special care managers) assess needs, which include the need for institutional care, while district nurses are responsible for the home health care needed. Nurse’s aides and assistant nurses provide the caring work. The municipality (or contractors) employs them on a part-time or full-time basis.

During the last two decades, the number of elders, who receive public home-help services and institutional care, has shown a relative and an absolute decrease – at least partly, because of strains on the public-sector economy. Among elders (80+), the
percentage receiving home help has decreased by one-third. The percentage receiving institutional care decreased by one-fourth (Szebehely, in press). There is also a tendency—in spite of the official policy—to a decreasing proportion of home-based care compared to institutional care. Of all elderly (65+) recipients of municipal care, the proportion who gets home-based care has decreased with 10-15 percentage points between 1985\(^2\) and 1995 (Statistics Sweden, 1986, National Board of Health and Welfare, 1996a).

Since the legal reform in 1992, there is strong economic incentive for the municipalities to arrange care outside the hospital for the so-called bed blockers, that is, hospital patients, who are medically ready for discharge but cannot manage on their own. The reform has increased the pressure on home-help services and other parts of the care continuum (Styrborn and Thorslund, 1993; National Board of Health and Welfare, 1996b).

In different ways, authorities are trying to mobilize alternative recourses, for example, from voluntary organizations. Thorslund and Parker (1995) and Szebehely (in press) report increased stress on families – to compensate for cutbacks in public care.

**Aims**

The aim of this article is to describe and compare home-help services and institutional care of elders in Sweden regarding the care-recipients, the care they receive and their care-givers. The following questions are raised:

- What differences and similarities are there between home-help recipients and elders living in institutional settings – regarding sociodemografic characteristics such as age, sex, and living situation?

\(^2\) The figures for 1985 are estimated because of changes in the statistical methods.
• What differences are there between the recipients of the two forms of care – regarding state of health, well-being, functional ability, and needs for assistance?

• What kind of help and assistance do older people receive in the different forms of care?

• What are the contributions of informal caregivers (family, neighbourhood, or voluntary organizations) in the different care settings?

Material and methods

This article is based on a study conducted in 1994 of social services and care of elders. The study investigated current changes in policy and practice and the consequences for elders in need of care.

Four municipalities, which vary in size, character, and social service organization, were selected for the study: two towns with 55,000 and 130,000 inhabitants and two Stockholm suburbs with 30,000 and 50,000 inhabitants. Besides population differences, the municipalities differed in resources for elderly care in relation to the size of the local population, regarding the scope of home-help services and the number of institutional beds.

In each municipality, 100 persons (65+) were randomly sampled from the local authority’s care-recipients lists: 50 who receive home-help services and 50 who live in institutions for elders (service houses, old age homes, nursing homes and group homes for the demented). The total sample then was 400 persons. The non-response rate was 9 percent (10.5 percent of the home-help recipients and 7 percent of the institutional-care residents).

Trained interviewers carried out face-to-face survey interviews. The questionnaire included questions about the respondents and their living conditions, health and functional ability, and their care situation. There were also questions – structured and open-ended – about the respondents’ judgment of the quality of care from different perspectives.
When direct interviews were impossible because of severe mental impairment or poor health (according to staff judgment), proxy interviews were used (12% in home-help services and 53% in institutional care). In the first place we chose the next of kin; otherwise the staff member who was most familiar with the respondent.

Because the four municipalities have different population sizes and 100 people were sampled from each municipality, data were weighted to adjust for the differences in population. All analyses in the next section are based on weighted data. The number of interviews agrees with the actual sample size.

### Results

#### Sociodemographic characteristics

Table 1 shows that most recipients of municipal elderly care were very old. About two-thirds of the home-help recipients, and three-fourths of the institutionalized elderly were over 80 years of age. Institutionalized elders tended to be older than the home-help recipients – about two years older on the average. Men were somewhat younger than women in both forms of care.

Women dominated both forms of care.

The recipients of municipal care lived alone to a great extent: 81 percent, who received home-help services, lived alone, while 16 percent lived with spouse. Only 3 percent lived with children or children-in-law. Among elders in institutions, a corresponding proportion (81% ) was single, that is, widowed, divorced, or unmarried. Of those who were married, no one shared rooms with a spouse. But every fifth person (19% ) shared rooms with one person or more, who were not family or kin. Compared to men, a larger proportion of women lived alone or were single.
Table 1. Sociodemographic description of elders (65+) in two different forms of municipal care in percent.

<table>
<thead>
<tr>
<th>Age</th>
<th>Home-based (n = 179)</th>
<th>Institution-based (n = 185)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>65-79 years</td>
<td>21.4</td>
<td>12.4</td>
</tr>
<tr>
<td>80-84</td>
<td>25.7</td>
<td>6.2</td>
</tr>
<tr>
<td>85-89</td>
<td>20.8</td>
<td>5.5</td>
</tr>
<tr>
<td>90+</td>
<td>7.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>75.0</td>
<td>25.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living situation/civil status</th>
<th>Home-based</th>
<th>Institution-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>84.9</td>
<td>88.4</td>
</tr>
<tr>
<td>Single&lt;sup&gt;a&lt;/sup&gt;</td>
<td>70.4</td>
<td>61.9</td>
</tr>
</tbody>
</table>

<sup>a</sup> i.e., unmarried, widowed, or divorced

Health status and functional ability

Table 2 shows reported health problems, functional disabilities, and existential problems among elders in the two forms of care. The table also accounts separately for those elders, who could participate in a direct interview.

Elders in institutions were, in almost every respect, worse off than the home-help recipients. There was a larger proportion in institutions who reported poor health and functional disability. The most obvious dividing line between the two forms of care was cognitive impairment: poor memory was three times as frequent among elders living in institutions. More than half in institutions were judged to be incapable of participating in a direct interview, mostly because of poor memory or confusion. Physical dysfunction was also much more frequent among those in institutions, for example, poor vision and mobility problems. Wheelchairs were used indoors by about 40 percent in institutions and by 5 percent in the home.
Table 2. Proportion of elders with reported health problems and functional disabilities in two different forms of municipal care in percent. Direct interviews reported separately.

<table>
<thead>
<tr>
<th>Care</th>
<th>All interviews</th>
<th>Direct interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home-based</td>
<td>Institution-based</td>
</tr>
<tr>
<td></td>
<td>179</td>
<td>185</td>
</tr>
<tr>
<td>Health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor or very poor health</td>
<td>36.2</td>
<td>42.0</td>
</tr>
<tr>
<td>Change for the worse during the last 12 months</td>
<td>47.9</td>
<td>56.8</td>
</tr>
<tr>
<td>Physical dysfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t read the newspaper, with or without glasses</td>
<td>18.6</td>
<td>49.7</td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t manage without mobility aid; indoors</td>
<td>45.6</td>
<td>76.2</td>
</tr>
<tr>
<td>out-doors</td>
<td>68.3</td>
<td>82.7</td>
</tr>
<tr>
<td>In bed most of the day</td>
<td>6.2</td>
<td>20.6</td>
</tr>
<tr>
<td>Balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vertigo or dizziness</td>
<td>51.6</td>
<td>49.4</td>
</tr>
<tr>
<td>Fallen indoors last 3 months</td>
<td>25.9</td>
<td>28.8</td>
</tr>
<tr>
<td>Cognitive dysfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor or very poor memory</td>
<td>18.9</td>
<td>57.1</td>
</tr>
<tr>
<td>Can’t participate in interview (according to staff)</td>
<td>12.3</td>
<td>53.0</td>
</tr>
<tr>
<td>Existential problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling lonesome</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Feeling unsafe</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

* Proxy interviews included.

Table 2 shows another apparent trend when comparing *all interviews* to the *direct interviews*. As mentioned earlier, proxy interviews were chosen when the staff reported that respondents suffered from severe cognitive impairment or were very unhealthy. So the direct interviews represent less impaired or healthier persons, which is especially reflected in the data from institution-based care. The data indicate that the directly
interviewed in institutions, to a minor extent, suffered from poor health, poor vision, and poor memory. In home-based care, where the proxy interviews were rather infrequent (13%), all respondents seem to show higher frequencies than those who were interviewed directly – only regarding poor memory.

There were also exceptions from the general pattern. Regarding the reported health problems, the differences between the two types of care were rather small. Among the directly interviewed, the home-help recipients reported poor health to an even greater extent than the institutionalized elderly. Vertigo or dizziness was somewhat more common among the home-help recipients, especially among the directly interviewed.

The direct interviews also included questions about feelings of loneliness and insecurity. Either living in the community with home help or in an institution, about one-third (with a small predominance for the institutionalized) said they were feeling lonesome, always or often, and stated that this was a problem for them. Feelings of insecurity were also reported to a similar extent, although from a minor portion.

Some other observations can be made about the findings in Table 2. One is that elders, who live in their homes with home-help services, reported health problems and were functionally impaired to a large extent. More than one-third suffered from poor and deteriorating health. Almost half needed mobility aids indoors and two-thirds needed them outdoors. Half the group had problems with vertigo or dizziness and one-fourth had recently fallen at home. Every fifth elder with home help suffered from poor memory. One out of eight could not participate in the interview, and there were also people who were bedridden most of the day (6%).

The data also revealed another side of the picture: among institutionalized elders, six out of ten said that they were rather healthy or very healthy. Among the directly interviewed in institutions, two-thirds had no problems concerning vision, and three-fourths considered their memory to be good or even very good.
Care consumption

What kind of help and assistance did elders receive in their homes – compared to in institutions? And to what extent? The questionnaire covered tasks in daily life; what elders could not manage on their own, and the help that they received. Table 3 shows the proportion of the elderly in the two forms of care, who received help in different regards from care providers of all kinds.

Table 3. Proportion of elders, receiving care (from all kinds of providers) in two different forms of municipal care in percent.

