

Special Issue

Home care for older people in Sweden: a universal model in transition

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Accepted for publication 14 October 2011

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What is known about this topic

- Public spending on eldercare in Sweden is very generous.
- Publicly funded and provided home care, used by all social groups, has long been regarded as significant in relation to Nordic universalism.
- Most seniors prefer formal care to family care, but in recent decades, publicly funded home care has declined substantially.

What this paper adds

- Family care has increased among older people with lower education – a re-familialisation of care opposite to older people's preferences and unintended by policy-makers.
- Private provision of publicly funded services has increased, as has privately purchased help among better-off older people – a marketisation of care stimulated by policy-makers.
- This dualisation of care signifies a threat to universalism.

Introduction

Home care and other welfare services in Sweden have been characterised as universal, that is, comprehensive, publicly financed, mainly publicly provided, high-quality services are available to all citizens according to need

Abstract

One aspect of universalism in Swedish eldercare services is that publicly financed and publicly provided services have been both affordable for the poor and attractive enough to be preferred by the middle class. This article identifies two trends in home care for older people in Sweden: a decline in the coverage of publicly funded services and their increasing marketisation. We explore the mechanisms behind these trends by reviewing policy documents and official reports, and discuss the distributional consequences of the changes by analysing two data sets from Statistics Sweden: the Swedish Level of Living surveys from 1988/1989 and 2004/2005 and a database on all users of tax deductions on household and care services in 2009. The analysis shows that the decline of tax-funded home care is not the result of changing eldercare legislation and was not intended by national policy-makers. Rather the decline was caused by a complex interplay of decision-making at central and local levels, resulting in stricter municipal targeting. The trend towards marketisation has been more clearly intended by national policy-makers. Legislative changes have opened up tax-funded services to private provision, and a customer-choice (voucher) model and a tax deduction for household- and care services have been introduced. As a result of declining tax-funded home-care services, older persons with lower education increasingly receive family care, while those with higher education are more likely to buy private services. The combination of income-related user fees, customer-choice models and the tax deduction has created an incentive for high-income older persons to turn to the market instead of using public home-care services. Thus, Swedish home care, as a universal welfare service, is now under threat and may become increasingly dominated by groups with less education and lower income which, in turn, could jeopardise the quality of care.

Keywords: care of elderly people, community care policies, consumerism, European and International Patterns of Social Care, home care, informal care

rather than ability to pay. Also characteristic of universalism is that the same services are directed towards, and also used by, all social groups (Sipilä 1997). Nordic scholars have discussed whether this image of a universal Nordic care regime is or ever has been accurate (see e.g. Anttonen 2002, Rauch 2007). From a historical perspective,

however, the development of municipal home-care services, from the early 1950s, was an important step in the building of the Swedish welfare state. Home care was the first form of eldercare to be offered not only to the poor, but to all social groups in the society. Services were regarded as an individualised alternative to the more standardised forms of care available in old-age homes and soon became very popular and widely used (Szebehely 1998). This was possible because not only were all social groups formally eligible, but also because services were affordable, even for the poor, and attractive enough to be preferred also by the middle class. In this sense, it can be argued that home care was a universal welfare service.

Sweden is probably one of the world's most generous countries when it comes to public spending on eldercare (Huber *et al.* 2009). However, for several decades, public spending on eldercare has not kept pace with the ageing population. Between 1990 and 2000, public resources for eldercare in relation to the number of people aged 80 years and over in the population were reduced by 14% (Government Report 2004:68, p. 147). Between 2000 and 2009, the spending decreased not only in relation to the ageing population but also fell 6% in absolute terms (Szebehely 2011, p. 219).

The coverage of home care has also declined. In Sweden in 1980, public home care was used by 16% of older people aged 65 years and over and by 34% of those aged 80 years and older. At that time, the coverage was similar in the neighbouring Nordic countries and much higher than in the rest of the world (Szebehely 2005). In 2008, 9% of the population aged 65 years and older and 22% of those aged 80 years and over were receiving home care in Sweden (Nososco 2009). The Nordic countries are no longer homogenous with respect to home-care coverage, and several European countries have higher coverage than Sweden (Huber *et al.* 2009).