<table>
<thead>
<tr>
<th>Facebook</th>
<th>LinkedIn</th>
<th>Twitter</th>
<th>Instagram</th>
<th>Website</th>
<th>Email</th>
<th>Blog</th>
<th>Contact</th>
<th>About</th>
<th>Resources</th>
<th>Terms of Use</th>
<th>Privacy Policy</th>
<th>Help</th>
<th>Sitemap</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Municipal elderly care</th>
<th>Home-based</th>
<th>Institution-based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 179</td>
<td>185</td>
</tr>
<tr>
<td><strong>ADL functions</strong></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Bath/shower</td>
<td>43.2</td>
<td>85.7</td>
</tr>
<tr>
<td>Toilet</td>
<td>8.2</td>
<td>44.6</td>
</tr>
<tr>
<td>Going to bed</td>
<td>10.3</td>
<td>44.8</td>
</tr>
<tr>
<td>Getting dressed</td>
<td>16.1</td>
<td>56.4</td>
</tr>
<tr>
<td>Turn around in bed</td>
<td>1.3</td>
<td>23.5</td>
</tr>
<tr>
<td><strong>IADL functions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>97.0</td>
<td>97.1</td>
</tr>
<tr>
<td>Making the bed</td>
<td>28.0</td>
<td>73.4</td>
</tr>
<tr>
<td>Washing clothes</td>
<td>55.9</td>
<td>88.1</td>
</tr>
<tr>
<td><strong>Leisure activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going for a walk</td>
<td>27.5</td>
<td>67.6</td>
</tr>
<tr>
<td>Reading the newspaper</td>
<td>12.6</td>
<td>31.0</td>
</tr>
<tr>
<td>Shopping for clothes</td>
<td>58.1</td>
<td>81.8</td>
</tr>
<tr>
<td><strong>Medical care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily medication</td>
<td>85.0</td>
<td>88.3</td>
</tr>
<tr>
<td>Sedatives each day/night</td>
<td>27.9</td>
<td>40.5</td>
</tr>
<tr>
<td>or several times a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help managing medication</td>
<td>19.7</td>
<td>67.8</td>
</tr>
</tbody>
</table>

As might be expected, elders in institutions received different kinds of care to a much greater extent than elders living in the
community. For example, help with ADL functions, such as using the toilet and going to bed, was four to five times as frequent in the institutionalized group. About one-fourth of the institutionalized group was also helped to turn over in bed, which was very rare in home-based care. Help with most IADL functions, leisure activities, and managing medication were also markedly more common in institutions.

There is some notable divergence in this care pattern. One IADL function was quite similar in both kinds of care: almost everyone (97%), either living in the home or in an institution, received cleaning help. There was also one similarity in the healthcare sector: most (85 and 88%, respectively) were taking medicine daily.

In an attempt to get more information about the health status among the home-help recipients, the interviewers asked the respondents if they had been hospitalized during the last year (not accounted for in Table 3). It appeared that more than one-third had been admitted to the hospital and often for quite serious reasons, such as stroke, vascular diseases, cancer, fractures, or complaints that required surgery.

The results indicate that elders received the care that they said they needed – with only a few exceptions. Help to go for a walk, for example, was desired but not received by 30 percent of the home-help recipients and by 6 percent in institutions. There were also unmet needs reported in other leisure activities, for example, help in getting to activities, shopping for clothes, reading the newspaper, and writing letters.

The caregivers

It is obvious that the municipal staff was the dominant caregiver in all respects for elders in institutional care. With a few exceptions, these elders received help from the staff for ADL and IADL functions and for managing medications. Leisure activities, such as going for a walk, were somewhat less dominated by municipal staff.
Table 4. Caregivers to elders receiving help with different tasks in two forms of municipal care in percent.

<table>
<thead>
<tr>
<th>ADL functions</th>
<th>Home-based</th>
<th>Institution-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help getting dressed from</td>
<td>%</td>
<td>(n)</td>
</tr>
<tr>
<td>municipal staff</td>
<td>86.2</td>
<td>98.0</td>
</tr>
<tr>
<td>family or friends</td>
<td>13.8</td>
<td>2.0</td>
</tr>
<tr>
<td>100 (29)</td>
<td>100 (104)</td>
<td></td>
</tr>
<tr>
<td>Help bathing or showering from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>municipal staff</td>
<td>85.7</td>
<td>98.7</td>
</tr>
<tr>
<td>family or friends</td>
<td>14.3</td>
<td>1.3</td>
</tr>
<tr>
<td>100 (77)</td>
<td>100 (159)</td>
<td></td>
</tr>
<tr>
<td>LADL functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help cleaning from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>municipal staff</td>
<td>88.5</td>
<td>97.2</td>
</tr>
<tr>
<td>family or friends</td>
<td>6.9</td>
<td>2.2</td>
</tr>
<tr>
<td>privately paid service</td>
<td>4.6</td>
<td>0.6</td>
</tr>
<tr>
<td>100 (174)</td>
<td>100 (179)</td>
<td></td>
</tr>
<tr>
<td>Help washing clothes from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>municipal staff</td>
<td>49.5</td>
<td>93.3</td>
</tr>
<tr>
<td>family or friends</td>
<td>42.1</td>
<td>3.7</td>
</tr>
<tr>
<td>privately paid service</td>
<td>8.4</td>
<td>3.1</td>
</tr>
<tr>
<td>100 (107)</td>
<td>100 (163)</td>
<td></td>
</tr>
<tr>
<td>Medical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help managing medication from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>municipal staff</td>
<td>68.6</td>
<td>100.0</td>
</tr>
<tr>
<td>family or friends</td>
<td>31.4</td>
<td>--</td>
</tr>
<tr>
<td>100 (35)</td>
<td>100 (125)</td>
<td></td>
</tr>
<tr>
<td>Leisure activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help going for a walk from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>municipal staff</td>
<td>36.7</td>
<td>75.2</td>
</tr>
<tr>
<td>family or friends</td>
<td>59.2</td>
<td>23.2</td>
</tr>
<tr>
<td>voluntary organization</td>
<td>4.1</td>
<td>1.6</td>
</tr>
<tr>
<td>100 (49)</td>
<td>100 (125)</td>
<td></td>
</tr>
</tbody>
</table>

In home-based care, the pattern was only partly the same: municipal staff mainly provided ADL assistance and cleaning. Half of the home-help recipients, who needed laundry assistance received this from staff members, like...
two-thirds of the few who needed help with managing medication. One-third was assisted by staff to go for a walk.

Family or friends (spouses, children and children-in-law, friends and neighbours) were the second source of care. They provided quite extensive home-based care regarding two tasks: going for a walk, where they exceeded municipal staff considerably, and washing clothes, where family and staff contributed almost to a similar extent. Note that almost one-third in home-based care received help from their families with managing medication. This task was totally staff-dominated in institutions.

Elders in institutions received help from family or friends mostly to go for a walk (about one-fourth). Otherwise family contributions were rare in institutions. Other caregivers, such as private service providers or volunteers, were rather sparse in both forms of care – only 5-8 percent of the home-help recipients and 1-3 percent of institutionalized elders used privately paid cleaning and laundry services. Voluntary organizations assisted in going for a walk, but to a very little extent.

**Care from municipal staff**

Table 5 provides more information about the care performed by municipal staff, its extent, and frequency. Note that there were difficulties in measuring the extent of care, counted in hours per week or per month. In institutions, for example, help and assistance from staff is given as needed and is not counted in hours or minutes. The same applies to home-help services. Today, this help is specified as assistance with certain tasks and not in hours.

Yet the interviews revealed that those who were receiving help occasionally, for example, cleaning help twice a month or bathing/showering help once or twice a week, could calculate more easily the approximate extent of the help that they received. Table 5 presents this rough measure called
low-extent help, which corresponds to less than 10 hours each month.

Table 5. Percentage of elders receiving help from municipal staff in two different forms of elderly care.

<table>
<thead>
<tr>
<th></th>
<th>Municipal elderly care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home-based</td>
</tr>
<tr>
<td></td>
<td>179</td>
</tr>
<tr>
<td>Help extent</td>
<td></td>
</tr>
<tr>
<td>Low-extent help (&lt;10 hours/month)</td>
<td>47.9</td>
</tr>
<tr>
<td>Help frequency</td>
<td></td>
</tr>
<tr>
<td>Help more than once a day</td>
<td>28.7</td>
</tr>
<tr>
<td>Help in the evenings (4 - 9 p.m.)</td>
<td>20.6</td>
</tr>
<tr>
<td>Help during the night (after 9 p.m.)</td>
<td>10.1</td>
</tr>
</tbody>
</table>

About half the recipients of home-help services, stated that they received this low-extent help – compared to one out of ten in institutions. As might be expected, there were also considerable differences in care frequency: elders in institutions received help from municipal staff more often and during evenings and nights to a far greater extent than the home-help recipients.

Note that about one-fourth in institutions stated that they did not receive help more than once a day. One-fourth reported no help in the evenings, and more than half did not report supervision or assistance during the night.

A closer scrutiny of the other half of the home-help recipients, those with high-extent help, revealed that they received help not only to a greater extent, but also more frequently. Almost all (97%) were getting help seven days a week, and half of them more than once a day. About 40 percent received help in the evenings and 20 percent during the night. The home-help recipients were thus divided into two different groups: a rather self-reliant group
vis-à-vis the municipal care, and a rather dependent group, with frequent and extensive help.

This forced the question: For the dependent group and its care situation, how did it differ from institutionalized elders, especially from those living in service houses? (Service houses are supposed to provide the lowest level of institutional elderly care. In this study, the main proportion of elders in institutions who received low-extent help, lived in service houses.)

Four diverse groups of care recipients?

As indicated in the above section, the respondents might be divided in four diverse groups:

1. Recipients of low-extent home help
2. Recipients of high-extent home help
3. Residents in service houses
4. Residents in other institutions, such as old age homes, nursing homes, and group homes

A comparison between these four groups revealed different tendencies.

The most striking tendency was that there were more similarities between the home-help recipients, who receive high-extent help, and the residents in service houses, than there were within the home-help groups or the institutional groups. This was the case, for example, regarding the proportion with poor health, use of mobility aids (indoors and outdoors), problems with vertigo or falls indoors, and poor memory. Likewise they were bedridden and used sedatives or sleeping drugs to an almost similar extent.
Figure 1. Comparisons between elders receiving home-help of low and high extent and elders living in service houses and other institutions, regarding health, functions and received care in percent.

The care they received was also comparable: similar proportions of those with high-extent home-help and the residents in service houses received help with bathing or
showering, getting dressed, managing medication, cleaning, and laundry. There was no large divergence in the proportion who received help more than once a day or during the night.

Also note that receivers of high-extent home help reported poor health and used medication daily to an almost similar extent as residents in old-age homes, nursing homes and groups homes. However, the latter suffered more often from poor memory and also received help with daily functions to a much greater extent than all other groups.

Discussion

In surveys of elderly care recipients, it is essential to be aware of problems in getting information from the most frail and dependent elders, especially those who are demented or confused. Nevertheless, they must not be excluded from investigations; this requires proxy interviews. This study conducted proxy interviews with 12 percent of the home-help recipients and 53 percent in institutional care. Efforts were made to find a family or staff member, who was most familiar with the respondent. In the proxy interviews, questions about value judgments such as the quality of care, were excluded. Personal questions on existential matters were also excluded from proxy interviews. According to Seeman (1994), data provided by proxy respondents do not seem to bias the results in specific, concrete questions, even if proxy respondents seem to be more likely to overestimate levels of functional impairment, while elderly, self-responding people tend to deny or rationalize their deteriorating health. In reference to Table 2, it might be noted that the contribution of the proxy interviews provided a different and probably more realistic picture of the elderly care recipients, especially of those living in institutions – compared to results based only on direct interviews with self-responding people.
This study demonstrated the differences between elders, who receive home-help and elders, who live in institutions in Sweden today. Institutionalized elders were, as expected, older and more often functionally disabled and especially cognitively impaired. In these respects, the study corresponds to earlier studies (for example, Kane and Kane, 1980; Jette et al., 1992; Victor, 1995).