Besides this trend of service decline, another important trend is marketisation. Private provision of publicly funded home-care services is a relatively recent development as the entire increase of welfare services after the Second World War was in the form of publicly provided services. The political argument had been that only the public sector could provide universal high-quality services that would be affordable also for poorer groups and at the same time be attractive to the better off (Blomqvist 2004). As recently as 1993, 98% of home-care users received publicly provided help (NBHW 1999). In the 1990s, the political arguments changed, private provision began to grow, and in 2010, 19% of home-care hours were privately provided (NBHW 2011). In the last few years, several new market policies have been introduced, such as a customer-choice model and a tax deduction on household services and personal care.

The aim of this article is to explore the mechanisms behind these two trends – the decline in home care and the marketisation of services – and to analyse their consequences for different social groups of older people in the perspective of universalism. We base our study on a review of policy documents, official reports and public statistics as well as on an original analysis of data from Statistics Sweden on use of services, described in more detail in the section 'Consequences for older people'.

The structure of Swedish eldercare

In Sweden, care of older and disabled persons is governed at three levels. The central government's instruments of control are legislation, policy declarations, state subsidies and supervision. At the regional level, the county councils are responsible for hospital care and the major part of primary health care. At the local level, the municipalities are legally obliged to provide social services, including home-based and residential care for persons of all ages in need of care.

Home care in Sweden is regulated by the Social Services Act, as are most care services for older and disabled people, including nursing homes which were moved to the municipal local level from the regional level in 1992 (the 'Ädel-reform'). The Social Services Act (introduced in 1982 and largely unchanged) is a goal-oriented framework law ensuring a general right to assistance if needs cannot be met in any other way, but without detailed regulations or specific rights. Everybody has a right to claim public service and support at all stages of life, and local authorities have a mandatory responsibility to see to that these needs are met. The assistance should be of good quality and given in ways that ensure a 'reasonable level of living'. A process of needs assessment is carried out by a care manager, mandated by locally elected politicians.

Home-care services include help with household tasks like cleaning, shopping, laundry and cooking (or the delivery of readymade food), as well as personal care such as bathing, getting dressed and moving around. Basic medical tasks can be included, for example insulin injections and treatment of wounds. Emotional and social support is also regarded an important aspect of the service. The amount of home care can vary from help once a month to six or more visits per day (over 24 h). On average, a home-care user receives around seven hours of help per week; the average is the same for younger and older age groups (NBHW 2009).

Services are not generally free, but the user fees cover only a fraction of the cost (4–5% in aggregate), and the vast majority of eldercare expenditure comes from municipal tax (around 85%), while the remaining 10% comes from national taxes (NBHW 2007a). A national maxi-

mum fee reform was introduced in 2002 which capped user fees in home care. In 2011, the maximum fee was SEK 1712 (€184). Municipalities still have discretion in setting the fees (up to the national maximum), and user fees are generally related to income and the amount of help provided.

The decline of publicly funded home-care services

To analyse the reduction of home-care services in Sweden, it is important to understand the role of the municipalities and their high degree of autonomy vis-à-vis the central government. Within the limits prescribed by the legislation, locally elected politicians in the 290 municipalities levy local taxes and decide on tax rates, establish local goals and guidelines, and set budgets.

The interplay between central and local decision-making is, however, complex, and the eldercare sector is clearly affected by changes in policy fields outside the sector itself. A significant change in central–local relations took place in 1993 when the vast majority of earmarked state subsidies were transformed to ‘municipal block-grants’ leaving the municipalities to decide their own priorities (Palme *et al.* 2003, p. 83). Local politicians therefore have to balance the needs of different groups in the population and prioritise between different welfare areas. However, all priorities have to be funded by existing financial resources and the economic recession in the early 1990s placed severe strain on municipal finances. Tax revenue declined because of increased unemployment, and during the same period, the government imposed restrictions on the municipalities’ latitude in raising tax rates (Palme *et al.* 2003, p. 84).