But the picture was not unambiguous. The occurrence of health problems was rather similar in the two types of care, as was daily use of medication. Also note that the home-help recipients in this study were physically impaired to a high extent and that it was not exceptional that they received help several times a day and even around the clock. About one-third had also experienced hospital care during the last 12 months for quite serious causes. There was also the other side of the picture: among elders in institutions, a majority stated that they were healthy and did not have problems regarding vision or balance.

Similarities between home-based and institution-based care were further emphasized through the analyses of the four subgroups of care recipients. Those who received high-extent home help and the elderly living in service houses were alike. In many aspects, they differed from the other two groups (the elderly with low-extent home-help and those living in institutions other than service houses).

To summarize, these results illustrate Hugman’s (1994, p. 102) thesis that the range of services for older people has two dimensions: residence and care. It is not always the case that a high level of communality in residence corresponds to a high level of care and vice versa. For example, domiciliary care, that is, a low degree of communality in residence, can be combined with a low, medium, or high level of care.

In this study, women made up the largest majority who received both kinds of care. This not only reflects the fact that there are more women than men in the highest age ranges: women are also more likely to receive public home-
help and to become institutionalized than older men, because women are less likely to be living with and cared for by a spouse late in life (Waerness, 1990; OECD, 1996; Szebehely, in press).

The majority of respondents in home-based care and in institutions were living alone or were unmarried, divorced, or widowed. Living alone at an advanced age is known to be a strong predictor for receiving home-help services and also for admittance to institutions (Sinclair et al., 1988; Thorslund et al., 1991; Bebbington and Davies, 1993; Higgs and Victor, 1993).

Feelings of loneliness and insecurity were reported from almost the same proportion of elderly in both kinds of care. Living in an institution, with staff and other residents around all the time, did not seem to eliminate feelings of loneliness. As shown by others (for example, Mullins, 1996), being alone is not equivalent to feeling lonesome. On the other hand, we might expect that elders living in ordinary housing, with more or less sparse visits from home-helpers and perhaps a visiting nurse every now and then, would feel lonesome and unsafe to a greater extent, but this was not the case. There were very few elders, in both kinds of care, who said they felt unsafe, irrespective of the distance to staff.

As might be expected, help and assistance were much more extensive and frequent in institutions than in home-based care. This was true about most ADL and IADL functions, health care, and leisure activities and could correspond to a higher need for help among the institutionalized elderly. But it could also (at least partly) illustrate what has been called a state of acquired incompetence among older people who live in institutions (Evers and Olk, 1991, p. 79), and a service package solution offered by the personal, as described by Wagner (1989, p. 52). It might be adherent to the institutional order to have the bed made, the clothes washed, the room cleaned, and professionals taking
care of medication – regardless of whether the resident needs help with these things. Likewise, the residents’ frequent use of wheelchairs indoors might meet the needs of the staff rather than the residents.

In home-based care, this study found some shared responsibility between family and staff, but in institutional care, the municipal staff performed most services. Family members and friends contributed rarely. It was only during leisure that they assist their institutionalized elders. Why didn’t family or friends seem to contribute to the same extent as in home-help services, when institutions, according to the Swedish policy, should be home-like and regarded as the residents’ housing? Is the explanation simply that institutionalized elders lack family and social networks to a larger extent and that public care therefore replaces the family? Was family contribution in institutional care of more invisible character, as Bowers (1988) found in her studies? Or could it be a sign of the traditional view of institutions, described by Goffman (1968), as the home ground of the staff, where residents and their relatives feel uncomfortable and uncertain of the routines and rules?

Besides the lack of family contributions in institutional care, there were also few signs of care contributions from voluntary organizations and privately paid services. But note that this sample represents elders, who were assessed to get the benefit of public care, because their needs cannot be met in any other way. So “consumer-based” studies like this one underestimate the informal care in society as a whole. A population-based study would probably provide another picture with a more apparent mix of welfare providers, as described, for example, by Baldock and Evers (1992).
Acknowledgements

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References


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DATE MANUSCRIPT RE-RECEIVED IN ACCEPTABLE FORM: 09/02/97
Inequality in the Welfare State?
Local Variation in Old-age care – the Case of Sweden.

Gun-Britt Trydegård & Mats Thorslund
Accepted for publication in International Journal of Social Welfare.

Abstract
Equality is a central goal of the Scandinavian welfare state and a main focus of political discussion and research. Geographic variation in the provision of essential services is reported from many countries in the industrialised world. This article aims to describe and analyse local variation in services and care for elderly people, using Sweden as a case. Responsibility for these services lies with the municipalities. National statistical data on municipalities are analysed to map out the variations in old-age care; to study compensating factors in the care system; and to explore the connection with municipal structural and political conditions. In 1997, the coverage rate of home help to elderly people (80+) ranged between 5 and 52 percent, average 19 percent. Municipalities did not even out low coverage by giving more hours of help per recipient, and only to some extent by providing institutional care. The overall finding of the bivariate analyses was that most relations with structure and policy were weak or non-existent. The final multivariate model explained only 15 percent of the variance. The large differences between municipalities makes it more appropriate to talk about a multitude of ‘welfare municipalities’ rather than one single welfare state. The article concludes that this municipal disparity constitutes a greater threat to the principle of equality in old-age care than gender and socioeconomic differences.
Key-words: Home help, municipal variation, regional inequality, welfare municipality.
Introduction
The Scandinavian countries, including Sweden, are often described as institutional welfare states characterised by values such as equality, universality and equity. Inhabitants have a basic right to a very broad range of benefits, which enable them to enjoy an adequate level of living. The Scandinavian welfare states have sought not only to eliminate poverty, but also to reduce inequality (Esping-Andersen, 1990; Esping-Andersen & Korpi, 1987; Kauto, Heikkilä, Hvinden, Marklund & Ploug, 1999). Inequality, as a consequence of socioeconomic position or gender, has been a main topic of discussion at central and local decision-making levels (SOU 2000:3), and has also been the theme of an extensive research tradition (see for instance Eriksson, Hansen, Ringen & Uusitalo, 1987; Korpi, in press).

One important feature of the Scandinavian welfare state model is general access to social services such as child-care, old-age care, and support and services for persons with disabilities; the Scandinavian welfare state is not merely a “social insurance state”, but to a great extent also a “social service state” (Anttonen, 1990). These services have been broadly accepted, are used by all classes in society, and have wide public support (Kautto et al., 1999; Szebehely, 1999).

Yet another distinctive trait of the Scandinavian model is that main responsibility for the social services rests with the smallest units of local government, the municipalities. The central government’s instruments of control within the field of old-age care, legislation and state subsidies, are of a general nature: Legislation constitutes a framework without detailed regulations, and state subsidies are distributed as block grants. Furthermore, recent years have seen a noticeable trend towards greater decentralisation of decision-making, from the state to the municipalities, and from higher to lower levels in the organisation (Pierre, 1997; Thorslund, Bergmark & Parker, 1997). The municipalities enjoy great freedom to decide on the scope and quality of their services, and at the individual level, to determine eligibility criteria as well as the amount and kind of help to be delivered. Locally elected politicians levy taxes and set the charges for services. “Welfare munici-
Article 3. Inequality in the welfare state?

“Equality” is the term which has been used to describe the significant role of local governments in the making of social policy in Scandinavia (Grønlie, 1991; Kröger, 1997).

A strong local autonomy in combination with increased decentralisation can lead to large variations in the distribution of municipal services (Stjernquist & Magnusson, 1988), which has turned out to be the case within eldercare in Scandinavia (see for instance Boll Hansen & Platz, 1995; Daatland, 1997; Naess & Waerness, 1996; Sundström & Thorslund, 1994). The differences across municipalities are great in terms of coverage, cost and accessibility and exist both in home-based and in institution-based care. The variations within the Scandinavian countries are said to be even larger than those that exist between the countries (Daatland, 1997).

Regional and local imbalances and variation, both in the need for care and available services, are also reported from countries outside Scandinavia. Studies of ‘welfare geography’ have identified spatial variations in the provision of essential services and highlighted questions of territorial injustice, for instance in Britain, New Zealand, the US (cf. Mohan, 1998). Local differences in old-age care have been particularly apparent between rural and urban areas in Eastern and Western Europe, in Japan and China, and in Canada (Olson, 1994). Other examples are reports on geographically uneven distribution of voluntary services for elderly people and their carers in the UK (Milligan, 1998); territorial differences in the provision of home help and of residential care, mainly between the Northern and Southern part of Italy (Gori, 2000); and regional inequities in health care for elderly people in Portugal (Santana, 2000).

It is more remarkable, however, to find geographical inequality within welfare states with a social policy of institutional and universal character (Esping-Andersen, 1990). Equitable public care of disabled and elderly persons is central to the notion of a ‘social service state’ (Anttonen, 1990; Hanssen, 1997), and it is not in accordance with established policy that the probability of receiving care and services in old age should depend on one’s residential location. Geographical inequality within one of the core social
services, old-age care, indeed challenges the concept of a uniform and universal welfare state. In this paper we address the geographical differences in home help services to elderly people, using Sweden as a case.

**Old-age care in Sweden**

In an international perspective, Sweden (as well as the rest of Scandinavia) has a far-reaching system of public home-help services which make it possible for elderly people to age in place; to stay in their own homes even when they are very frail and are in extensive need of care and support, often around the clock (Hugman, 1994; OECD, 1996). Help with domestic duties and personal care can be combined with meals-on-wheels, security alarms, transport services, day care and the like. Visiting nurses provide medical care in the home or in health centres. The smallest units of local government, the municipalities, which vary greatly in size and population density, are responsible for home-help services as well as for the institutional care\(^1\) of old people. Since the ‘ÄDEL-reform’ in 1992, they are also responsible for the main bulk of long-term medical care for elderly people, except for acute hospital care and medical attendance from physicians.

The home help services are regulated in the Social Service Act, which states that local authorities have a mandatory responsibility to provide domiciliary services to elderly people. Everyone is entitled to help and assistance according to need, if he or she cannot manage on his/her own and his/her needs cannot be met in any other way (section 6). However, the act is a goal-oriented framework law, which leaves to the municipalities to decide what measures are to be taken, and what level of service to offer. The

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1 The formal term for all kinds of institutional care for elderly people in Sweden is ‘special housing for service and nursing’. This includes sheltered housing in so called service-homes as well as more traditional forms of residential care, for instance old people’s homes and nursing homes. In this paper we use the terms special housing and institutional or institution-based care.
local social welfare committee takes the overarching decisions and sets local guidelines for old-age care. At individual level, a municipal social worker – either a home-help supervisor who may also have managing duties within the home help services, or a special ‘care manager’ – is commissioned to assess needs and to decide what kind of and how much assistance and help a person shall receive.