Furthermore, increased government ambitions in other welfare areas without full compensation to the municipalities for the increased costs have also reduced the scope of action for municipal politicians. Important legislative changes include the Disability Act 1994 (which enacted extensive rights for persons with certain disabilities) and the School Act 1995 (which made it mandatory for municipalities to offer childcare to all children 1–12 years of age). Since the mid 1990s, public resources allocated to these two fields have increased significantly. Between 2000 and 2009, the resources for childcare increased by 67% (National Agency for Education 2011, p. 7) and for disability services by 66% (Szebehely 2011, p. 218). In a recent report on social services, the National Board of Health and Welfare concludes ‘Older people’s need for care has been sacrificed for other groups’ need for support’ (NBHW 2010a, p. 23).

One important change in the health care field, governed at the regional level, which has clearly affected the home-care services, is the radical cut in the number of

hospital beds since the early 1990s. Between 1992 and 2005, the number of beds was reduced by almost 50% and as a result, Sweden today has significantly fewer hospital beds and shorter lengths of stay than all other EU-countries (OECD 2009, pp. 94–98). For example, the average length of stay in geriatric care was reduced from 21.5 days in 1993 to 12 days by 2005 (NBHW 2007a). The reduced length of stay in hospital was an intended effect of the previously mentioned Ädel-reform in 1992. It established a strong economic incentive for the municipalities to find care outside the hospital as municipalities were required to pay for the very expensive hospital care of older people considered medically ready for discharge. Therefore, older people more often leave hospital with remaining care needs, which in turn has increased the demands for municipal eldercare services. As a result, both residential and home-based eldercare services are increasingly targeted to those with greatest need (Trydegård 2003).

A consequence of the tighter resources for eldercare is that many municipalities have made their guidelines for care services more stringent. The gate-keeping role of the care manager has been sharpened. They are often urged by local politicians and senior managers to consider the municipal budget and make necessary priorities, and to stick to the restrictive local guidelines, rather than to consider the individual older person’s situation and needs as prescribed by the legislation (Dunér & Nordström 2006). Many municipalities also use fees as a device for reducing demand by setting comparatively high charges for older persons with higher income and small care needs.

Marketisation of home-care services

From the previous section, we can see that the declining coverage of home care in Sweden is not the result of an explicit government policy to actually reduce services. In contrast, marketisation of the publicly funded services is more clearly a policy shift intended by the central government. The Swedish eldercare sector has been greatly influenced by the global wave of New Public Management reforms since the second half of the 1980s (Montin & Elander 1995, Green-Pedersen 2002, Blomqvist 2004). After a long period of social democratic governments, in 1991, a centre-right coalition proclaimed a ‘Choice revolution’ within the welfare services. However, just before they lost power, the social democrats had already opened up for marketisation of the publicly funded welfare services by implementing a new Local Government Act. The act gave the municipalities the right to introduce a split between purchaser and provider and to contract out care services to private providers – not-for-profit as well as for-profit. By 1993, 10% of Swedish

municipalities had introduced a purchaser-provider model; only 10 years later, the share had grown to 82% and today virtually all municipalities have introduced such a model (Gustafsson & Szebehely 2009).

One aspect of the high degree of municipal autonomy in Sweden is that the municipalities may decide whether or not to open up eldercare to private providers. In 2010, in two-thirds of the Swedish municipalities (65%), all publicly funded home care was also publicly provided. In contrast, in 4% of the municipalities, more than half of the home-care services were privately provided. Thus, behind the national average of 19% private provision, there is a huge variation, and the two biggest cities in Sweden have chosen different ways forward in this respect: in 2010, 60% of the home-care hours in Stockholm were privately provided compared to zero in Gothenburg (NBHW 2011).

It is not possible to differentiate between for-profit and not-for-profit providers in the service statistics, but it is possible to do so in the employment statistics. Figure 1 shows the increase between 1993 and 2010 of the proportion of personnel in care for older and disabled persons employed by for-profit and not-for-profit employers (the graph does not show the majority of care workers who are public sector employees). During the entire period, 2–3% of the workforce was employed by a not-for-profit organisation, while the proportion employed by for-profit companies increased from virtually zero to close to 17% – considerably more than in Denmark and Norway, two other representatives of the Scandinavian welfare model (Szebehely 2011). The comparatively high consensus between the political blocs in Sweden with respect to market actors in publicly funded welfare services (Green-Pedersen 2002) has probably contributed to the relatively rapid increase of private provision.

Another explanation for the comparatively strong position of for-profit actors in Swedish eldercare is that until recently, the outsourcing to private providers took place after a process of competitive tendering. Especially during the recession of the 1990s, the competition was about price rather than quality (Edebalk & Svensson 2005). This has favoured larger companies as they have greater capacity to meet the paperwork related to the bidding procedure than small companies or not-for-profit organisations, and they can also submit an underbid if needed to enter the market (Government Report 2007:37). As a result, the private sector is highly concentrated: only two corporations make up half of the private eldercare market (Meagher & Szebehely 2010).

More recently, and encouraged by the introduction in 2009 of the Act on Free Choice Systems implemented by the centre-right government that has been in power since 2006, this kind of competitive tendering has become less common. The aim of the choice legislation was to make it easier for municipalities to introduce a customer-choice (voucher) system, where the individual user chooses from among authorised providers the one perceived as having the best quality. Private and public providers receive the same reimbursement, and the users pay the same fee. Thus, the providers are supposed to compete only on quality, not on cost (Government Bill 2008/2009:29).

The government expressed strong hopes that the introduction of choice models would empower users; that competition would increase as smaller companies were encouraged to enter the market and that the competition in itself would enhance quality (Ministry of Health and Social Affairs 2007). Disabled people in Sweden, especially the Independent Living Movement, have strongly and successfully advocated for choice models in disability services, in particular for personal

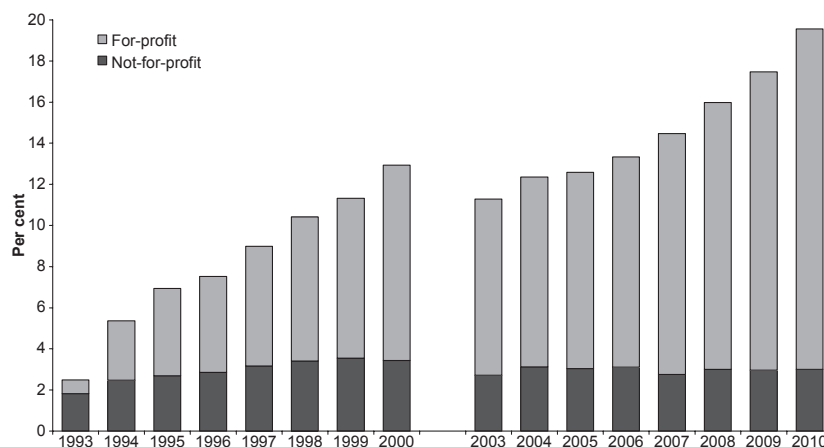


Figure 1 Personnel in publicly funded care of older and disabled persons. Proportions of all employees employed by for-profit and not-for-profit organisations 1993–2010. Source: Statistics Sweden's Business Register, authors' own calculations. Note: The two time periods are not fully comparable because of a shift in the codes in the industrial statistics, which most probably explains the decline between 2000 and 2003.

assistance. In contrast, the emergence of choice models in Swedish eldercare is an ideological decision rather than demanded by older people or their representative organisations (Edebalk & Svensson 2005, p. 19).