To improve case processing and targeting, and also to increase efficiency, a large number of municipalities (more than 50 percent) have in recent years chosen to organise their old-age care according to a ‘purchaser-provider model’. Special municipal officials have the authority to administer needs-assessments and purchase the decided services and care from special care-providers, which can be either the municipal home-help services (regarded as ‘business units’) or private entrepreneurs. In 1999, private providers delivered about 9 percent of public old-age care (NBHW 1999). The services provided are all still publicly financed and controlled, and the users pay fees to the municipality according to their ability to pay and the scope of services. However, only a fraction of the total costs for old-age care is covered by user fees (National Board of Health and Welfare, Swedish Association of Local Authorities & Statistics Sweden, 1999).

**Rethinking and change**

In the 1970s, which were the ‘golden days’ of old-age care in Sweden with expansion on all fronts, home help services were very far-reaching and, at their peak, nearly a quarter of all retired elderly people (65+) received home help in the course of a year. All socio-economic groups used the services, not only the poorest (Szebehely, 1998). However, the late 1980s and the 1990s were characterised by a hard-pressed public economy with cut-backs and demands for increased efficiency, at the same time as the elderly population increased substantially. These circumstances have led to rethinking and changes in the welfare systems (Baldock & Evers, 1992). Where care of the elderly is concerned, the municipalities began to apply the Social Service Act more
strictly and stress target efficiency and prioritisation (Thorslund et al., 1997; Szebehely, 1999). Public care has more or less become reserved for the most frail elderly, often living alone, who need extensive help and assistance, sometimes around the clock. It is also increasingly concentrated on help with personal care. Among the very old (80+) the percentage receiving home help has fallen by one-third, while the percentage in residential care has fallen by one-fourth over the last two decades (NBHW, 1998). See Table 1 below, for present average figures for the two main forms of old-age care: home help in ordinary housing and special housing.

### Table 1. The average proportion (%) receiving public home help and living in special housing in different age groups in Sweden, 31-12-1997.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>0-64</th>
<th>65-79</th>
<th>80+</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-help in ordinary housing</td>
<td>0.2</td>
<td>4</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Special housing</td>
<td>0.1</td>
<td>3</td>
<td>24</td>
<td>9</td>
</tr>
</tbody>
</table>


Municipal home-help services in Sweden have, on the whole, been described as fairly equally distributed, both in terms of class and gender (Sundström & Thorslund, 1994; Szebehely, 1998). The current cut-backs do not seem to have affected this equality, even though growing differences have been seen in the informal care sector with more family care among less well-off groups while more well-off persons turn to market solutions (Szebehely, 1998). However, the local variations, mentioned earlier, regarding access to home-help services and special housing for elderly people may be a sign of geographical inequality. It has also been reported, that fees for old-age care vary unacceptably from one municipality to another. Whether the quality of care also differs has not so far been systematically investigated (NBHW, 1999). As differences
can also be expected to increase with the greater degree of decentralisation, they must be considered a definite threat to the basic principles of equality and equity in the Swedish welfare state (Thorslund et al., 1997).

Studies of regional and local variation
Several efforts have been made, both by authorities and researchers, to explore and explain the local variation in the Scandinavian old-age care distribution. No one, however, has succeeded in explaining more than a very small part of the variation, or in finding any distinct pattern. Various hypotheses have been examined, some concerning the care needs in the population (Berg & Sundström, 1989; NBHW, 1996), others the structure of the municipality in terms of size, urbanisation rate, and regional location (Boll Hansen & Platz, 1995; Næss & Wæreness, 1996). Factors linked to economic resources and political ambitions or prioritisations have also been looked into (Berg & Sundström, 1989), but only very weak relations were found. Hörstedt, Prütz, Wells, Edebalk & Lindgren (1996) managed to explain much of the variation in costs per capita (i.e. the total costs distributed across all inhabitants in the municipality) for old-age care in Sweden by – as might be expected – structural and instrumental factors such as the number of old and disabled persons in the population and the proportion of elders receiving public care, especially institutional care or home nursing care.

In adjacent fields such as child welfare or social assistance, studies have been performed from an "ecological perspective", that is, with the aim of exploring factors in the environment, which might affect child maltreatment and child welfare contributions (Garbarino, 1992; Lundström, 1999) or need of social assistance (Bergmark & Sandgren, 1998). In this article, local variations in the old-age care in Swedish municipalities – chiefly home-help services to the oldest age group, 80 years of age or over – are researched, using aggregated data which reflect municipal characteristics rather than individuals.
**Aims and research questions**

The aim of this article is to describe and analyse the local variations in the distribution of home-help services for elderly people, using Sweden as a case, and also to explore whether these variations are connected with differences in municipal structural and political conditions.

The following questions are raised:

- What is the present distribution of public home help in the Swedish municipalities – what are the local variations in 1997?
- Are there any compensating factors in the system of care for the elderly which ‘even out’ the local variations; for example, do municipalities with low rates of home-based care instead have high rates of institution-based care, and vice versa? Or do municipalities with low coverage rates of home help offer services of high intensity instead, i.e. many hours of assistance per user, and vice versa?
- Are the local variations in home help coverage related to demographic or other structural conditions in the municipalities? Or do they indicate disparate local policies and resource allocation?

**Material and methods**

**Data**

The analyses are based on current official statistical information about social services in the Swedish municipalities. Data on old-age care and services, financed and controlled by the municipalities, are provided by the municipal administrations once a year, then checked and revised before publication by the National Board of Health and Welfare (NBHW). Data are also published in

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2 note that in 1997, the year of our analysis, there were 288 municipalities; in 1999 the number increased to 289.
the form of a database: "Comparison Material for the Social Services" by the NBHW in co-operation with Statistics Sweden and Swedish Association of Local Authorities. It should be noted that care provided by private entrepreneurs on commission from local authorities is also included in these statistics.

The quality of these data is judged to be satisfactory, although there is some uncertainty, for instance about how the category of "special housing" has been defined (Swedish Association of Local Authorities, 1999). Carsjö, Thorslund & Wärneryd (1994) studied the validity of administrative registers of service utilisation and concluded that registers that also are used for service charges – such as the home help register and the special housing register – seem to be largely accurate, since it is an economic incentive for the municipality to maintain accurate registers.

For demographic, structural, political and economic information about the Swedish municipalities as well as facts on available municipal services, we used a database, ‘KFAKTA99’, compiled from various official sources at the Department of Political Science, University of Lund. Information about the current organisation of old-age care in the Swedish municipalities was obtained from the NBHW.

However, some unfortunate limitations do characterise data categorising municipalities. Firstly, the statistical information focuses on the elderly population as a whole, not on individuals. For instance, we know very little – only age and sex - about who are receiving home help or whether they also have access to supplementary services, such as meals-on-wheels, day care, safety alarms, etc. Secondly, none of these services, essential in the old-age care system, are accounted for in the annual statistics. Thirdly, there is no data at municipal level on health status, functional ability, or the use of medical care, nor is there any information on social networks or family circumstances, all of which are important in studies of care-needs and care utilisation in the elderly population. For this kind of information we were obliged to rely on indirect indicators available in public databases.

The data were analysed by the SPSS programme, using bivariate and multivariate regression techniques.
**Choice of variables**

**Coverage and intensity**

In our study we used the *coverage rate of home help*, i.e. the percentage of municipal residents of a certain age receiving public home-help or home nursing care in ordinary housing at a given time. This relative measure makes it possible to compare municipalities of varying size and with differing proportions of elderly people in their population. We focused on home help because, in contrast to institutional care, it does not have the inertia caused by investments in physical buildings, and can therefore change scope and direction more easily. To use a metaphor, home help is the ‘light brigade of the municipality’s elder-care forces’, easy to move and to adjust to the needs of the moment. For analytic purposes we were also interested in the *intensity* of home help, measured by the number of help-hours per recipient per month, and the *coverage rate of special housing*.

We have chosen to study the oldest age group (80 years of age and over), because in this age group we find the most frail elderly whose needs are difficult to ignore. Living alone is also most common in the oldest age group, a condition that makes elderly people more dependent on public services.

We used data from 1997 because changes in the statistical methods and missing values in the latest available data (from 1998 and 1999) made these less usable.

**Demand and supply of services**

The selection of variables for the analyses was based partly on previous studies, partly on our own considerations. Influenced by Hanssen (1997) and Hörstedt et al. (1996) we used two kinds of variables: indicators of the *demand* for care and services among the elderly at municipal level (the structure of the population and of the municipality), and indicators of the *supply* of services (local-government economy and politics). The latter are instrumental factors which the municipality can influence, unlike the former, structural factors.
Population structure
When looking at demand, we considered the possibility that the elderly population in different municipalities may have different levels of need in terms of health status and functional capacity. As mentioned above, this kind of information is not available at aggregated level, and we were obliged to rely on indirect indicators. We chose demographic information, such as life expectancy at 60 years of age, a measure related to health status and functional capacity in the elderly population. The percentage of the oldest (80+) in the population, of persons 80+ living alone and of female population were included, since these have proved to be predictors of home help utilisation at individual level (Thorslund, Norström & Wernberg, 1991; Szebehely, 1998; Trydegård, 1998). We also used a variable that might have the opposite effect on home help utilisation, namely the percentage of non-Scandinavian immigrants in the population – immigrants are reported to use public old-age care much less than the Swedish population in general (Eriksson, 1996). One further demographic factor was included, namely the population change over the last ten years (index; 1986 = 100), because depopulation can be assumed to give rise to a higher demand for public home help for the elderly persons left behind.

As indicators of the general health status in the municipality we used ill-health rate, defined as average days of absence from work with compensation from the social insurance system among those under retirement age, and average income (given the connection between income, health and functional ability respectively, showed by Lundberg & Thorslund (1994)).

Municipal structure
Our assumption was that structural and environmental conditions in the municipality also may affect the demand for home help services. The annual national analyses of old-age care distribution, for instance, indicate that home help coverage differs between different types of municipality. In censuses the Swedish municipalities are classified in nine categories: big cities, suburbs, industrial municipalities, sparsely populated municipalities, etc.,
according to a combination of population, location, and economic factors. We used the municipal categories as (9) dummy variables. We also included data about the structure of trade and industry in terms of percentage of the labour force in farming or industry and building, or service sector employment. The influence of the percentage of unemployed of the working age (16 – 64 years), and the percentage of those in gainful employment, especially among women, were explored. The situation in the labour force may be seen as a sign of the supply of manpower, but also as an indicator of the economic structure in the municipality.