In October 2010, stimulated by state incentives, more than half of the Swedish municipalities had introduced customer-choice models or decided to do so (NBHW 2010b). This is a dramatic increase from <10% of the municipalities only 4 years earlier (NBHW 2007b, p. 7). However, despite the fact that it is voluntary for municipalities to introduce the choice models, the government finds the pace too slow. Further financial incentives have been introduced for 2011–2014, and if all municipalities have not introduced choice models by 2014 ‘compulsory legislation will be considered’ (Government Bill 2010/2011:1, p. 163).

The introduction of a customer-choice model in publicly funded services combines with another market-oriented measure introduced 18 months earlier that promotes the development of private sector provision in domestic help. In July 2007, a tax deduction on household services and personal care was introduced. Under this reform, taxpayers of all ages are entitled to deduct 50% of the price of household services up to SEK 100 000 (close to €11 000) per person, per year if the service company has a business tax certificate. The services may be carried out in the purchaser’s own home or in a parent’s home (Government Bill 2006/2007:94). These services are not needs assessed and they are not regulated by the state or local authority, but as we will discuss, they interact with the publicly funded home-care services.

Consequences for older people

As mentioned in the introduction to this article, an important aspect of Nordic universalism is the idea that the same type of services should be offered to and used by all social groups in the population. The quite dramatic changes in the Swedish home-care services described in the previous sections raise the question of whether the changes have affected different social groups differently. In this section, we turn to the actual use of services among older people to investigate whether services are still universally used. We base our analysis on two sets of statistics, firstly a large-scale Survey of Living Conditions and secondly, recent statistics on use of the tax deduction on household and care services.

The Surveys of Living Conditions are based on a national representative sample of the population and carried out yearly by Statistics Sweden. The oldest age group (85 years and older), who use the largest proportion of eldercare services, has only been included in the survey in 1988–1989 and since 2002. A shift from personal interviews to telephone interviews in 2006 makes

comparison with earlier years less reliable, so we therefore compare 1988–1989 with 2004–2005 (the response rate of the entire sample, 16 years and older, was 78% in 1988–1989 and 75% in 2004–2005). At both points of time, respondents were asked about sources of help (more than one source could be mentioned). We focus here on publicly funded home-care services and help from family or friends living outside the older person’s household (excluding care from a spouse or other household member). The analysis presented here is based on non-institutionalised older people (65 years and older) who reported an impairment (cannot walk 5 minutes, board a bus or read a newspaper without difficulty) and who need help with at least one household task (cleaning, grocery shopping, laundry or cooking), a total of 810 individuals in 1988–1989 and 348 individuals in 2004–2005. Numbers and percentages in these two groups were compared using Pearson’s chi-square test. In the 2004–2005 group, each of three sources of help were analysed by level of education (compulsory only versus more than compulsory) adjusted for suitable confounders using logistic regression.

Between 1988–1989 and 2004–2005, fewer older people with an impairment and self-reported care needs were receiving needs assessed home care (a decrease from 46.2–39.8%; $P = 0.043$). Instead the proportion reporting that they received care from family or friends outside their own household increased from 40.8–50.6% ($P = 0.002$). As a result, in 2004–2005, more older people received family care than home care, while in 1988–1989, home care was more common than care by family members. This suggests that a re-familialisation of care has taken place, an unexpected trend given the fact that in Sweden, as in all the Nordic countries, children are not formally responsible for caring for their elderly parents. In this context, it is also important to note that Swedes prefer to rely on the public services rather than the family: only 17% would prefer family care rather than formal care for an older and frail parent, compared to an EU27 average of 54% (Eurobarometer 2007, p. 67).

However, as Tables 1 and 2 suggest, not all groups of older people are equally affected. As shown in Table 1, home care has decreased only among older persons with smaller care needs. Yet family and friends have increased their help not only to older persons with smaller needs outside the home-care system, but also to those with more extensive needs who receive home care but seemingly not enough.