However, the utilisation of home help depends not only on the demand for care but also on the supply of services in the municipality, which, in turn, depends on the local government’s resources and political will. We therefore included indicators of the local economy and organisation, and also of politics in general and political priorities.

**Local economy and organisation**

The financial status of the municipality was measured by tax rate, financial result, long-term municipal debt and total municipal expenses, the three latter in SEK per inhabitant. Our assumption was that municipalities with healthy finances would be better able to afford home help for their elderly than municipalities with financial problems. The tendency to contract out municipal services to private entrepreneurs was measured partly by the degree of privatisation (index of 5 services), partly by the occurrence of a purchaser – provider model for municipal old-age care. The choice of this organisational model might imply a stricter assessment of needs and a harder control of resources, and therefore a lower coverage of home help.

**Local politics and priorities**

The political profile of a municipality was investigated by the percentage left-wing politicians (social democrats and left party) on the municipal council for the period 1994 – 1998, i.e. those who might be expected to support public care-contributions. As old-age care is a mainly female domain and responsibility, the impact of the percentage of women on the municipal council and of
female chairpersons of local authorities was explored. We also tested the consequences for home help of the age of the chairperson of the municipal executive board, with the hypothesis that politicians of a more advanced age would prioritise old-age care in their municipality, since they themselves might well have elderly parents in need of services or care.

Local political priorities in other fields of social policy were measured by the costs in SEK per inhabitant for child-care services, education, and social services, including child welfare, drug-abuse treatment and social assistance. The amount of housing allowance in SEK per pensioner was supposed, together with the average number of home-help hours and the coverage rate of special housing, to reflect the priority given to care of the elderly.

**Missing values**

We had complete data from all 288 municipalities except for two variables: ‘life expectancy at 60’, which was missing for two big cities, and ‘divided organisation’ which was missing for six municipalities belonging to a variety of categories.

**Analyses**

The current distribution of the coverage rates for home help and special housing and the intensity of home help provision in Swedish municipalities were explored univariately and bivariately, and presented in numerical and graphic form.

The first step of the concluding multivariate analyses was to examine each separate independent variable for bivariate correlation (Pearson’s correlation coefficient) with the home help coverage rate. To examine the combined effect of independent variables, we tested those significant in the bivariate analysis in multiple models (linear regression) with the aim of finding as high an explained variance as possible. We also wanted to study the effects of each independent variable while controlling for the effects of others. For the variables ‘municipal type’ (nine dummy variables) and ‘trade and industry’ (three variables) the explained $r^2$
of the bivariate analyses refers to the combined explained variance.

In the multiple models the coverage rate of special housing was first included because to some degree it compensates for home help. The theoretical considerations earlier mentioned (see Hanssen, 1997) suggested the order between the four headings (population structure, municipality structure, local economy and organisation and local politics and priorities). Following a forward stepwise procedure (Edlund, 1997), the variables under each heading were then included, maximising the explained variance. The criteria were the contributed explained variance and level of significance. We started with the variable with the highest explained variance and then included the other variables under the same heading one at a time, and selected those which contributed most to the explained variance (contribution still being significant). Variables once selected under each heading were then kept in the model.

Results

The provision of old-age care in the Swedish municipalities

In 1997, the coverage rates of old-age care varied considerably in the 288 Swedish municipalities, independent of age group and location of services. Home help for the oldest age group (80+) demonstrated the greatest variation, from 5 to 52 percent. Some values were extreme\(^3\), but half of the municipalities varied between 17 and 23 percent. There was a smaller but nevertheless considerable dispersion of the coverage rate for special housing, which ranged between 13 and 41 percent in the oldest age group.

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\(^3\) The extreme value ‘52’ may seem erroneous, but as this value has been checked and published by the producers of statistics, we used it in the analyses. We also performed parallel analyses with this observation replaced by an average rate of the two surrounding years. However, this made very little impact on the results.
Table 2. The dispersion of the coverage rates (%) for public home help and special housing in different age groups in the 288 Swedish municipalities, 31-12-1997.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>65-79</th>
<th>80+</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard deviation</td>
<td>1.716</td>
<td>5.544</td>
<td>2.692</td>
</tr>
<tr>
<td>Special housing</td>
<td>1</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0.922</td>
<td>4.226</td>
<td>1.760</td>
</tr>
</tbody>
</table>


Figure 1, below, shows the wide-spread distribution of home help coverage rates for the oldest age group (80+), in all Swedish municipalities on 31-12-1997.

Figure 1. Coverage rates of home help for elderly people (80+) in the 288 Swedish municipalities, 31-12-1997.
(Source: NBHW et al. (1998), table 4.)
Do the different forms of care compensate for each other?

Given the considerable variation that can also be found in the coverage rate of special housing (see Table 2), one might expect there to be some form of compensation between the two forms of care, or within the home help services. At least four kinds of compensation of this kind are feasible:

1. Low rates of home help provision could be compensated for by high availability of special housing, and vice versa;

2. Low rates of home help provision could be compensated for by high intensity, i.e. a high average of home-help hours calculated per care-recipient, and vice versa;

3. A high intensity of home help could compensate for low availability of special housing, and vice versa;

4. A high proportion (in the population 80+) of home help-recipients with many hours of assistance per month could compensate for low availability of special housing, and vice versa.

The compensation between home-based and institution-based care (number 1) is presented in Figure 2 below, which seems to demonstrate a 'shot gun pattern', i.e. a zero relation (Sundström & Berg, 1988). However, the Pearson’s correlation coefficient (see Table 3) resulted in a weak negative relation ($r = -0.179$, $p<0.01$). The graph indicates that there are a number of models in the distribution of old-age care. Some municipalities have low and others high coverage of both forms of care; some municipalities concentrate on home-based and others on institution-based care, while others are to be found somewhere in-between.
Figure 2. The Swedish municipalities according to percentage of persons (80+) living in special housing and with home help in ordinary housing, 31-12-1997. Source: NBHW et al. (1998), table 4.

Table 3 also shows the rest of the suggested relations, which turned out to be similarly weak, with a non-significant correlation between home-help coverage rate and intensity.
Table 3. The correlation between the coverage rates of two forms of old-age care for elderly people 80+, and between the coverage rate of home help and the number of home help hours in the Swedish municipalities 1997/1998. N = 288

<table>
<thead>
<tr>
<th>Possible compensation between…</th>
<th>Correlation (Pearson’s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. home help and special housing coverage rates 1)</td>
<td>- 0.179**</td>
</tr>
<tr>
<td>2. home help coverage rate and average hours of home help per recipient 2)</td>
<td>- 0.021 n.s.</td>
</tr>
<tr>
<td>3. average hours of home help per recipient and special housing coverage rate 2)</td>
<td>- 0.147 *</td>
</tr>
<tr>
<td>4. home help recipients (proportion 80+ in population) with help of high intensity (&gt;50 hours per month) and special housing 2)</td>
<td>- 0.140*</td>
</tr>
</tbody>
</table>

** p<0.01, * p<0.05

1) NBHW et al. (1998), table 4
2) NBHW et al. (1999), table 4; own calculations

To summarise, municipalities do not compensate low coverage rates of home help for the oldest age group by giving a greater number of hours of help per recipient, and only to a limited extent do they seem to compensate by offering institutional care as an alternative.

Differences in structure or politics?

The next questions were then: Are the local variations in home help related to structural or political conditions in the municipalities? Do they indicate, for example, that the elderly population and its demands vary from one municipality to another, or are they indicators of an unequal supply of services, resulting from local policies and resource allocation?

The bivariate analyses demonstrated that most relations were weak or non-existent. For care demands and population struc-
Inequality in the welfare state?

Health indicators (average life expectancy at 60, ill-health rate, average income) were significant, but the correlations were all fairly weak (–0.2 or less). Municipalities with a high number of elderly residents were significantly more likely to provide home help to a high proportion of them. Surprisingly, characteristics usually associated with home-help utilisation at individual level, such as a high proportion of women in the population and of elderly people living alone, were not positively correlated to the home-help coverage rate when studied on aggregated data. Neither was the proportion of immigrants in the municipality correlated in the opposite direction, which might have been expected. Population change over a ten year period was negatively correlated — however weakly — with home help: municipalities with a falling population tended to have higher rates of home help, while those with a growing population had lower rates — it is mostly people of working age who move, while elderly people stay.

Many of the variables reflecting municipal structure had no significant relation to the coverage rate of home help. None of the separate variables measuring ‘trade and industry’ was significant, but taken together they had a significant effect. Of the municipal categories, only ‘sparsely populated municipalities’ had significantly higher home help coverage rates. Gainful employment, especially among women, was negatively correlated with home help while unemployment had a positive correlation. One explanation of these results might be that municipalities with high unemployment rates and a low proportion (women) in gainful employment have a large manpower reserve, while other municipalities may have difficulty in recruiting staff to old-age care. To summarise: the indicators of care demands were weakly or not at all related to home-help coverage.

The correlations for supply were even weaker than they were for demand. Most of the tested variables for local economy and organisation had no or only a very weak relation to home help coverage. Somewhat surprisingly, the municipal economy, measured by financial result and municipal debt, appeared to have no relation to the supply of home help, while the level of the munici-
pal tax rate and total municipal expenses demonstrated a positive, although weak, correlation. The degree of privatisation, i.e. to what extent the municipalities have handed over to private companies tasks for which they themselves were previously responsible, also had a weak but negative relation to home help. A stronger correlation could be observed for the purchaser-provider model; municipalities that have organised their old-age care services in this way tended to have a lower home help coverage rate than municipalities with a traditional, integrated organisation.

Local politics and priorities seemed to have little relation to home help coverage. Left-wing majority in the local government was weakly correlated, while the presence of female politicians, and the age of the leading municipal politician were both not significant. There were no unambiguous results concerning the prioritisation or balance between different policy domains: municipal expenses for child care services was weakly correlated (negatively) to home help, while expenses for education and for social services to other groups in the municipality was not related to home help for the elderly. A weak positive correlation was noted with housing allowances for old people, another social policy measure aimed at elderly people living in the community, but remarkably enough, the strongest correlation (negative) was, as noted earlier, with the coverage rate of special housing for elderly people.

The bivariate analyses did little to help us understand the disparate distribution of home help in the Swedish municipalities. In multiple models we included variables reflecting demand and supply of services, and in a final model we reached an adjusted explained variance of 15 percent. Some variables seem to have at least a slight impact on the coverage rate of home help: the coverage of special housing, life expectancy at 60 years of age, municipal type and the structure of trade and industry, and a divided organisation according to a purchaser-provider model. Most of the local variation, however, remains to be explained.
Table 4. Regression analyses of local variations in home help for elderly people (80+) in the Swedish municipalities 1997. Bivariate r, r², partial r², model r², and model r² change.