Furthermore, the trend of re-familialisation has not affected all social groups similarly. Table 2 shows that at the end of the 1980s as well as in 2004–2005, the use of publicly funded home-care services was similar among older people with different levels of education. In that respect, home care seems to be used by different social

Table 1 Sources of help among non-institutionalised older people (65 years and older) with smaller and larger care needs, 1988–1989 and 2004–2005 (*n* within brackets)

Proportions (%) receiving help from	Older people with smaller care needs (need help with 1–3 household tasks)			Older people with larger care needs (need help with all four household tasks)		
	1988–1989 (575)	2004–2005 (236)	Change over time (<i>P</i> -value)	1988–1989 (235)	2004–2005 (112)	Change over time (<i>P</i> -value)
Publicly funded home-care services (public or private)	43.8	33.9	0.009	52.3	51.8	0.923
Nonresiding family or friends	41.6	49.2	0.048	38.3	53.2	0.009
Combinations of care						
Home care only (no care by family or friends)	27.1	18.2	0.007	27.5	15.2	0.011
Home care plus care by family or friends	16.7	15.7	0.722	24.7	35.7	0.033
Care by family or friends only (no home care)	24.9	33.5	0.013	13.6	17.0	0.410

Source: Statistics Sweden's Surveys of Living Conditions, authors' own calculations.

Table 2 Sources of help by education level among non-institutionalised older people (65 years and older) needing help with one or more practical tasks, 1988–1989 and 2004–2005 (*n* within brackets)

Proportions (%) receiving help from	Older people with compulsory education only			Older people with more than compulsory education		
	1988–1989 (601)	2004–2005 (220)	Change over time (<i>P</i> -value)	1988–1989 (208)	2004–2005 (126)	Change over time (<i>P</i> -value)
Publicly funded home-care services (public or private)	46.9	40.9	0.125	44.4	37.8	0.232
Nonresiding family or friends	43.4	57.7	0.000	32.7	37.3	0.390
Combinations of care						
Home care only (no care by family or friends)	27.5	15.9	0.001	26.9	20.3	0.171
Home care plus care by family or friends	19.5	25.0	0.084	17.8	17.2	0.888
Care by family or friends only (no home care)	24.0	32.7	0.012	15.0	20.3	0.207

Source: Statistics Sweden's Surveys of Living Conditions, authors' own calculations.

groups to the same extent. But there is a clear class-related pattern in the consequences of the declining home-care services: family care has increased only among older people with lower levels of education (Table 2). (We use educational level as a proxy for social class, but an analysis (not reported here) shows that this trend is very similar whether we compare those with lower and higher education levels or manual workers and salaried employees.)

Older people with higher levels of education purchase significantly more private services in the market than do those with less education (and probably fewer financial resources): in 2004–2005, 16.7% of older people with higher education and self-reported care needs

reported that they purchased help at the private market (paid out of pocket) compared to 6.9% in the group with lower level of education ($P = 0.004$). The question about private help was not asked in 1988–1989, so it is not possible from this data set to determine whether there has been an increase in privately purchased help over time. However, we can conclude that in 2004–2005, there is a dualisation of care: family care is clearly more common among people with less education while privately purchased care is clearly more common among older people with higher education levels.

Table 3 reports a multivariate logistic regression on the use of care in the two educational groups. The analysis shows that the higher use of family care among older

Table 3 Sources of help by education level among non-institutionalised older people (65 years and older) needing help with one or more practical tasks, 2004–2005. Odds ratios (OR) controlling for gender, age, household type and number of needs

	Publicly funded home-care services OR (<i>P</i> -value)	Help by nonresiding family or friends OR (<i>P</i> -value)	Privately purchased help OR (<i>P</i> -value)
Compulsory education only	1	1	1
More than compulsory education	1.041 (0.796)	0.599 (0.003)	2.985 (0.001)

Source: Statistics Sweden's Surveys of Living Conditions, authors' own calculations.

people with lower education as well as the higher use of privately purchased help among those with higher education is evident also when we control for possible differences between the groups when it comes to gender, age, household type and level of needs.