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>Bivar. r</th>
<th>Bivar. r²</th>
<th>Model 1 Part. r²</th>
<th>Model 2 Part. r²</th>
<th>Model 3 Part. r²</th>
<th>Model 4 Part. r²</th>
<th>Model 5 Part. r²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special housing accommodation</td>
<td>-.179**</td>
<td>.032**</td>
<td>.058***</td>
<td>.062***</td>
<td>.056***</td>
<td>.052***</td>
<td>.065***</td>
</tr>
<tr>
<td>Population structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at 60</td>
<td>-.203***</td>
<td>.041***</td>
<td>.068***</td>
<td>.050***</td>
<td>.033***</td>
<td>.033***</td>
<td>.030**</td>
</tr>
<tr>
<td>Population 80+</td>
<td>-.165**</td>
<td>.027**</td>
<td></td>
<td>.016*</td>
<td>.013*</td>
<td>.012</td>
<td>.007</td>
</tr>
<tr>
<td>Average income</td>
<td>-.177**</td>
<td>.031**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ill-health rate</td>
<td>.128*</td>
<td>.016*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population change</td>
<td>-.166**</td>
<td>.028**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Municipal structure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipal type</td>
<td>……</td>
<td>.049**</td>
<td>.025</td>
<td>.042</td>
<td>.030*</td>
<td>.028*</td>
<td></td>
</tr>
<tr>
<td>Trade and industry</td>
<td>……</td>
<td>.028*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>.212***</td>
<td>.045***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gainfully employed women</td>
<td>-.031</td>
<td>.017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Local economy and organisation</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Divided organisation</td>
<td>-.184**</td>
<td>.033**</td>
<td>.025</td>
<td>.042</td>
<td>.030*</td>
<td>.028*</td>
<td></td>
</tr>
<tr>
<td>Municipal tax rate</td>
<td>.133*</td>
<td>.018*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipal expenses in total</td>
<td>.129*</td>
<td>.017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Local politics and priorities</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left wing politicians</td>
<td>.127*</td>
<td>.016*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing allowances for pensioners</td>
<td>.140*</td>
<td>.020*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care services</td>
<td>-.116</td>
<td>.014*</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

***p<0.001 **p<0.01 *p<0.05

Concluding discussion

In the field of ‘welfare geography’ there is a range of studies from all over the industrialised world, reporting local variation in care distribution, especially within the health care sector. This article has demonstrated that there is considerable geographical variation also in public old-age care in Sweden, a small, homogeneous welfare state, declaring equity as a central goal, and with legislation
stating that the population’s needs should be met irrespective of age, gender, income, or residence. Even if we exclude the most extreme observations, in some municipalities one in three persons, aged 80+, is receiving home help, while elsewhere only one in ten. One might assume that municipalities with few recipients of home help instead provide those recipients with more hours of assistance, or conversely that municipalities which offer home help to a broader group instead will ‘spread the butter more thinly’, i.e. provide each user with fewer hours of assistance. Neither is the case, however. And only to a limited extent do municipalities with low home help coverage compensate by providing institutional forms of care. Our efforts to explain the widely-varying coverage of home help by means of indicators of care demands in the municipality were no more successful than those of earlier studies. Neither did we find that local authorities’ economic circumstances or political policies affect the supply and coverage of home help to any more than a very limited extent.

Can our results have something to do with the kind of data we used for the study? Are our data reliable and valid? Do we have access to the right measures? The authorities behind the annual statistics for public care for the elderly endeavour to check data to minimise local errors, and to produce public statistics of good quality. There are, nevertheless, limitations. For instance, mistakes caused by unclear definitions have been reported with regard to special housing (NBHW, 1998). Also, the range of statistics about the alternative services is limited – there are home-based services in the old-age care system such as meals-on-wheels, safety alarms, transport services etc., that are not accounted for in the annual statistics. Johansson & Sundström (1999), with reference to local studies, suggest that these supplemental forms of care compensate to quite a large extent for the more traditional home help and residential care. Given the strict needs assessments which are carried out and the fact that the most frail are given priority, it seems more likely that also services of this kind are allocated to the elderly with the greatest needs, to complement rather than to replace home help. That is, it is likely that elderly people who
receive municipal home help are also receiving these supplemental services.

The study is based on data which provide information at municipal level; as a consequence we cannot draw conclusions about individual circumstances. We do not know, for example, whether care and services are targeted at those in need; we cannot say whether dependent elderly persons in municipalities with low-coverage have to do without public home help; we cannot say what level of home help provision is adequate for the oldest in the population, etc. These limitations together with the earlier-mentioned lack of information at municipal level about health status and living-conditions makes it difficult to measure home help needs at an aggregated level.

In conclusion, we have succeeded in explaining only some of the large municipal variations in home help coverage. The differences in the coverage rate do not seem to be related to the elderly’s needs or to the municipal economy. This finding could possibly be a result of the shortage of variables – the number of suitable variables available at municipal level is of course limited. Alternatively, the explanation may well lie in the past rather than in how the municipalities deal with old-age care today. Despite the fact that home help services do not need buildings or other “fixed assets”, there is undoubtedly a time-lag. Municipalities may have established norms for what is “reasonable” provision, which creates a historical continuity (Sundström & Thorslund, 1994). Such local traditions may influence the scope and structure of old-age care today. To explore the extent of this and to look for possible local traditions, calls for further studies and other research methods.

How elderly people’s needs are met depends on the social policy that is in operation (Higgs & Victor, 1993). The results of this study suggest that a variety of local social policies co-exist. Since the study presented here like earlier studies have found few – if any – indications that the demonstrated differences correspond with different needs, a reasonable conclusion must be that considerable regional inequality exists in Sweden in the care and services provided for the oldest in the community. If the local
variations prove to be permanent, it might be more appropriate to talk about a multitude of different welfare municipalities for the elderly, rather than one single welfare state. Inequality as a consequence of socio-economic position or gender has been largely eliminated as regards the access to old-age care in Sweden; today the municipal disparity constitutes a greater threat to the principle of equality in old-age care.

Acknowledgements

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References


Article 3. Inequality in the welfare state?


KFAKTA99. Kommundatabas [Information on municipalities, a database]. University of Lund, Department of Political Science.


Article 3. Inequality in the welfare state?


Gun-Britt Trydegård & Mats Thorslund
Submitted.

Abstract

The purpose was to study local variation in home-help services over time in the Swedish municipalities. Home help coverage for elderly people (65+) is studied for the period 1976-1997. The correlations between past and present coverage are compared within and across municipalities, as well as the relation between the municipalities and the national median. There has been an overall decline in home help coverage in Sweden from 1976 to 1997. Local variation between municipalities was substantial – and increased – during this period. Municipalities seemed to follow their own coverage trajectories, e.g., more generous municipalities remained generous two decades later. The municipal trajectories were more or less parallel to the national average. Rather than regressing to the median, municipalities maintained their position relative to the national median over time. In contrast to the national social policy, Swedish municipalities demonstrate extensive variation concerning services for elderly people. Variation seems to depend more on historical factors, i.e., previous coverage rates, than actual local differences in levels of need or in local economy and politics. Neither national legislation nor levelling state grants have minimised local variation over the past decades.

Key-words: Old-age care, local traditions, welfare municipalities, welfare state.
Introduction

An increasing awareness of the considerable social policy implications of the growing elderly population has brought about changes and reforms in extant systems of long-term care services (Kosberg, 1994). One such pattern of change is de-institutionalisation, which is focused on community-based instead of institution-based solutions; another is decentralisation of decision-making and responsibility ‘downwards’ in the organisation, and from central government to local authorities (Baldock & Evers, 1992; Parker, in press; Thorslund & Parker, 1997). The trend of decentralisation is an international phenomenon in welfare states (Olsson, 1994) but also in developing countries (see for example Hentic & Bernier, 1999).

Regarding the care of elderly people, there are also reports from many countries on regional and local imbalances and variation, both in the need for care and available services. Such differences are particularly apparent between rural and urban areas, for instance in Eastern and Western Europe, in Japan and China, and in Canada (Gori, in press; Milligan, 1998; Olsson, 1994). Even in Sweden – a small, homogeneous welfare state, declaring equity as a central goal, and with legislation stating that the population’s needs should be met irrespective of age, gender, income, or residence – there is considerable geographical variation in the public care of elderly people (Trydegård & Thorslund, in press).

In Sweden, old-age care is regarded as a cornerstone of the welfare state; that elderly people receive the care and services they need is a public responsibility (Government Proposal, 1987/88:176; 1997/98:113). Public old-age care – home-based as well as institution-based, and since the ‘ÄDEL-reform’ in 1992 also the bulk of long-term medical care for elderly people – comes under the auspices of the smallest units of local government, the 289 Swedish municipalities, and is organised and funded by locally elected authorities at the municipal level.

By tradition, local autonomy is strong, just as in the rest of Scandinavia. The municipalities enjoy great freedom to determine the scope and quality of their services. Each municipality can
Article 4. Explaining local variation in home-help services

determine eligibility criteria as well as the amount and kind of help to be delivered, and also set service charges. Referring to the local autonomy, scholars (for instance Grønlie, 1991; Kröger 1997) have used the concept of ‘welfare municipalities’ instead of the uniform ‘welfare state’ to characterise the social policy construction in Scandinavia and to underline the significant role of independent municipalities in the distribution of social services. In the provision of services and care for elderly people, the differences between municipalities are great in terms of coverage, cost and accessibility, and are found both in home-based and institution-based care (Sundström & Thorslund, 1994). In 1999, the proportion of the population 80 years and over receiving home help in their ordinary housing ranged between 3 and 44 percent across municipalities (mean 19 percent); institutional care or sheltered housing ranged between 3 and 40 percent (mean 20 percent) (NBHW, 2000).

A previous study (Trydegård & Thorslund, in press) of local variation in home help coverage demonstrated that it could only be explained to a very limited extent by present structural or economic factors in the municipalities or by the current supply of institutional care. Neither did municipalities seem to compensate low home help coverage with high intensity, that is, many hours of assistance per care recipient. These results raised the question of the extent to which today’s great variation might be explained by past municipal tendencies, in conformity with the suggestion by Daatland (1997b) that established traditions and policies influence national eldercare policy in the form of ‘path dependency’. Derived from historical institutionalism, the concept of ‘path dependency’ implies that institutions in society continue to evolve in response to changing environmental conditions and ongoing political manoeuvring, but in ways that are constrained by past trajectories (Thelen, 1999). Bearing in mind the strong municipal autonomy in Sweden, it might be hypothesised that also municipalities establish traditions and follow their own path in the development of local eldercare policy.
Home-help services in Sweden

Home-based care for elderly people has, for half a century, constituted an essential part of the Eldercare system in Sweden – as well as in the rest of Scandinavia and the UK – and has become increasingly favored in Eldercare policy in many other countries, for instance in the rest of Europe, Japan, and the US (Monk, 1994; OECD, 1996).