In this context, it is important to note that there is no difference between educational groups in satisfaction with the publicly funded services (NBHW 2010c) and there are no signs that older people with less education more than other social groups prefer to receive family care: according to the latest available Swedish figures from 2000, only around 10% of older people (with higher as well as with lower levels of education) prefer to get help with cleaning or laundry from a daughter or another relative or friend and even fewer prefer family help with more intimate tasks such as help with a

shower (Szebehely & Trydegård 2007). Thus, the re-familialisation of eldercare among older people with less education seems to be coerced rather than voluntarily chosen.

The possible effects of the tax deduction on household and care services introduced in 2007 are not captured in the analysis above as the last year of comparison was 2005. Therefore, we do not know whether there has been a recent increase of privately purchased help and whether publicly funded home-care services are still used to the same extent by different social groups. However, in most municipalities, the tax deduction makes it cheaper for older people with higher income to buy services in the private market than to use the publicly funded home-care services – at least if they only need a couple of hours of help per week (Karlsson & Molin 2010).

Even if we do not know whether older people with more educational or financial resources actually have opted out from publicly funded home care in recent years, it is clear that the take-up of the tax deduction for household and care services has increased from 1.7% of persons 65 years and older in 2008 to 3.5% in 2009. Preliminary statistics suggest a continued increase in 2010 (Sköld & Heggemann 2011, p. 3). In 2009, the average amount deducted was 2900 SEK (around €320) corresponding to an average of approximately 20 h of help per year (Statistics Sweden 2011). Thus, privately purchased household services are still marginal compared to publicly funded home-care services and in particular compared to family care.

However, there is a clear income gradient when it comes to claiming the tax deduction, suggesting that some high-income older people now are using private services instead of, or as a supplement to, publicly

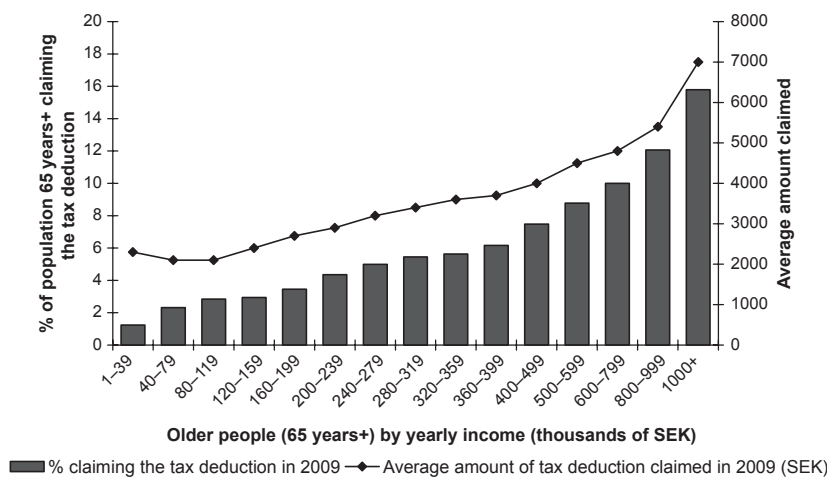


Figure 2 Tax deduction for privately purchased household and care services among older people (65 and older) by income level. Proportion claiming the tax deduction and amount claimed, 2009. Source: Statistics Sweden (2011), authors' own compilation.

funded home care. Figure 2, based on data from Statistics Sweden, shows that the tax deduction is claimed considerably more often by high-income older persons and that higher-income groups also use more services, reflected in a higher yearly amount deducted per person (there are no statistics on the use of the tax deduction in different educational groups).

Discussion and conclusion

In this article, we have analysed the decline in the take-up of publicly funded home-care services in Sweden, followed by an apparently coerced increase of care provided by family members – re-familialisation – among older people with less education. Furthermore, we have analysed the trend of marketisation – the increase of private providers within the publicly funded services as well as the increase of privately purchased help. We can conclude that change in home-care services in Sweden is driven by a complex interplay between decision-making at central and local levels, and it is clear that the eldercare sector is affected also by changes in policy fields outside the sector itself.