A broad range of services and care.

After a needs assessment by a professional social worker, home helpers may assist elderly people with domestic tasks, such as cleaning, washing, shopping, preparing food etc, but also with personal care, for instance help getting in and out of bed, using the toilet, showering or bathing, dressing, eating, and – although to a decreasing extent – also assistance in connection with leisure activities. Other services may also supplement home help, for instance, home nursing care, help managing medication, meals-on-wheels, safety alarm, day care, transportation services, housing adaptation etc. 

Domestic and social duties have earlier dominated the program, but, in the 1990s, home help has become more occupied with personal care issues, and can also be delivered around the clock. The services have become more or less focused upon those with the greatest needs. The number of home help working hours distributed to elderly people in Sweden increased substantially during the 1970s and 1980s, and has subsequently remained unchanged during the 1990s. Almost 65 percent of home help recipients in 1999 received more than 10 hours of assistance per month, and about 20 percent received more than 50 hours (NBHW, 2000). A local study (Trydegård 1998a) demonstrated that home help recipients were often physically impaired and that health problems, daily use of medication, and hospital care experience were almost as frequent among them as among elders in institutional care.
A local responsibility

Having started in Sweden in the 1950s as an initiative from voluntary organisations, home-help services for the elderly rather soon became the responsibility of local authorities, the municipalities\(^1\). Locally elected politicians levy taxes and make the overarching decisions on the aim, direction and scope of care provision. For implementation there is a social service administration, which can be organised in different ways. One is a ‘traditional’ organisation with a head of social services and a district head, under which are found case officers and supervisory staff who deal both with needs assessments and staff administration of home help auxiliaries. Another alternative, which lately has become frequent, is a ‘purchaser-provider model’, with special municipal officials to administer needs assessment and to purchase services and care from special care-providers (Baldock, 1999). These providers can be either municipal home help teams (regarded as ‘business units’) or private entrepreneurs. In both cases, the services provided are still publicly financed and controlled, and the users pay fees to the municipality according to their ability to pay and the scope of service. However, only a fraction of the total costs for old-age care is covered by user fees (NBHW, Swedish Association of Local Authorities & Statistics Sweden, 1999).

Central government issues

Although Sweden’s municipalities are fiscally and administratively responsible for eldercare, the national political level is crucial in many respects. Direct influence is exercised through legislation, which delegates the municipalities’ responsibilities. The national government can also exert influence through the system of state subsidies to the municipalities (Thorslund, Bergmark & Parker,

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\(^1\) For the time being, there are 289 Swedish municipalities of varying size and character. The municipalities have between 2,800 to 740,000 inhabitants, median 15,500. Their population density varies between 1 and 3,900 inhabitants per square-kilometre, average 27 (NBHW, Swedish Association of Local Authorities & Statistics Sweden, 1999).
1997), and through supervision by the National Board of Health and Welfare as well as by regional state authorities, the county administrative boards.

Home-help services were first regulated in law in 1982, when *the Social Services Act* was passed. However, home help had at that time already expanded considerably and reached, at its peak in the early 1980s, one-fourth of all elderly persons over retirement age (see Figure 1, below). The municipalities had, with the help of state subsidies and the encouragement of appreciative elderly people, built a far-reaching home help system. The Social Services Act rather confirmed this development and established home help as a right for elderly and disabled people, if their needs could not be provided for in any other way (section 6). They also received the right to appeal negative decisions to an administrative court. Although the Act has been revised repeatedly, home-help services have maintained their legal status. However, there are reports that in recent years municipalities have applied the Act more narrowly, trying in particular ‘other ways’ of providing for old people’s needs, most often from next of kin (Szebehely 1998).

The first *state subsidies* for home-help services to elderly people were introduced in the mid-1960s to stimulate expansion and reform of this kind of old-age care (Edebalk & Lindgren, 1996). The subsidies were ‘earmarked’ for specific services and, as a main principle, subsidy size was based on the number of personnel and the amount of services rendered (Thorslund et al., 1997). In 1993, and later in 1996, the state grants were radically changed such that they no longer accounted for what the municipalities produce within the domain of eldercare. The new, general, state subsidies are given in a lump sum, calculated on basis of the municipalities’ incomes and estimated costs, taking into account structural factors such as the age, living conditions, and socio-economic status of the local population. The official intention was to achieve economic parity among the municipalities as regards meeting their obligations (Government Proposal 1997/98:113). However, state control of how money is used ceased to exist in this new system, thereby bringing greater freedom to the municipalities – and potentially also leading to greater diversification.
Aims

The aim of this article is to study local variation in home-help services over time in Swedish municipalities. A special objective is to explore to what extent the actual provision of home help is related to the municipalities’ previous situation of old-age care. We focus the study on home-help services to elderly people because, in contrast to institutional care, home help does not require investments in physical buildings, and therefore can more easily be adjusted to current care needs and demands as well as to the actual political and economic situation in the municipalities. Thus, coverage of home help might be a good indicator of the current trends in old-age care within a municipality.

In this article, we pose the following questions:

• How has the provision of home help to elderly people developed on the local level? Is the variation between municipalities constant, or has it increased or decreased over time?
• Do the individual municipalities follow the national trend over time, or do they follow a local path in the provision of care and services for older people?
• How strong related is today’s local coverage of home-help services to the coverage of previous years?

Data and methods

Indicators

For our analyses, we have used the home help coverage rate, that is the percentage of municipal residents of a certain age receiving public home help at a given time in all Swedish municipalities. This relative measure allows comparison of years with varying numbers of elderly people as well as of municipalities of varying size and with differing proportions of elderly people in the population. (Note that our study concerns the home help given, excluding complimentary home care services such as meals-on-wheels, safety alarm, day care etc.)
We have chosen to study home help provided to people over retirement age, today 65 years and over, living in ordinary housing or in so-called service homes, during the years 1976 – 1997. There are several reasons for these choices. Since 1965 – the start of regular official statistics in the field – home help to people over retirement age has been accounted for each year, whereas separate statistics on home help to the oldest age group, 80 years and over, are not available until 1982. Since 1976, retirement age in Sweden has been 65 years (earlier 67 years) and therefore we chose 1976 as the starting point of our analyses. Statistical information by municipality, which is essential for our study, was first reported in 1975, and, accordingly, available during the time period chosen. We used 1997 as the last year of the time-span because we could not get comparable data for 1998 and 1999 – according to NBHW (2000), several 1998/1999 local reports on home help coverage in service-homes are unreliable.

Sources of data

The analyses in this study are based on official statistics on social services in the Swedish municipalities. The municipal administrations provide yearly information on publicly financed and controlled old-age care and services, which is – after quality control – accounted for in statistical reports. Until 1993, the responsible authority was Statistics Sweden, and from 1994, the National Board of Health and Welfare.

For the years 1991 – 1998, we also used supplementary information from the database: Comparison Material for the Social Services, edited by the National Board of Health and Welfare in co-operation with Statistics Sweden and the Swedish Association of Local Authorities. Data on the total number of home help recipients from 1960 – 1982 were taken from Daatland (1997a, Appendix A12).

The quality of the reported data is judged to be satisfactory, although there is some uncertainty connected with the local reports. For instance, from the late 1990s mistakes caused by unclear definitions with regard to special housing have been
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reported (NBHW, 1999). However, the authorities responsible for annual statistics endeavour to check data to minimise local errors, and to produce statistics of good quality. Moreover, registers that are also used for service charges – for instance the municipal home help register – seem to be largely accurate, since the municipalities have an economic incentive to maintain accurate registers (Carsjö, Thorslund & Wärneryd 1994).

Missing values and changes in statistical methods

The official data used in this study are, as stated earlier, quite accurate; the missing values are limited to 0.4 percent of all observations. However, the number of municipalities in Sweden has changed from 277 to 288 during the study period – eleven new municipalities have been established through division. The longitudinal analysis shown in Table 1 is performed on the 277 municipalities that existed in 1976, which is judged to be satisfactory, as the new municipalities represent a very small proportion of the population – about one percent of all Swedish inhabitants and the same proportion of elderly inhabitants (65+).

Comparing Swedish home help statistics over time requires awareness of longitudinal changes in data collection and statistical methods. First, home help figures up to and including 1992 refer to all elderly persons who had received home help at least once during the year, whereas data from 1993 refer to persons receiving home help on a given day at the end of the year (the 31st of December, and from 1998 the 1st of November). The year-measure has been calculated to correspond to 124 percent of the day-measure (Daatland 1997a), and in the analyses shown in Figures 2 and 3, we have adjusted data in accordance with this formula.

Second, as a consequence of the extensive care reform in 1993 – transferring responsibility of medical services for elderly people to the local authorities – home help data from 1993 to 1997 also included persons receiving medical services in the home, delivered by municipal staff, which means that results from these
years probably somewhat overestimate the actual home help provided.

Third, up to and including 1992, home help statistics referred to home help provided by the municipality in ordinary housing as well as in so-called service-homes. From 1993, home help in these two kinds of living accommodations was separated in the statistics, but for 1994 the annual report only accounted for home help in ordinary housing, due to uncertain local information. However, complimentary information was obtained from NBHW.

### Methods

In order to assess the longitudinal variation in home help coverage rates in the Swedish municipalities, we calculated the standard deviation for each year. However, it is problematic to compare standard deviations in absolute magnitudes when the distributions compared have different means (Frankfort-Nachmias & Nachmias, 1992) – and the national mean of the coverage rate has decreased substantially during the same period. Therefore we also calculated the coefficient of variation, that is, the degree of dispersion relative to the mean. A high coefficient of variation reflects a low degree of homogeneity and vice versa.

To assess patterns of change in the municipalities’ positions in the distribution of home help coverage, we used a cross-tabulation accounting for the relative position (in percentiles) of each municipality in 1976 and 1997.

We have also followed a sub-sample of municipalities and their home help coverage rate as compared to the national median, and the 5th and 95th percentiles. These four municipalities were selected in an earlier project (see Trydegård, 1998a) as representing municipalities of different size and character, and with different ways of organising their old-age care. In the present study, they serve as illustrations of different patterns in the distribution of home help. The four municipalities are: **Falun,** a town with 55,000 inhabitants in the middle of Sweden, and with a traditional (publicly governed) organisation; **Linköping,** a major town (130,000 inhabitants) in the south-east of Sweden, where a
purchaser-provider organisation of old-age care was introduced in 1994. *Sollentuna* and *Sundbyberg* are both suburbs of Stockholm (with 60,000 and 30,000 inhabitants respectively), the former having a purchaser-provider organisation since 1992, and the latter a traditional organisation. (Note that, independent of organisation of services, home help is publicly funded and controlled, and included in the public statistics.)

To assess the degree of path dependency or inertia, we calculated the correlation between the coverage rate in 1976, on the one hand, and the coverage rate in each successive year up to 1997, on the other. This calculation is also performed between the coverage rate in 1997 and each preceding year back to 1976.