The decline of home care and the increase of family care are not a result of legislative changes at the national level. The social legislation still ensures the individual a right to assistance. Children and other relatives still have no formal responsibility to care for frail older people, and there are no advocates for increased family care in Sweden. At the local level, however, many municipalities have been affected by economic pressure since the recession of the early 1990s. They have adapted to tighter budgets by introducing stricter guidelines, resulting in raised thresholds for services. The municipal actions are also circumscribed by decisions at the central level (e.g. increased national ambitions for disability services as well as for childcare, and restrictions in the municipalities' right to raise tax rates) and at the regional level (a drastically reduced number of hospital beds).

While re-familialisation seems to be an unintended consequence of the contraction of home care, marketisation of Swedish home-care services is more clearly intended by national policy-makers. Important legislative changes include the Local Government Act of 1991 which made it possible for Swedish municipalities to out-source their publicly funded services to private providers, the Act on Free Choice Systems (2009) and the tax deduction for household and care services (2007).

Choice models in eldercare were introduced on the basis of arguments about empowering users, and the Swedish government expects that older people's possibilities to 'vote with their feet' and exit services if they are not satisfied will increase the quality of services. However, probably partly because continuity is such a

central aspect of quality in eldercare (Edebalk *et al.* 1995), very few older people actually change their home-care provider. For example, in 2009, only 4% of home-care users changed provider, and one of five of these changes was caused by the provider having closed down (Svensson & Edebalk 2010).

Several scholars have stressed the difficulties in making well-informed choices when it comes to care services, in particular at the stage of life when eldercare is on the agenda (e.g. Meinow *et al.* 2011). Furthermore, not all social groups have the same capacity to find their way in a system built on choice. Those with more educational resources have greater chances of finding the best services which in turn may lead to increased differences in the quality of care (Barnes & Prior 1995, Eika 2006, Glendinning 2008). This is in line with Titmuss (1968) notion that services for poor people tend to become poor services – the 'sharp elbows' of the middle class are important for ensuring the quality of services. The negative consequences for disadvantaged groups are amplified by the fact that when Swedish municipalities introduce choice models, they tend to leave part of the quality control to the 'customers', relying on their active choices and complaints (Swedish Competition Authority 2009, Svensson & Edebalk 2010). The increased focus on consumerism and choice in Sweden therefore constitutes a challenge to universalism.

Universalism is further challenged by the interplay between customer-choice models and the tax deduction for household services combined with income-related user fees. The combination creates an incentive for well-to-do older people with smaller care needs to refrain from using publicly funded home care and instead buying private services, subsidised by the tax deduction. For those with more extensive care needs, there is an incentive to choose a private rather than a public provider for their needs assessed home-care services. This is because within the choice model, private but not public providers are allowed to offer additional services, paid out of pocket by the user. Thus, the older person with a higher income who chooses a private provider for the needs assessed home care can 'top up' by buying extra services from the same staff, paying half the actual cost thanks to the tax deduction. An older person with a lower income can probably not afford to buy these extra services and therefore has a higher probability of sticking to the public home-care provider. We cannot say whether this is actually happening in Sweden because of lack of statistics, but the incentives are obviously there.

Swedish home care as a universal welfare service is under threat. The accumulation of small gradual steps may lead to major institutional changes in the long run and to a dualisation of care. Extrapolating from present trends, older people with fewer resources may increas-

ingly have to rely on family care while those with more resources turn to the market and buy (tax-subsidised) services. Better resourced groups of older people may choose private rather than public providers for their needs assessed home care. As a result, publicly provided services might become dominated by those with fewer resources, which in turn may lead to reduced quality of public home care. The decline of home-care services and the present emphasis on choice therefore signify a threat to universalism and may lead to increased inequalities whereby older people with more resources are winners and more disadvantaged groups are losers.

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