The data were analysed using SPSS and Microsoft Excel.

**Results**

*The home help distribution over time*

At its peak (in the mid-1970s and the beginning of the 1980s), public home help in Sweden reached about 350,000 persons in the course of a year, of which 300,000 were elderly persons, corresponding to one-fourth of all elderly over retirement age (65/67+). However, during the 1980s and 1990s, there has been both an absolute and a relative decline, and in 1997, the corresponding figure was 200,000, of which 175,000 were persons 65+, roughly one-tenth of retirees\(^2\).

As shown in Figure 1, the number of home help recipients is now, at the end of the 1990s, at about the same level as at the end of the 1960s. Since the elderly population has increased by approximately 500,000 during the same period, we speak of a widening care gap between needs and resources (Thorslund et al.,

\(^2\) Furthermore, in 1997, 130,000 elderly persons, or about 8 percent of the elderly (65+), were cared for in ‘special housing for elderly people’, that is institutions of various forms, compared to 115,000 (9 percent) in 1976 (Daatland, 1997a; NBHW, statistics 1998).
1997). Home help as well as institutional care has become concentrated to elders who are most frail and in need of care, resulting in a substantial increase in care load in all forms of care (NBHW 2000).

Figure 1. The number of home help recipients in Sweden 1960-1998.

Local variation over time

Figure 2, below, shows the variation trend – across municipalities – in the coverage rate of home help to elderly people, 65+, for the years 1976 – 1997.
The national average (mean) has decreased considerably (from a peak value of 23.2 percent to a low 14.4), while the absolute variation, measured by the standard deviation, seems to be rather stable, fluctuating between 5.6 and 3.9, and demonstrating a weak decline over the time period. When we use the coefficient of variation to measure relative dispersion, we note a somewhat irregular but decreasing tendency up to 1992, then a substantial increase from a low 21.4 to a peak value of 28.6 in 1997. In other words, the large decrease in the home help coverage rate in Swedish municipalities during the last two decades was first accompanied by tendencies towards increasing homogeneity between municipalities, but, in the last five years, by considerable
heterogeneity; that is, the variation across municipalities has, on the whole, not decreased but rather increased.

How has home help coverage developed at the local level, in individual municipalities, during this time span? An earlier research project (see Trydegård, 1998b) on old-age care in four different Swedish municipalities suggested the existence of local pathways in the development of home help coverage, illustrated in Figure 3.

The figure shows changes in the coverage rate of home help to elderly people (65+) from 1976 – 1997 in 90 percent of the Swedish municipalities (the shadowed area), and – as an illustration – in our four selected cases separately, as well as in the national median. The four selected municipalities seem to follow their own pathways, more or less parallel to the national average. The development looks rather stable and the four municipalities keep their positions, above or below average. One exception is the
municipality of Linköping, which has a more unstable projection, decreasing rapidly from above to below the average at two occasions: some years in the mid-1980s, and again, between 1992 and 1994 (unfortunately data for 1993 are missing). (It should be noted that in 1994 this municipality changed to a purchaser–provider organisation and decided to sharpen home help eligibility criteria.)

On the whole, the 1990s were turbulent in Sweden, with economic restrictions and reorganisations in the municipalities and also the comprehensive ÄDEL-reform in 1992; thus, the trajectories of municipal coverage rates are also rather unstable during these years.

Changes in position between 1976 and 1997

Table 1 displays a cross-tabulation of the positions of Swedish municipalities according to their home help coverage rates in 1976 and 1997, respectively.

The table indicates different patterns of change in relation to the national average (median). About one-third of the municipalities, 32 percent, have not changed their position and can be classified as constant (the white squares). The other two-thirds have changed; the majority, 42 percent, moderately from one percentile position to the nearest (the light shadowed squares), the rest strongly, 21 percent (the dark shadowed squares), or extremely, 5 percent (the black squares). The direction of change was about equally divided between shifts to a higher and to a lower percentile position. In summary, three out of four municipalities seem to have a rather stable position (constant or moderately changed) in the distribution of home help coverage in relation to the national average, while one out of four has changed position to a great extent (note the resemblance to the four selected municipalities in Figure 3).
Table 1. Location in percentiles of home help coverage in the Swedish municipalities 1976 and 1997. Percent. (N=277)

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<td>6th – 35th</td>
<td>1.8</td>
<td>10.8</td>
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<td>6.9</td>
<td>0.4</td>
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<tr>
<td>36th – 65th</td>
<td>1.8</td>
<td>6.5</td>
<td>10.5</td>
<td>9.7</td>
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<tr>
<td>66th – 95th</td>
<td>1.1</td>
<td>9.4</td>
<td>7.6</td>
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<td>95th</td>
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1) Figures rounded to nearest whole percent

For a further analysis, we compared the four cells in each corner of Table 1. Almost half of the municipalities, which had a low position in 1976, kept this position also in 1997 (the upper left corner), compared to about one third which changed from a low to a high position (the lower left corner). Likewise, almost half of the municipalities with a high position in 1976 stayed in this high position (the lower right corner) compared to about one forth which changed from a high to a low position (the upper right corner). Also this kind of analysis suggests that municipalities are more unchanging than changing as regards home help coverage for elderly people.
Another question raised in this article is how current home help coverage is related to that of earlier years. To explore this, we calculated the correlation (Pearson’s r) between the coverage rates of all municipalities in 1976 to those each succeeding year up to 1997 (Figure 4a), as well as between 1997 and each preceding year back to 1976 (Figure 4b).

**Figure 4a.** Correlation (Pearson’s r) between coverage rate of home help to 65+ 1976 and succeeding years.

**Figure 4b.** Correlation (Pearson’s r) between coverage rate of home help to 65+ 1997 and preceding years.
Although the two distributions display a similar shape, they differ in correlation decay rate. The correlation between 1976 and subsequent years is quite high for several years (exceeding .5 for nine years, .4 for 15 years and .3 for 19 years) – there is thus a substantial inertia in the coverage rates. This should be compared to the correlation between 1997 and earlier years, where the correlation drops rather quickly (exceeding .5 for two years; .4 for four years and .3 for six years), subsequently levelling off – a fast transition and a long stable period of fairly low correlation. Based on these analyses, one conclusion is that there seems to have existed a strong municipal tradition in home help coverage during the first half of the studied period, and a weaker but still not unimportant relation during the subsequent years as well. For instance, the result suggests that, in 1997, home help coverage five years earlier explains almost 22 percent of the variation across municipalities. The same calculation for the first five years of the time span, 1976 vs. 1980, gives an explained variation of more than 50 percent. This is to be compared to results from our study on the present variation across municipalities (Trydegård & Thorslund, in press), in which we obtained an explained variance of 15 percent using variables reflecting current municipal structure and policy. Indeed, there is a strong tradition, and local home help history seems to be the most important predictor of current home help coverage.

Concluding discussion
This article has accounted for different ways of describing and exploring the large local variation over time in home help coverage for elderly people in Sweden. The main results were:

- variation across municipalities has been substantial during the entire period studied, and has not decreased but rather increased, taking into account the decline in coverage rates during the last two decades;
- most municipalities have a rather stable position in the distribution of home help coverage in relation to the average development in Sweden, and seem to follow a pathway more or less parallel to the national average;
there is an inertia in municipal home help coverage, which is very strong during the late 1970s and the early 1980s and weaker, but not unimportant, in the turbulent 1990s as well. The situation of preceding years seems to be a stronger predictor of today’s home help coverage than is the present structural and political situation.

How can we understand these results, which at first glance seem to be somewhat contradictory? The municipalities in Sweden, like in the other Scandinavian countries, have by tradition a solid autonomy and a very strong position in relation to the central government. Even in a small and, thus far, rather homogeneous country like Sweden, there seems to be a variety of local social policies as regards care and services for the elderly. That municipalities differ in their welfare services to the elderly has been true for more than twenty years, and this heterogeneous tendency has, relatively speaking, increased rather than decreased. Neither the establishment of compulsory legislation (1982) nor the introduction of levelling state grants (1993) seems to have reduced this cross-municipal variation. On the contrary, the reformed state grants coincide with a large increase in relative dispersion. Thus, because local variation seems to be lasting, it might be more appropriate to describe Sweden as a collection of 289 ‘welfare municipalities’ for the elderly, rather than as a uniform welfare state.

This phenomenon – that municipalities follow their own trajectories and maintain their position in relation to the national average to such a great extent – might imply that there are greater needs for eldercare in some municipalities than in others, or that some municipalities have healthier economies than others and can better afford widespread home help service to the elderly. However, according to our previously mentioned study (Trydegård & Thorslund, in press), such factors can only partly explain the variation across municipalities. Instead, the results of the present study support the thesis, suggested by Sundström & Thorslund (1994), that there is historical continuity in the individual municipalities, and that traditions and history have
more influence on the scope and structure of eldercare than does the current situation.

As suggested, ‘path dependency’ might be one way of understanding why the home help coverage of the past seems to be such a strong predictor of the coverage of the present in most Swedish municipalities. The 1990s were a decade of economic strain in all Swedish municipalities. Concurrently, the elderly population has been growing and new demands have been raised. A common trait has been to restrict obligations to the elderly, but municipalities seem to have implemented such restrictions in accordance with their previous institutional traditions. Some municipalities have long offered far-reaching services and care for the elderly, others have been more restrictive, and still others have fallen in between. In most cases, the chosen path seems to have formed a municipal tradition that is rather strong.

As mentioned earlier, there are reports from different Western and Eastern countries in the world on regional imbalances in eldercare. What might be more remarkable, however, is that we also find geographical inequality within the Scandinavian welfare states (Berg & Sundström, 1989; Boll Hansen & Platz, 1995; Daatland, 1997b, Naess & Waerness, 1996; Trydegård & Thorslund, in press), bearing in mind that social policy here is of an institutional and universal character (Esping-Andersen, 1990). Equitable public care of disabled and elderly persons is central to the notion of a ‘social service state’ (Anttonen, 1990; Hanssen, 1997). It is not in accordance with established policy that the probability of receiving care and services in old age should depend on one's residential location.

Our study is restricted to the time period 1976 to 1997. This period has seen a remarkable change in home-based care for elderly people in Sweden: a decrease from very far-reaching services to rather restricted care for the most frail. The extensive local variation found shows few signs of regression to the national mean. Neither a compulsory legal provision nor levelling state grants seem to have brought about greater homogeneity of home help coverage in Sweden. The international trend of ongoing decentralisation of public responsibility and decisions gives us no
reason to expect that geographical differences will decrease. The consequences of this trend for both central social politicians and legislators as well as elderly persons and their families are worthy of our continued attention.

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References


Article 4. Explaining local variation in home-help services


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Statistical data sources:


