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**Bibliographic note**

The author has a background in sociology, geography and social work and has mainly done work on family care and the public services for older people, in the Nordic countries and internationally. His studies have dealt with both micro aspects and macro features of care, such as local variations in needs and service coverage. A recent study for the Swedish government on informal caregiving is a response to growing interest in this topic in the Nordic countries. Other research areas are demography and support for family carers. The author is professor at the Institute of Gerontology, but also consultant for SPF, Sveriges Pensionärsförbund (The Association of Swedish Senior Citizens).

# AGEING AND OLD-AGE CARE IN SWEDEN. ADMINISTRATIVE, DEMOGRAPHIC, POLITICAL AND FINANCIAL ASPECTS

## Abstract

An historical overview shows how ancient the roots are of the Swedish welfare state. Expenses for older people - pensions, housing allowances, institutional and community care - kept growing in the post-war years, but stagnated in the 1990s. After that, cutbacks in service coverage have lead to more care and support from families, and streamlining of services, but more efficient targeting, diversification and rationing has meant that older people are still served reasonably well, usually through joint efforts by family and state. To give perspective to the findings, several comparisons are made with other countries.

**Introduction**

The aim of this presentation is to clarify present patterns of care for older people in Sweden. This requires a historical perspective, but also knowledge about contemporary factors that affect demand for support and determinants of variations in supply of public services and family care. I will first describe some significant aspects of demography and family patterns, and then public services. Even in the welfare state family and kin are of great importance. As I have worked a good deal with international comparisons of patterns of care and services etc., I will also draw on some of these to provide a context for my Swedish data and conclusions.

**The foreigner's view of Sweden**

To understand Swedish old-age care, be it the big part that takes place inside the family, or that which is publicly provided, requires an historical odyssey. A very common misunderstanding, often shared by Swedes as well, is that 'modern' services for old people in Sweden and the other Nordic countries are just that, modern constructions, and that indeed the whole welfare state is a modern invention. This is flattering for the Swedish self-image among laymen, politicians and administrators, and is propagated in Swedish textbooks. Modern Sweden is seen as a product of liberal (in the European sense) and socialist efforts to create welfare for everybody, not just for the few rich, in time coinciding with universal franchise somewhere in the early 1900s. An example often used is the "universal" old-age pension introduced in Sweden in 1914 (it was not even nearly universal before 1937, below). The image of Sweden as a modern, progressive state was spread by influential books already in the 1930s. The most well-known was Marquis Child's Sweden, The Middle Way, about a country that somehow chose the best from both capitalism and socialism. (Extensive social security and services are sometimes erronously seen as 'socialism'.)

Foreigners reporting on Sweden in the era 1600-1800 mostly tell us about a dirty and backward country, although some of them noticed the well-organized conscription army (in contrast to unreliable soldiers of fortune usually recruited on the continent) and the near-total joint control over people by the state and the Lutheran church. French visitors in the 1700s also observed how well-dressed, proud and self-confident Swedish farmers were - different from France by the time - and that priests had to work the land for a living. In more recent times, the country received many foreign visitors in the early 1900s, eager to learn about progressive things like handicrafts and callistenics for the elementary school.

When Swedish natural scientist Sten Bergman spent a year in the Kurile Islands (Jap. *Chishima*) in 1929-1930, supported by prince Takatsukasa and others, he was surprised to find Japanese children in a remote village school (Naibo on Etorofu) doing exercise according to the Swedish training manual that many of us remember only all too well. (His book from this stay was published also in English.) And, already in 1905 Sweden had an important Chinese guest, the fugitive dissenter Kang Youwei. He stayed a couple of years, visited factories, schools, working-class families, prisons - and an old-age home (it was really a poor-house) in Stockholm. He was deeply impressed: clean rooms, orderliness and good warm food three times a day! His diary noted that 'not even the upper classes in China live this well'…(Kang Youwei 1975, 2008). Half a century later professor Koyama Iwao from Kyoto toured the fledgling Swedish welfare state and praised Swedish old-age care in Jönköping and other places (*Jönköpings-Posten* Aug. 26 1952, a series of articles in *Shizuoka Shimbun* Sept. 1952).

Yet, both residences visited by these gentlemen were soon after the visits condemned by the local authorities, torn down or rebuilt. A contemporary photograph of the poor-house visited by Kang Youwei shows a dormitory with some 16 ladies living in the same room. The old-age home that professor Koyama saw had mostly two persons to a room and doors too narrow for wheel-chairs, toilets in the corridor etc. It was brand new by the time and has since been rebuilt three times. New residents in these places were by that time typically asked to bring only a few small things like photographs of their family, but nothing more substantial. Rooms were furnished, in boarding-house style. Some decade later, this also had changed.

Seeing these modern and modernizing ambitions, it is easy to overlook the path dependency of the ‘modern’ welfare state, that is, how much of its roots that go back to older structures. Modern Swedish (and other Nordic) welfare is unthinkable without contemporary political ambitions and conflicts, but is just as unconceivable without its historical past. A theme in the following will also be the local variations: it has been established that there are bigger variations inside the Nordic countries in old-age care than between them. We all tend to 'homogenize' foreign countries and cultures, and more so, the farther away they are in time and space.

## HISTORICAL AND ADMINISTRATIVE ASPECTS

### Seeds of the Swedish (Nordic) welfare state

The Nordic countries were christened in early medival times around 1100-1200 AD and the church established administrative routines that continue into this day. The c. 2500 Swedish parishes, later (1862) transmogrified into municipalities, have mostly remained intact. A special feature of the Nordic countries was the far-reaching amalgamation of religious life and secular administration, and a socially and culturally quite homogeneous population. Indeed, the keeping of population records was a task of the local parish office up till year 2000 in Sweden, when the church and the state were finally separated.

Already in the 1300s the local parish administrations were granted a degree of autonomy in their own matters. The Nordic parishes were on the periphery of the civilized world and far from the administrative centers of the Roman Catholic church. They therefore were permitted to collect the poor tithe locally and use it locally to provide for the poor. Decisions on who should get support from the the parish was taken jointly at regular meetings - open to everybody - by the priest and six men trusted by residents in the parish. (On the continent, the funds were transfered up the church hierarchy.) (Odén 1985). This helped to reinforce and stabilise a tradition of local autonomy that already existed, but also helped to create local commitment to solve social issues routinely by communal and standardized decisions. It is hard to overemphasize the significance of this historical heritage for today’s welfare programs. In a way, it is just the size of the undertaking that is much larger now, due to rising standards of living and increased productivity. The Nordic countries, including Sweden, have a very long history of systematic, local and collective provision for the destitute, poor, sick and frail, including older people. The foundation of the welfare state is ancient indeed.

After the reformation in the early 1500s, parishes continued to care for their poor, but with more meager means. In 1571 they were required by law to do so, and reminded about this from time to time by central authorities. The bishops would monitor that parishes fulfilled this in regular inspections of parishes. The state took away most of the property of the church during the reformation, but entrusted priests with educating, monitoring and registering their parishioners, and also to control their morals and law-abiding. (Detected breaches against the Ten Commandments meant fines that were paid to the church, which had a handsome income

from this.) Poor-relief taxes were collected, and communal decisions were taken on the use of these funds. Parishes were also required in the 1600s to build poor-houses and organize poor-relief efficiently.

Reliable population records, established in 1749, were important for tax purposes. Already in the 1600s a highly efficient mail and coach system with lodgings every 10-20 km was established. Monitoring the population was also necessary for recruitment into the army. Every parish had to maintain a fixed number of soldiers, who lived in the parish and worked the land with their family, as did their officers. They left for annual exercises if not for war: Sweden was at near constant war in the 1600s and 1700s. Teaching parishioners to read was surprisingly successful as many people were literate long before the compulsory school was instituted in 1842. Attendance to church services was compulsory and new regulations and laws, government versions of the tidings, announcements about missing or wanted persons etc. were read aloud from the church pulpit. Compliance was high up till the mid-1800s, with local variations (Reuterswärd 2002).

Swedish culture has been relatively homogeneous up till recently (post-war immigration now has 20 % of Swedes foreign-born), although Sweden was – and is still – a class society. Yet, social cleavages were smaller in the Nordic countries than on the feudal continent. Farmers usually owned their land and sent their representatives to the parliament; they were frequently allies of the king against the landed aristocracy, when the latter grew to powerful. Most aristocrats owned little and had to work for a living, often as officers. They were decimated in the wars, and new groups had to be knighted, providing opportunities for farmers and others. Their property was often managed by wives when husbands were absent or by widows, and the position of women was comparatively good in the Nordic countries. A very important feature of Swedish society in the 1600s and 1700s was high social mobility, providing outlets for able and hard-working men and women.

Law and order applied not only to the poorer segments of society. Sweden prides itself of a tradition of civil servants that strive to treat all people equally. Examples of poor people getting their right against richer or more powerful adversaries is easy to find in old court records. There are certainly exceptions, but in general Swedes expect to meet with neutrality and objectivity when they have to deal with bureaucracies. A strong sentiment is also that one expects being treated according to the law, although Swedish administrations have very little of the legalistic character found in some other countries. In the 1992 EuroBarometer Study many older people in Southern and continental Europe reported being better treated than others due to their age, but just as many said that they were treated worse, in contacts with government agencies, post-office staff, doctors etc. The Danish and Swedish elderly said mostly that they had not noticed any difference (Walker 1993).

**Administrative and legal aspects of old-age care**

In 1862 the poor relief administration and other worldly tasks - mainly elementary schools - were assigned to a secular body created for this purpose but geographically the same, the municipality (*kommun*). The same separation between the ecclesiastical and the worldly administrations took place in the other Nordic countries at about the same time. Long before universal suffrage in Sweden, municipalities were run in a quasi-democratic fashion and records from meetings of their poor relief boards offer interesting reading. Paupers generally had to be grateful and comply with what was decided for them, but there are also examples of obstinate paupers who made trouble, appealed to higher administrative courts, and indeed sometimes had their way (Engberg 2005).

The Nordic countries have as of old a simple administrative structure. Beyond the municipality, there are 23 regional associations of municipalities (*landsting*) that were established in 1869 to provide health care, a thing that was not practicable for the small municipalities. About a third of the municipal tax goes to this organization which runs hospitals and primary care. Both municipality and landsting are politically governed and financed from 'below': the tax averages at 31 % of one's income. Only persons with quite high incomes pay national, progressive tax. On average, Swedes spend some 55 % of their income on tax (including the 25 % VAT etc.). The national government is in comparison relatively weak, and the long arm of the government, the county office (*län*, corresponds to Jap. *ken*) with its governor and rather small office does not have capacity to monitor all municipalities and their doings. After some recent scandals in old age care, they are now (since 2005) equipped with inspectors who act on complaints, but also take their own initiatives. (This was done also before by the county office, but they were then even more understaffed for the task.) The *län* does not always cover the same area as the *landsting.*

The relationship between the local authorities (municipality and *landsting*) and the national government was and is to some degree a negotiated one: the national authorities could and can not have their way in all matters. Conflicts between center and periphery are part of Swedish history, as well as in other European countries. Many aspects of public old-age care today can be understood in the light of this tension. The author attended a series of conferences held by Socialstyrelsen (the government's board to oversee health care and social services) in the 1980s, where the message was to close down old-age homes and build more modern institutions instead. This was listened to by municipal representatives, but one of them stood up and said that "I hear what you say, but in our municipality we like our old-age homes, and old people and their families like them. Therefore we are going to keep them. Thank you for the word!".

Most (c. two thirds) individual income tax paid in Sweden never leaves the local arena, being tax to the municipality and the *landsting*. New taxes and other burdens levied from "above" were often fought in different ways, and at least some understanding of the local needs was expected. The last major uprising against the state was in 1743, when many rebels were massacred by the military. There was also major unrest during WW I, with hunger riots etc. and up till the 1930s Sweden had the world's highest strike rates. The 1600s responded to popular discontent with the authorities by creating an administrative court system, paralleling the civil and criminal court system.

Anyone affected by an administrative decision – also in poor relief (with some interruption in the 1800s) - and who was dissatisfied with it could appeal it at little or no cost to this court system. (Finland and Germany have similar systems.) Also today this holds, although it is rare for applicants of/users of services to appeal their cases. Still, this serves as a check on the discretionary power of local administrations. About 900 persons appeal their cases in one year; this should be related to the about thirty thousand decisions made in old-age care every month. Appeals mostly concern that Home Help or an institutional placement has been denied. The low number of appeals may be due to potential clients not applying when they deem their chances slim or assess the services in critical terms. There may also be a practice among care managers to talk clients-to-be out of even applying. Hence there will be few applications – and appeals - from clients who may feel that there is no point in asking for what they will not get. It is likely that the latter are the clients that increasingly receive

support from their families (below) or who buy private services (often so-called ‘black work’).

In international perspective, Nordic municipalities enjoy a remarkable autonomy in administrative and financial matters. Nordic municipalities set their own tax levels to finance their programs and Swedes who don’t have income above a rather high ceiling only pay a flat-rate municipal tax, amounting to about 31 % of their income. (A third of this goes to the *landsting*; income earners above the ceiling also have to pay progressive national tax.) An inter-municipal tax equalization scheme enforced by the parliament makes sure that the capacity of municipalities to provide services is about equal, a scheme little popular with the more affluent municipalities. The tax rate was some 6 % in the 1920s and 20 % in the 1970s; at some 31 % today it is now considered impossible to raise further.

The administration of these communal affairs was and is a rather transparent matter and all public records are (formalized in law since 1762) publicly available. Only classified military documents and records on individual clients of the social security, health care and social services are closed to the public. For example, records on income and taxes are public documents. After all, people may be willing to pay tax – opinion polls show astonishing inclination to do that in Sweden – but they want to have the chance to control that other people also pay their due. In Swedish news media even small instances of tax cheating/avoidance (even if quite legal) of public figures is a much bigger news item than for example their (potential) erotic escapades.

Another important aspect of Swedish life and mentality is the quite recent urbanization: over 90 % of all Swedes lived in sparsely populated rural areas up till the 1900s and half of them still did so in 1945 (c. 5 % in 2000). In 1749 Sweden had 1.8 million inhabitants, that is, on average some 700 persons/parish. One easily understands that this meant that overseers of poor-relief knew all their fellow parishioners and v.v., a practical but maybe not always enviable situation for recipients of relief. Many municipalities are still quite small, averaging at ca. 30,000 inhabitants.

People have always organized locally to see to their common needs; the concepts and routines of the nation state took longer to catch on, also in Sweden, and real 'nationalism' was unknown before the ca. the 1880s. The national government tried to regulate the poor and poor relief already in the 1500s (the church meeting in 1571). In 1642 and again in 1686 parishes were urged to build poor-houses for ‘their’ paupers “without delay”, although parishioners were not quick to follow, nor afraid to air their deviant opinion. For example, bishop Haqvin Spegel inspected Habo parish (near Jönköping) in 1687 and also scrutinized their poor relief, which he found unsatisfactory. The trustees of the poor relief board, according to the records, stubbornly told him that they “may or may not in future consider building a poor house”. These instructions were repeated, but a government inventory in 1829 found that many parishes were still lacking in fulfillment after more than two hundred years of central directives (Skoglund 1992). In fact, this was still the case with a tenth of them in the early 1900s.

In the 1700s and 1800s population growth and shortage of land caused increasing poverty in Sweden. In combination with conflicts between dissenters and Lutheran orthodoxy this eventually caused many to emigrate. It became necessary to regulate the responsibility for paupers more explicitly, as parishes often fought over which one was responsible for a certain pauper. This was done in 1788, when the local responsibility was clearly stipulated:

everybody should have a ‘Home Right’ (hemortsrätt) in his/her parish (municipality) that was by law responsible for providing for him/her. After age 60, this could not be changed, except for widows who remarried. When a pauper received help outside his/her own parish, the home parish would receive a bill for the costs. This was a common feature of poor relief and the last traces of it were not removed till 1999, when free movement of institutionalized old people was guaranteed in the Social Service Act, against some municipal skepticism and reportedly still not fully operational. The preference in Swedish administrations is for consensus, and that social policy ‘filters down’. Changes are often enacted piecemeal and by ‘muddling through’, rather than through heavy-handed government decrees.

In spite of somewhat improved pensions in the 1930s old people made up the majority of poor-relief recipients up till the late 1940s, when pensions were raised substantially and many municipalities introduced housing allowances. In1950 there were still nearly 2500 municipalities, usually geographically synonymous with the parish, most of them quite small and each with their own administration, public elections etc. Bigger municipalities and towns - still half the population lived in rural settings in 1945 - had subdivisions of local units to monitor people and poor relief, somewhat like traditional Japanese and Chinese systems. For example, the author's grandfather was on the poor relief board and the school board in our small rural municipality, and he knew literally everybody there, and they knew him. Reforms reduced the number of municipalities to ca. 1,000 (in 1952) and today's 290 (in 1975). The government wants another reform, but there is little local political interest in this. As local self-governance is protected in the constitution, there is not much the national government can do, except manipulating economic incentives (below). About 250,000 persons held unremunerated, elected posts in the municipalities in the early 1950s,that is, about 1 in 30 of the population (7 millions in 1950). Today they are reduced to ca. 50,000 and getting ever more difficult to recruit. Like in China, where the *hukou* is a kind of successor of the *baojia*, more modern systems of administration and control emerged out of the traditional ones in Sweden. Creativity is based on continuity.

Notwithstanding these changes in Swedish administrations, local welfare workers and health care staff usually know their catchment area and (potential) clients quite well. A number of studies illustrate this fact, both in urban areas and more rural ones. Recently the author with colleagues interviewed all residents 55+ in a small municipality about care and care-giving. Many care-givers and nearly everyone who needs personal care were known by social workers and district nurses (work in progress for the National Board of Social Welfare). This transparency may to some observers, like the author, seem reassuring and be interpreted as continuation of traditional links between citizens and authorities. To others this may appear a suspicious feature of a society with too little privacy, reminiscent of totalitarian systems.

Soon after 1788 the government in a law placed the primary responsibility for old people with their off-spring. The filial obligation in Sweden officially never extended beyond parents and children, although attempts to have other relatives shoulder maintenance of paupers can easily be found in the protocols of local poor relief administrations. This obligation disappeared with the Poor Law itself in 1956 and it was removed from the Civil Code in 1978: it was then argued that public old-age care was now so extensive that this law was obsolete (but obligations still apply for spouses). The lawmakers emphasized that they in no way wanted to abolish the *moral* duty to care for parents, as if they could regulate that (government bill 1978/79:12). From the old poor-relief era we can find in the records many cases of overlapping responsibility, where the municipality paid family members in kind or sometimes in cash for their efforts to care for parents, siblings or more distant kin. Sometimes

the outspoken motive was to avoid their burdening the municipality, which might happen if the family was overburdened, sometimes the reason was explicitly humanistic.

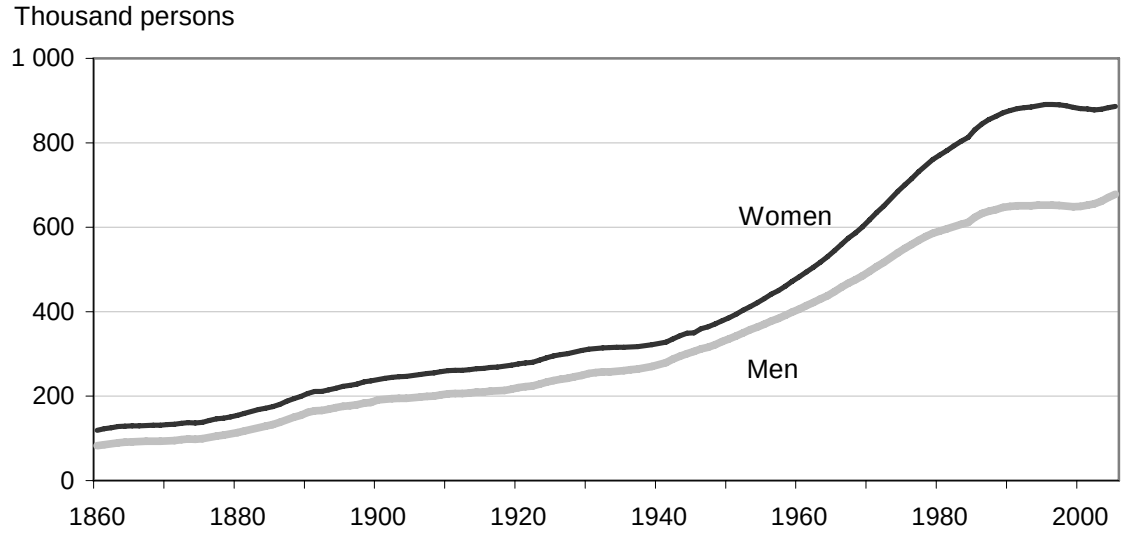
The general sentiment of the time was that familial piety was declining, which of course is an old idea. It is echoed in writings from the 1700s and 1800s and asked explicitly in a 1929 government survey about poor-relief to 250 municipalities. Many chairmen of the local poor-relief boards reported that people no longer had the same feeling of responsibility for their kin as "earlier" (SOU 1932:36). Declining or not, reliance on kin was often insecure, and many people organized in mutual aid societies in the 1800s and early 1900s. The local, private and voluntary health care associations eventually were taken over by the state and made compulsory in 1953. Locally elected representatives have been on the regional boards of these until recently (2006). This is typical of the Nordic, reformistic approach to social welfare, where the private and the state gradually overlap and penetrate each other. An important part was also played by the large organizations of popular culture, the temperance movement, the labour movement (still administering unemployment benefits), dissenting religious and political movements, various self-help organizations (such as the cooperative movement and the voluntary health insurance) that all contributed to the 'social capital' of Swedish society.

## DEMOGRAPHIC ASPECTS

### Population ageing

When Swedish population data were collected for the first time in 1749 the results were immediately classified as state-secrets because they were considered politically sensitive. It was found that the country had only 1.8 million inhabitants, after devastating wars with Russia, crop failures and epidemics. These early records show that 6 per cent of the population was old (aged 65+) at that time. During the later 1700s and the 1800s, as the Nordic countries underwent the demographic transition, there was rapid population increase and proletarization. The proportion of older people in the populations of Nordic countries rose slowly in the nineteenth century, reaching 8 % in Sweden in 1900 (out of a quite youthful total population of about 5 million), and 17 % today, out of 9 million inhabitants (and 5 % are 80+). In absolute terms, the number of old Swedes doubled in the four decades following 1860, as shown in Figure 1. A century ago demographers were predicting further increases in the elderly population. The main concern at that time was drastic declines of fertility, but Sweden was also among the first to set up a near-universal - although very meagre - pension system in 1914 (Sundbärg 1915).

**Figure 1. Number of men and women aged 65 and older in Sweden, 1860-2005**




Source: national population statistics

Historical changes in marital patterns contributed to population aging by their effects on fertility. The increasing proportions of the never-married in the Nordic populations during the 1700s and 1800s mirrored increasing difficulties that young adults had in establishing independent lives, in spite of substantial emigration to the United States and other destinations. More men than women emigrated, causing a severe imbalance between the sexes: in the beginning of the 1900s there were about 1200 women of marriageable age for 1000 men in Sweden, in Norway the ratio was about 1400 women for 1000 men (ages 20-50). The "north-west European family system", as it has been termed, implied that many people entered marriage quite late and many not at all. In Sweden in 1749, about 5 % of the men (50+) and 9 % of the women were single (never-married); there was a severe shortage of men in these cohorts after devastating wars with Russia. By the 1920s 19 % of the women and 12 % of the men were still single as they approached old age (60-64). The very low rates of nuptiality that continued up to WW II meant that rates of singlehood were high among elderly cohorts well past the 1950s. (Among Swedish people aged 60-64 in 1950, 14 % of the men and 21 % of women were still single.) The long decline in fertility rates meant rising proportions of old people in the Nordic countries, though there were some variations, as shown in Table 1. The Nordic countries were among the first to experience population ageing, because of increasing longevity and declining fertility. After a temporary plateau at present, there will be another growth in ageing around 2020-2030. Swedish planning commissions and others have repeatedly analysed this and speculated on the implications for costs and services (Lagergren & Batljan 2000, Klevmarken & Lindgren 2008).

**The family situation of older people**

In contrast to popular stereotypes about waning family solidarity – in other people's families, mainly - a number of studies now conclude that the Western and Nordic family is far from dead. Recently a Swedish study established that old persons in just a few decades have seen their family networks expand and available evidence indicates that support, help and care in the family is stable or even increasing.

The marital status of the elderly population is important in this context because it tells us something about the availability of an immediate source of care, the spouse. It varies somewhat across the Nordic countries, for historical and cultural reasons. Data in Table 1,

giving marital status in 1950 and 2005, show a decreasing proportion of single and rising proportion of married elderly in all the Nordic countries.
The large discrepancy in singlehood between men and women, with more women being never-married, that was seen in 1950, has become much smaller or even reversed by 2000. The only exception to the decline in sex differences in never marrying has been in Finland, which had very heavy losses of men in the Second World War (proportionally among the heaviest of the participants in that war).

Noteworthy is the rising proportion that has a spouse. Further, the length of time lived with a spouse is much longer than in the past. Local historical studies have illustrated the extremely rapid turnover of farms due to death of the owner well into the 1800s. Now death takes its toll much later in life, although probabilities of divorce among old people have been rising (Table 1). Yet, never before have so many people been married so long to the same person, as is evident from statistics for Finland and Sweden. A visible sign of this is the large number of Golden Weddings that nowadays meet readers of the so-called family page of Nordic newspapers. This should not surprise us: marriages dissolved by death on average lasted about 15 years during the 1700s, about 25 years in the early 1900s, 36 in 1952, 42 in 1981, about 49 years in 2000 and 50 years in 2006. This is about the same level as in Japan.

**Table 1. Percent distribution of old people (65+) in the Nordic countries by marital status, 1950 and 2005.**

| | *Single* | *Married* | *Widowed* | *Divorced* | *Total* |
|---|---|---|---|---|---|
| Denmark | | | | | |
| 1950 | 12 | 51 | 36 | 2 | 100 |
| 2005 | 5 | 52 | 33 | 10 | 100 |
| Finland | | | | | |
| 1950 | 14 | 39 | - - - --46 - - - | ---------- | 100 |
| 2005 | 9 | 50 | 30 | 11 | 100 |
| Iceland | | | | | |
| 1950 | 19 | 39 | 41 | 1 | 100 |
| 2005 | 10 | 54 | 27 | 8 | 100 |
| Norway | | | | | |
| 1950 | 17 | 46 | 36 | 1 | 100 |
| 2005 | 7 | 52 | 33 | 8 | 100 |
| Sweden | | | | | |
| 1950 | 15 | 46 | 37 | 2 | 100 |
| 2005 | 8 | 51 | 28 | 13 | 100 |

Sources: official publications and information from national statistical offices

About 14 % of Swedish marriages contracted in 1906-10 were intact 50 years later, compared to 24 % of those contracted in 1946-50. It is indeed possible to find marital unions contracted

before the Russian revolution and which outlived the Soviet state. Table 2 provides more detail on marriages of old people in Sweden. Finland, that was lagging in this regard earlier, has recently caught up, due to rapidly increasing longevity of in particular Finnish men. Almost 26 % of Finnish marriages contracted 50-54 years earlier were still intact in 2005, as were 12 % of those contracted 55-59 years earlier and 3.4 % of those contracted 60-64 years earlier (calculated on data provided by Ms. Erja Ahokas, Statistics Finland).

A rising proportion of older people are married and stay married into advanced age, visible in many long-lived marriages, and most (88 %) are in their first marriage. By comparison, only 62 % of married persons aged 61+ in Norway in 1801 were still in first marriages, reflecting high mortality in that era. Farmers were more often remarried than the landless, and remarkably many of the women in the former group were older than their husband (Statistics Norway 1980 Table 14, our own calculations). Due to high rates of remarriage about the same proportion of elderly Norwegians were married in the 1860s as in more recent times. It appears from the Swedish evidence that there are two tendencies: rising longevity bolsters survival of marriages, but if those who are widowed or divorced find a new partner, they will usually not remarry. Norms have changed, and remarriage is now punished with reduced pension.

It should be mentioned that many people – young and old – live in relationships outside conventional marriages. Beyond rising rates of marriage among older persons, about 5 % live in common-law relationships, and some 4% - 7% have a LAT-relationship (living-apart-together)(Sundström 2009). The rising marriage rates of the past imply that an increasing proportion of old people will have off-spring. When the Swedish government in the 1930 and 1935 censuses required information about child-bearing for all women who were or had been married (information cross-checked by the parish priest against records), it was found that 14 % of all marriages were childless, and on average married couples had 3.3 children. For marriages that had lasted 25 years or more – which a minority did - only 3 % were childless, and on average they had 5.1 children. In the early 1950s these cohorts had entered old age and in a 1954 survey 22 % of the Swedish elderly (67+) were childless, 32 % had 1-2 children, 22 % had 3 or 4 children, and 23 % had 5 or more children (11 % of the married, 32 % of the unmarried, 19 % of the men and 25 % of the women were childless; SOU 1956:1 Table 6 p. 257).

**Table 2. Proportion married older persons, by age, Sweden 1950, 1975 and 2000,**

*Age group, per cent married*

| | 65+ | 65-79 | 85-94 | 80+ | 90+ | 95+ |
|---|---|---|---|---|---|---|
| 1950 | 46 | 50 | -- | 20 | 10 | -- |
| 1975 | 50 | 56 | 17 | 25 | 10 | 5 |
| 2000 | 51 | 59 | 22 | 31 | 12 | 6 |

*Percent remaining marriages by marital cohort duration*

| | 50-54 | 55-59 | 60-64 years | 50 years-w | 65 years-w |
|---|---|---|---|---|---|
| 1960 | 13.5 | 5.0 | 1.2 | 31 947 | 197 |
| 2000 | 23.9 | 12.6 | 3.9 | 121 557 | 1 606 |

Source: our own calculations on offical statistics.

Note: these data are not immediately available, as numbers of weddings a given year have to be combined with dissolution of marriage by cause and length of marital union 50-54 years later etc.

In other words, over half of old people from an era without modern birth control techniques were childless or had just one or two children. A similar pattern emerges for Denmark in 1962: 18 % was childless, 20 % had one, 20 % two children, and a minority (27 %) had 5 or more children. The large families were most common among the oldest of the old, and least common among the 65-69 population who more most likely (23 %) to have just one child (Shanas et al. 1968, our own elaborations on Table VI-14). Comparable later data are scarce, but childlessness was about the same among Danish elderly in 1977 (17 %) and 1988 (19 %), though somewhat higher proportions had one, two or three children (55 % in 1962, 61 % in 1988) (Platz 1981, 1989). Childlessness clearly is decreasing among the Danes, as it was only 13 % among 60-64 year olds and 10 % among 50-54 year olds in 1987 (EGV 1989).

Finland had a somewhat deviant pattern in 1950: about the same proportion of old people were childless (19 %), but a substantial fraction had many children (29 % had 5 or more and fewer had one (13 %) or two (13 %)(Statistics Finland 1953 p. 42). At a later point in time, 1991, 17 % of 56 year olds – about representative of today's old Finns - were childless, 16 % had had just one child, and 32 % had two children. Only six per cent had ever had five or more children (figures refer to live children ever born to 56 year old Finns: our own calculations on Statistics Finland 1992, Table 24a).

For Norway we can draw on data in the OASIS project. In 2000-01 a fifth of the 75+ were childless, but among the 'young-elderly' (65-74) about 15 % were childless and among the middle-aged (55-64) only 11-13 % were childless (Daatland & Herlofson 2004). For Sweden in 1976 26 % of the 65-74 were childless as against 17 % of the 45-64 year old (Statistics Sweden 1980). In 1988-89 19 % of the 65+ had no children, in 2002-03 it was down to 15 % (Socialstyrelsen 2004b).

In other words, the proportion that is childless has decreased in the Nordic countries and seems to have leveled off at about 10-15 % of elderly people. It can not be expected to decrease much further, as a rather high fraction of middle-aged cohorts report that they have never lived in a relationship. For example, 9 % of the Danish men and 6 % of the Danish women aged 45-49 years in 2002-03 report this situation (Aeldre Sagen 2004). Similar figures are reported from Swedish fertility surveys of men and women. In a European perspective, childlessness is higher among the 50+ in for example Germany and Spain (analysis of SHARE). Increasingly, old people in the Nordic countries - and even more so among the cohorts in turn to become old soon - have children. Just having a single child has by no means become more common, and may be even less frequent than before.

**Kinship patterns of older people**

It is well-known that kinship networks of old people in some ways are more extensive today than in the not-so-distant past. For example, more generations are alive at the same time, a trend that is noticeable among Nordic elderly. In cohorts entering old age in the mid-nineteenhundreds many had lost either or both their parents quite early in life. That is now a rare situation, though for example in Finland many lost their fathers earlier than in Sweden, reflecting both shorter longevity of Finnish men and the vast losses of men during the war. Another reason for losing parents later is the long trend of earlier child-birth, lately also more

compressed in the life-course of the parents. There are also class gradients to family patterns, as workers and farmers tend to lose their parents earlier than middle- and upper-class persons.

In Denmark 19 % of old people belonged to a four-generation constellation in 1962 and 25 % in 1977, though the majority are part of three-generation families (EGV 1989). For a chronological perspective we may draw on another source: in Denmark 74 % of the 67+ had grandchildren in 1962 as against 78 % in 1977, for greatgrandchildren the rate was of course lower but also increased, from 15 % to 21 % (Platz 1989). In Sweden in 1994, 65 % of old people had grandchildren (Socialstyrelsen 2006). Analysis of data in SHARE indicates that a higher fraction of older (50+) persons in Denmark and Sweden (the two Nordic countries participating in SHARE) have grandchildren, than in other European countries. They also provide care for their grand-children just as often (below).

Access to one or more siblings is also more common now than previously. In Denmark for the 67+ the availability of a sibling rose from 82 % in 1962 to 85 % in 1977), and increased also in Sweden (65+) from 75 % in 1988-89 to 79 % in 2002-03 (Socialstyrelsen 2004a Table 4). The more comprehensive panorama of having both partner and children seems to show an increase as well; in the case of Sweden from 47 % to 51 % (same age and years as earlier) and the proportion having neither decreased from 14 % to 9 % (ibid.). If *all* near family – defined as partner, children and siblings - are considered, availability was stable at 39 % of old people.
Conversely, a small and shrinking group of old people have neither of these family ties: In Sweden of 1988-89 4 % had neither partner, child nor sibling, as against 3 % in 2002-03. Due to mortality of spouses this is even lower among middle-aged persons: in Denmark 1 % of the 60-64 year age group had neither of these in 1987 (EGV 1989). In Norway in 1981 this held for 4 %, 35 % had all of them (Gulbrandsen & Ås 1986). It should be noted that women and working-class elderly people are at a disadvantage in these respects, primarily because they lose their partners earlier (or have remained unmarried). Yet, in all social classes more people have parents alive, and they lose them ever later in their own life-course.

Comparable data for the other Nordic countries are unavailable, but there are indications of more old people in the past lacking close family. Thus 14 % of elderly Finns in 1950 had neither spouse nor children. In Sweden in 1954 the figure was 17 % and in Denmark in 1962 it was 13 %, in 1977 11 % (Statistics Finland 1953, SOU 1956:1, Platz 1981).

Family relations beyond these close ones have been assessed in more global terms in a few studies, but are harder to compare. Thus, in a representative population survey of Swedes 75+ in year 2000, no one reported that they lacked relatives altogether, though the exact meaning of this remains unclear (Socialstyrelsen 2004a).

**The geography of family ties of older people**

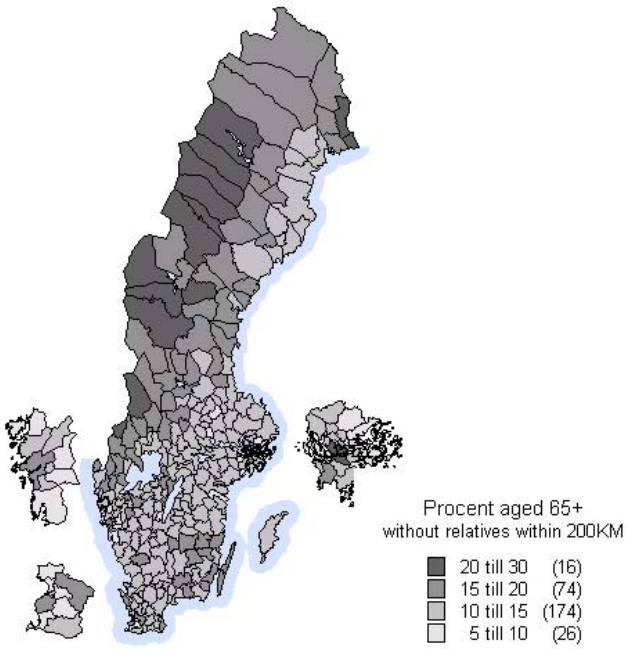
To these purely demographic aspects of the kinship panorama we may add the geographic availability of kin. This provides a somewhat different picture. Among the 75+ in Sweden in 2000, 25 % were married and had children and siblings, though only 5 % were married *and* had at least one child and one sibling living ‘nearby’ (within 15 KM);17 % had neither partner, children, siblings or ‘other kin’ living ‘nearby’, and only 3 % were married and had representatives of all the three latter relationship types within that close range. (36 % had both partner and child, 22 % had partner and child living ‘nearby’)(Socialstyrelsen 2004a).

Generally speaking, we would expect relatively high local density of kin networks, considering that most people in for example Sweden live on or quite near the place where they grew up. Geographical mobility has been remarkably stable since 1749 at about 8 % of adult Swedes moving across a parish border annually. Many moves take place *inside* a parish, as most moves are short distance. Simple cross-tabulations also indicate that most adults live in the county where they were born: 81 % of the population in Scania (Malmö), 68 % of those who live in Stockholm county (our own computations on Table 1.3.2 in Statistics Sweden 2006). Nine out of ten geographic moves are related to family (moving out from parents, marrying etc.); few move for reasons related to work. In surveys old people report low inclination to move, and lower now than in the 1950s and 1970s, when substantial numbers wanted to move, just to get access to modern housing.

Nevertheless, access to close kin does vary locally in at least Norway and Sweden, with potential consequences for frail older persons. At the most basic level, it is found that living alone varies regionally (Brevik 1985, Davey et al. 2006) and probably does so also in the other Nordic countries.

Swedish data in Figure 2 shows the percentage of very old (80+) persons in each of the 290 municipalities that lack a partner (nearly all live alone) *and* have no child/ren within a 200 KM radius. The source of this information is the unique Swedish multi-generation registry, established in 1947 and covering the whole population. On average 15 % of the 80+ have neither partner nor a child reasonably near, but local variations are big, with much higher rates in many northern municipalities (Alm Stenflo 2006). These variations have obvious implications for the public services, as we shall see below.

**Figure 2. Availability* of close kin (partner and children) for elderly (65+) Swedes in 2004. Percent**



* No partner and no child within 200 KM distance. Only "biological" off-spring is considered. The fractions in border municipalities are somewhat overestimated as children living in neighboring countries are not registered.
Source: courtesy data provided by Gun Alm Stenflo, formerly at Statistics Sweden, now at Statisticon, Uppsala.

There is thus a good deal of geographic closeness, with important local variations, but also many old people who have relatively thin family networks around them, even although this group, as we have seen, may be proportionally smaller today than, say, 50 years ago. A follow-up for a Danish town (Odense) in the 1700s found that many of those who attained old age by then often had off-spring, but off-spring that was not available for sheer distance and/or small possibilities to overcome that distance (Johansen 1987). Similar patterns in Sweden in the 1800s have been described by Gaunt (1983). It is possible that old people deprived of *all* near family (blood-ties) that were singled out in some early studies in the 1950s and 1960s today is a small group indeed, but that other types of vulnerabilities now step in the foreground. In Sweden in 1954 2 % were categorized as 'isolated' (SOU 1956:1), in Denmark in 1962 'between 2 per cent and 3 per cent' lived in 'extreme isolation' (Shanas et al. p. 262). The Norwegian survey in 1953 reported that 5 % had no contact at all with family, though after considering contacts with friends few were considered to be completely isolated (Ström 1956).

If we restrict the perspective to children, maybe the most significant social tie for old people beyond a partner, it is by now well-known that distance to closest child is small in most European countries including the Nordic ones, nor has this distance grown substantially, judging from Danish and Swedish evidence, whether measured in travel time or geographic distance. Off-spring have moved out of their parents' home near-completely in the Nordic countries, but have not moved far away. Yet, about a tenth of elderly Swedes have their closest child at a considerable distance that rules out frequent physical contact (Socialstyrelsen 2004a) and a quarter of the Danish elderly had their closest child more than thirty minutes travel time away. In Finland in 1976 76 % reported to have children "in the same locality" (Karjalainen 1980) and in Norway in 1985 9 % lived with children and 19 % had them in their vicinity (Sundström & Waerness 1987). The European SHARE-project gives more, and comparable, details on these aspects (SHARE 2005).

The perspective of off-spring naturally provides a more diversified picture, and a sizable minority will have their parents rather far away. For example, in Sweden in 1984 2 % of the 30-49 olds lived with parents, but 6 % had them in the same house or the immediate neighbourhood, and in total 37 % had them within 15 KM distance, 29 % within the 15-150 KM rayon, but a fifth (19 %) also had them more than 150 KM away, and 13 % lacked parents (after Sundström 1984).

Frequency of contacts with relatives is a staple in surveys of old people, and without going into detail it is obvious that interaction remains high though more of the social life took place inside their households in the past, when co-residence with children and others was more common. It is illustrative that co-residence declined in Denmark between 1962 and 1975, but at the same time *temporary* stays in each other's homes increased vastly (Platz 1981). There is regrettably no later information on this, except that studies of vacation patterns find visits to relatives to be one of the most common 'tourist' activities.

To some extent geographic and social mobility go together, resulting in longer distances between old people and their off-spring, when the latter are upwardly mobile, with less chance for physical contacts between them. Not observing this may lead to premature

conclusions about old parents being neglected by children who have 'made it' socially. If the distance factor is accounted for – social and geographic mobility go together - variations in social contacts between generations of different social status vanish (Sundström 1986), although a qualitative study found that 'careerists' tended to provide less care to ailing parents living in the vicinity (Winqvist 1999). In a demographic perspective it emerges that middle-class adults more often have ageing parents still alive, though these seem to be healthier and in less need of help than parents of working-class adults. The latter, on the other hand, less often have parents alive, resulting in care-giving for parents about equally often in all social classes (Socialstyrelsen 2004a, 2006). It may also be well to note that in spite of substantial social mobility in the earlier half of the 1900s in the Nordic countries, parents are likely to have off-spring in the same social stratum.

**Living arrangements and housing of older people**

As indicated above, marital status does not translate all too smoothly into living arrangements of old people. In general, most older people in the Nordic countries now either live alone or with a partner only, as co-residing with off-spring or others has become rare indeed. A trend toward increasing household atomization holds for the populations at large. In Norway, which like Finland was affected by housing shortages and other difficulties after the war, 12 % of all households contained relatives or non-kin in 1967, compared to 7 % just two decades later (information distilled from the ingenious Norwegian household surveys, Ås 1989). Census data in the Nordic countries rarely provide relevant data (censuses are no longer undertaken in Denmark and Sweden) to describe the household structure of older people in any detail, but we may gain some evidence from surveys.

The stereotypical image of old people historically mostly living with off-spring in complex households of three generations and/or similar constellations has some support in demographic studies, but variations between local areas were often great (Moring 2003). Some Northern areas in Sweden shifted from great complexity towards simpler, nuclear family types in the later 1800s (Egerbladh 1989). But in other areas with industrial centers, households grew more complex with more generations living together or with other types of household extension (Tedebrand 1999). This has been interpreted as a survival strategy along the lines described by Michael Andersson for England. Before 1800, many old people lived alone or just with their spouse, but it is hard to pinpoint a single structure or development. Also in Norway household structures varied a good deal, and in Eastern and Northern Finland stem families were common (many of these vanished with the evacuation of Karelians away from the advancing Soviet army in 1940). Complex families may historically have been somewhat less common in Denmark (Moring 2003).

From a demographical perspective, the rural three-generation household stereotype is problematic, not only because it assumes that members of all three generations were alive at the same time, but also because it often assumes that at least one generation was propertied. Possibly ownership of property was widespread a few centuries ago, but around 1900, when most Swedes still lived in the countryside, the large majority of new fathers were proletarians. At most 25 % of the newborn in Sweden had a father who possessed real estate, judging from information on fathers' professions in the statistical yearbooks.

The trend in three-generation households can be assessed for Denmark thanks to a special analysis done in connection with the wellknown 1962 three-countries study (Shanas et al. 1968). A representative subsample of 2700 persons in the Danish 1845 census was compared

with the 1962 evidence. It emerged that living alone among old people (65+) rose from 9 % to 28 % and living just with one's spouse from 10 % to 45 %, but living with children shrank from 52 % to 27 %. At both times, most of these children were unmarried, and a majority of them lived with ageing, but still married parents (Stehouwer 1970, my own calculations on Table 3.7). The 'typical' three-generation household had over a century declined from 7 % of *all* households in 1845 to 2 % in 1962. Two thirds of them were headed by the second generation in 1845 and about half of them in 1962. There were rarely at either time *two* complete families in these constellations, and it seems that the arrangement was mostly a response to death, divorce, illness or some other calamity in either generation in the family (ibid.).

Notwithstanding these objections to simplified views of historical family patterns, it remains that co-residence was much more common in the recent past. For example, in 1954 three out of ten old Swedes lived with one or more of their adult children, although only 9 % lived with a grandchild in the household. In 1975 these arrangements had shrunk to 9 % and 1 % respectively. In Norway in 1973, 4 % of old (67+) people lived with grandchildren under 16 (personal communication from Dagfinn Ås, Norges Byggforsknings-institutt). Of the grandchildren residing in Swedish households of old people in 1954, half were children of a married middle-generation, a quarter the children of an unmarried daughter and a quarter were children without any parent present (own computations from original data). Thus, even when the household was extended, the stereotypical three generations household was rather unusual. However, it was indeed common to live in an extended family at *some* point in time, for example sometime during childhood. Surveys in Finland and Norway in 1983 show that three out of ten adults (25-65 year old) had lived with relatives beyond parents and siblings when they grew up, whereof a minority (7 % in Norway, 11 % in Finland) did so in their own home, the rest in someone else's home. Many thus have experiences of growing up in other people's households up to rather recent times (Sundström & Waerness 1987). And, even if fewer old people than expected lived permanently with their off-spring in the past, it was common that they spent their last year(s) in life in co-residence (Gaunt 1983).

To this perspective may be added information on adults living with their (ageing) parents. This was occurred for 14 % of the 30-44 year old persons living in seven rural Swedish parishes in 1880, but only 3 % of those living in Stockholm in 1900 or in all of Sweden in 1980-81. Rates of co-residence for adult children were higher in Finland (1978) and Norway (1981), with 7 % and 6 % respectively (after Sundström 1985). In more decades, these rates have declined substantially, although they are still rather high among the never-married (esp. men) and persons on early retirement due to illness etc. Interestingly, adults co-residing with parents in Sweden in the 1800s were about equally often married and single; in recent times the vast majority are single (never-married). Men all along made up the majority of the co-residents, but more so today than in the past. It is not unusual to find off-spring with various handicaps among these adults today, but proportionally less so in the past. This has been interpreted as today's aging parents being more resourceful than in the past, so that they now are better able to shelter off-spring who are unsuccessful in the housing-, marriage- and/or labour markets (Sundström 1987). Consistent with this, children from working-class families move out much earlier than those from middle- and upper-class families.

The debate on how to interpret historical evidence on household structures of old people has also taken place in Sweden. There were as indicated more, in some areas many more, old people who eventually moved in or joined households of family members before they died than emerges from cross-sectional evidence (Gaunt 1987). Conflicts between the generations

in these retirement arrangements were not unheard of and sometimes ended in court hearings (Gaunt 1983). The inclination for autonomy was, and is, strong among old people in the Nordic countries. It was common that the older party who shared house with a child tried to establish an independent 'sub-household', with a kitchen of their own etc. In the records this may appear as generations 'living together'.

Propertied persons could set up formal retirement contracts (*undantagskontrakt*), where the older party – often about 50 years old - traded their property for shelter, food and care. Such contracts were frequently very concrete in their specifications and sometimes included insurance of care from a hired helper, should satisfactory help from the family not be forthcoming. A decent burial would often also be part of the deal (Gaunt 1983, 1987). There are indications that co-residence between older and younger generations, contracted or not, was much more common on the smaller farm holdings than on the bigger ones (Hamrin 1954, Byggforskningsrådet 1979). Around 1910 about 10 % of old Swedes lived in these arrangements, in 1954 it was 6 %. Today these arrangements have vanished altogether in Sweden, although substantial numbers still remain in Norway (where even new contracts are established) and Finland.

Of particular significance for issues of services and care is how common it is for old people to live alone. This may signify a situation of vulnerability, but also is consistent with preferences of old people who cherish their independence, often seen as a central feature of Nordic mentality. (The influence of regional norms and preferences for choice of co-residence with offspring has been seen also in Japan; Takagi, Silverstein & Crimmins 2007). In the early 1900s about a tenth – with large local variations - of elderly persons seem to have lived alone, based on cross-sectional Swedish data. Many of the rest shared living quarters with family and/or others, consistent with Danish household patterns in 1845 described above (Kjellman 1984). Table 3 shows the changes in living arrangements in the Nordic countries in recent decades.

**Table 3. Living arrangements of community-residing old people in Denmark, Finland, Norway and Sweden, 1954 - 2005. Percent**

| | **Denmark** | | **Finland** | | **Norway** | | **Sweden** | |
|---|---|---|---|---|---|---|---|---|
| | 1962 | 1988 | 1950 | 2005 | 1953 | 2001 | 1954 | 2002 |
| | 65+ | 70+ | 65+ | 65+ | 67+ | 67+ | 67+ | 65+ |
| Living alone | 28 | 53 | 18 | 38 | 21 | 42 | 27 | 40 |
| With spouse* only | 45 | 40 | 16 | 48 | 41 | 47 | 30 | 58 |
| With spouse & children** | | | 20 | 5 | | 7 | 11 | |
| With children* | 27 | 7 | 35 | 3 | 27 | 4 | 16 | 2 |
| With others | | | 11 | 6 | 10 | | 16 | |
| **Sum** | **100** | **100** | **100** | **100** | **100** | **100** | **100** | **100** |

* including co-habitational partner
** and possible other persons
Sources:

DENMARK 1962 Shanas et al. Table VII-1 our own calculations; 1988 Platz 1989 Table 4.6. Note that 27 % and 7 % respectively are percentage of sum total of spouse and children, and persons living with children, and persons in other types of constellations.
FINLAND 1950 Statistics Finland 1953. (For 1990 – see Tables 3 and on 2.3 and 3.1 in Appendix, United Nations 1999. In 1990 most of the 'other' category were persons living with spouse and child/ren, abmuch smaller group were unmarried persons living with child(ren): Table 2.3). 2005 information provided by Ms Ahokas Erja, Statistics Finland.
NORWAY 1953 Ström 1956 (41 % with spouse and potential children); 2001 Census data provided by Statistics Norway, our own calculations. Information identifies parents with/without children, hence a few of 'with spouses only' may coreside with others (good data for 1981 in Guldbrandsen & Ås 1986).
SWEDEN 1954 SOU 1956:1; 2002 Socialstyrelsen 2004b (2 % sum total of spouse and potential others and persons in other constellations).

Living arrangements are conditioned by norms and by norms and material factors such as availability of affordable housing and access to family. An analysis of Norwegian household data for 1981 revealed that unmarried childless old persons often lived with siblings, and those who lived with wholly unrelated persons usually were never-married persons who lacked both children and siblings. Generally speaking, the availability of family influenced both whether old people lived alone or with family (or others) and whom they lived with. Only about half of never-married old Norwegians lived alone in 1981 (33 % of the men, 54 % of the women; Gulbrandsen & Ås 1986). A similar conclusion was drawn from a tabulation in the three-country study in 1962, where it emerges that it was especially the never-married and childless who lived with siblings and that persons without close relatives also were more likely to live alone (Shanas et al. 1968 Table VI-18a). As we will see below, kin availability also helps to determine patterns of care.

For OECD I have collected and published data on the changing proportions of older people who live alone and with their children respectively, for several European countries, Japan and USA (Sundström 1994). Living alone has been on the increase in many countries - and it has already climaxed in the Nordic countries - whilst coresidence with children is declining. Table 4 shows living arrangements of older persons today (2004) in several European countries.

**Table 4. Household structure in selected European countries about 2004 for 65+ living in the community. Per cent**

| | Living alone | With partner only | Other arrangements* |
|---|---|---|---|
| *Nordic* | | | |
| Denmark | 41 | 55 | 4 |
| Sweden | 39 | 59 | 2 |
| Northern | | | |
| Belgium/Flanders | 27 | 63 | 10 |
| Britain (1998) | 36 | 51 | 13 |
| France | 36 | 55 | 10 |
| Germany | 39 | 53 | 8 |
| Netherlands | 42 | 54 | 5 |
| *Southern* | | | |
| Austria | 43 | 43 | 14 |
| Greece | 38 | 44 | 19 |
| Italy | 32 | 42 | 26 |
| Spain | 27 | 38 | 35 |

| | | | |
|---|---|---|---|
| *Switzerland* | 35 | 57 | 8 |
| *Israel (2004)* | 25 | 45 | 30 |

*any kind of living arrangement: with partner+child, with child(ren) etc.

Source: our own computations on SHARE. Denmark and Sweden corrected for institutional population (8 % and 7 % respectively) by us, in the other European countries samples are of persons living in the community.
Belgium: calculated from the LOVO-survey (2001), courtesy Benedicte de Koker.
Israel: Brodsky, J, Shnoor, Y & Be'er, S (Eds.) The Elderly in Israel. Statistical Abstract 2005 /in Hebrew/ JDC Brookdale and ESHEL. Information kindly provided by Ariela Lowenstein.
Britain: our own calculations on Glaser & Tomassini 2003.
Note: Rates may differ from national, more exact surveys. For example, in Spain 21 % lived alone in 2006.

A 1954 national survey of representative old people in Sweden – the oldest preserved of its kind – disclosed quite poor conditions of the housing of older people. A tenth of the elderly did not possess a dwelling of their own and many lacked even basic amenities, not to mention running hot and cold water, central heating etc.(SOU 1956:1). This changed gradually (old people always live in the oldest segments of the housing stock) and can be followed in the censuses (the last was done in 1990). In the most recent surveys of old people like the year 2000 survey of the 75+ living in the community, no questions were asked about housing standards as substandard housing is now extremely rare, although accessibility can still be problematic. Instead it emerged that many old people have cellphones and computers, are connected to the internet and in several ways take a more active part in community life today than in the recent past. Surveys of living conditions done since 1975 show that all kinds of activities, outdoor and indoor, increase, with exception for religious activities like church-going that have declined (Statistics Sweden 2006).

In spite of so many older people living alone in the Nordic countries, there is no indication that loneliness and isolation is high or has increased among them. If anything, the opposite conclusion can be drawn from available data. Indeed, older people in the Southern European countries report (much) higher rates of loneliness and feelings of being abandoned (Walker 1993, Sundström et al. 2008).

**Arithmetics of kinship: can the caregiver pool be calculated?**

Many scholarly studies of needs for care of the elderly have considered the capacity of their social network to provide care and tried to estimate potential changes. Moroney in a seminal work (1976) gave an important impulse to use an indicator of the demographical size of what he called the 'care-taker pool'. This typically relates the number of persons (women) in the population of presumable care-giving age – often 45-59 – to the number of old people. Whatever the definition, this quotient shows a clear and rather dramatic decline, and most visibly so in the later 1900s; in 1900 there were 858 Swedish women 45-59 per 1 000 old persons (and many more in 1750), in 1960 848, in 1975 591, in 2000 586 (the small decline after 1975 was due to the baby-boom cohort in the numerator) and can be projected to be about 480 in 2025. Using single or non-employed women shows an even more drastic shrinking of the 'care-taker pool'. Obviously, including men can not hinder the pool from shrinking historically (Sundström 1983).

Easily calculable as it is, this indicator of (potential) access to informal care has serious limitations in describing the access to potential kin carers. Incidentally, it also identifies the

waning supply of potential professional carer in that age group. In 1935 there were 250,000 recorded maid-servants in the Swedish census, in 1945 120 000, though the decline probably was more due to new avenues for female workers opening up during and after the war than to demographic changes such as a shrinking pool of young, unmarried women that maid-servants were mainly recruited from. An unknown number worked for elderly people, though we know that 3 % of the elderly had a maid-servant in 1954 (ca. 20,000). By then, the recruitment basis was already severely eroded.

The crucial question is of course whether the care-taker pool does indeed mirror real (change in) access to close relatives in individual, concrete families, if we assume that these will usually be providing the core part of informal care. The preceding section about *increasing* access to immediate family raises serious doubts on the usefulness of any arithmetical indicator. To this may be added the observation that being married and/or employed seems – at least in the Nordic countries – to be less of an hindrance to caregiving than often assumed (below). Empirical studies in the Nordic countries find that carers often have terminated their work or be on part-time etc. for other reasons when they become carers, be it for an ailing parent or someone else (Socialstyrelsen 2006).

Yet, even with this caveat it may be argued that the care-taker pool concept is a useful heuristic to indicate the degree of pressure on the family. This makes more sense, but is still problematic in its somewhat mechanistic view of *the* family. An increased risk to become a carer seems to have occurred in the final years of the 1900s in at least Sweden (Olsson, Svedberg & Jeppsson Grassman 2006, Socialstyrelsen 2006), but is it reasonable to equate a somewhat raised risk (chance) for individual family members to help an ageing parent over one's life-course with an abstract Family that is 'squeezed'? All available studies of family care for the Nordic elderly and public services for the same old people and the interaction between these two providers point to the flexibility of individual families in dealing with these challenges and the less than flexible public systems, but also to important synergisms between them (below).

**Interaction between generations, the contents of exchange and caregiving**

Less is known about the contents of interaction across Nordic generations than about the frequency of contacts and distances, but in general terms it can be stated that old people in the 1950s were mainly receivers of housing, help and financial support. This was quite visible in the Finnish survey of older people in 1950. A majority of them received various types of help from family; not surprising in a situation of widespread poverty, no universal pension system and a very serious housing shortage after war-time destruction and housing nearly half a million Finns evacuated in 1944-45 from Karelia, lost to the Soviet Union. Eight out of ten old Finns who had off-spring were helped by them and most said that they could not get more help than they already received. Yet, the majority affirmed that support for ageing parents was the responsibility of off-spring rather than of the state (Statistics Finland 1953).

Filial obligations of children and grand-children still applied in Finland by that time. In Sweden it was abolished with the poor-law itself in 1956 (and in the Family Act in 1979) and somewhat later in Finland and Norway, last in Iceland (1991). Denmark never had this legal statute, neither in civil law nor in the poor law, to our knowledge without any noticeable effect on family relations. The Danish minister of social affairs in an interview in 2008 suggested legal filial obligations: a public outcry and an opinion poll that showed no support for this idea made her later declare that it was a "misunderstanding". Her only intention had been to point out the importance of family care...

A Swedish survey already in the early 1950s and the Danish 1962 study observed that some old people were *givers* of help and money etc., rather than receivers (Elmér 1960, Shanas et al. 1968). Two per cent of the Swedish elderly in 1954 were 'substantial' givers of help to somebody in another household (SOU 1956:1), in 2002-03 about 5 % were givers of extensive informal care outside their own household and another 17 % gave less extensive help. Another five per cent gave mostly intensive help inside their household, typically to a partner, in absolute numbers equally many men and women (Socialstyrelsen 2006). In 1999-2000 six per cent of old Finns reported that they had in the last four weeks been giving care to "sick or elderly" people in another household (10 % of the 50+)(personal communication from Laura Iisakka Statistics Finland). Today older people are often *givers* of informal care and financial support to younger generations.

In 1962 29 % of old Danes gave some kind of help to children and 14 % to grandchildren, in 1977 the percentages had risen to 49 and 52, respectively (Platz 1981). Only a minor fraction of this is attributable to more old people having these ties (above). Rather few old Finns in the 1950 survey reported that they 'had to' take care of grand-children, in a 1999-2000 time-use study 19 % report having been child-minders within the last four weeks (23 % of the 50+)(Laura Iisakka as above). In 1980 50 % of Swedes aged 55-64 reported "regularly" doing child-minding (SOU 1981:70). Even higher figures were reported at that time from Finland and Norway for temporary help and it appears that this has become more, not less, common. This is supported by more recent data in the SHARE survey, which also indicate that caring for grandchildren is no more common among the 50+ in Southern Europe than in Denmark and Sweden. In Finnish retrospective data, few persons born 1915-30 reported having been taken care of by grand-parents in their childhood (5 % in their own home, 2 % in another household). It was much more common to have been cared for by siblings, other relatives or a hired child-minder. The same pattern emerged from similar data collected in Norway (Sundström & Waerness 1987).

In both Finland and Norway, having been taken care of by grand-parents was more common among cohorts born after 1940. Noteworthy is the significant number of hired helpers in the older cohorts; in the Finnish data 75 % report having at some point in time a professional maidservant in their home when they were children (op.cit.). There has therefore not been a simple transition from (extended) informal care to formal care, whether in old-age care or for regular child-care. Nor does frequent child-care by grandparents for their off-spring necessarily imply that they occupy an unambiguous position in the family network. A qualitative Finnish study of mother-daughter-grandchild ties indicates a certain rolelessness for the grandmothers and a degree of ambivalence between the adult generations (Hurme 1988).

A common stereotype holds that the contemporary family is 'typically' burdened by both small children and ageing parents that need care. This is rarely the case, but data in SHARE for all European countries including Denmark and Sweden support a looser version: the 50+ do have a pivotal role for exchanges in both directions in these constellations (Attias-Donfut, Ogg & Wolff 2005). Danish studies in 1987, 1997 and 2002 assessed exchanges from the perspective of middle-aged cohorts: reports of socializing, vacationing, caring for grand-children, maintenance of housing etc. were simply massive, but financial help was marginal (EGV 1989, Aeldre Sagen 2004). The large majority also expected to get help from their children, should needs for that arise, and most reported that they were prepared to help their parents (in future). Asked about values in life, the family and what it stands for emerged as

paramount in importance (Aeldre Sagen 2004). It has been suggested that when resources were directed to old people by the welfare state, this made it possible even for ageing parents to remain givers, and not just for adult children in trouble as we seen above (Sundström 1983, 1987).

Community living old persons are often givers of care, and indeed as often (22 %) as the fraction that reports that they need care (21 %)(Socialstyrelsen 2006). In Table 5 this is described with data for the 55+. (Data in SHARE for 50+ show quite similar patterns of caregiving for Danes and Swedes: Socialstyrelsen 2006). Table 5 shows, maybe unexpectedly, that care-giving in total – inside *and* outside of one's household - is more common among the 50+ in central European and in the Nordic countries Denmark and Sweden with their extensive welfare programs, than in Southern countries such as Spain and Italy, with their strong family traditions. Yet, 'external' care-giving may frequently be help with less demanding tasks than 'heavy' personal care inside the household. Care for someone in one's own household is two-three times more common in the Southern than in the Northern and Nordic countries, for example 10 % in Spain as against 4 % in Denmark-Sweden. In the latter countries in-household care is mostly spouse care, as it is rare for old persons to live with anyone else than their spouse. In the continental and Southern countries this will often be care for parents(in-law). When Danes and Swedes help parents, this will be help to another household, as co-residence with parents is very rare for this age-group in these countries (near zero), as against 4.1 % in Italy and 5.6 % in Spain (Attias-Donfut, Ogg & Wolff 2005). Needy Nordic elders mostly were helped from 'outside', Southern elderly mostly from 'inside' their households, but in total they received help about equally often. The same pattern held for the *giving* of help and support by old people themselves (Socialstyrelsen 2006). It is also possible that 'help' is interpreted differently in northern and southern Europe, due to *i.a*. how common is co-residence (Ogg & Renault 2006).

**Table 5. Prevalence of care and employment in selected European countries for 50+ by gender, 2004. Per cent**

| | Age 50+ | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Gives care* in hhld | | Gives help** to other hhld | | Employed | | Employed among hhld carers | |
| | All | Women | All | Women | All | Women | All | Women |
| *Nordic* | | | | | | | | |
| Denmark | 4 | 4 | 47 | 37 | 52 | 47 | 35 | 25 |
| Sweden | 4 | 4 | 41 | 39 | 52 | 51 | 38 | 30 |
| Netherlands | 5 | 5 | 41 | 38 | 40 | 32 | 27 | 15 |
| *Northern* | | | | | | | | |
| Germany | 6 | 7 | 32 | 29 | 46 | 33 | 18 | 15 |
| France | 6 | 8 | 31 | 31 | 33 | 30 | 17 | 16 |
| *Southern* | | | | | | | | |
| Austria | 8 | 9 | 25 | 24 | 32 | 26 | 21 | 18 |
| Greece | 6 | 7 | 20 | 21 | 35 | 24 | 22 | 19 |
| Italy | 8 | 9 | 23 | 22 | 25 | 18 | 16 | 10 |
| Spain | 10 | 12 | 14 | 15 | 27 | 20 | 17 | 12 |
| *Switzerland* | *6* | *8* | *36* | *37* | *54* | *48* | *36* | *27* |

* 'regular care for sick or disabled adult in household last year'.

** ‘help to family, friend or neighbour in other household’. Help can be with personal care, household and/or ‘paper work’
Source: SHARE, our own computations

In this context, it should also be observed that these cross-sectional rates of caregiving greatly underestimate the life-long risk of ever being a caregiver, which is roughly two-three times greater. Many stop, and many begin, a caregiving episode every year (Hirst 2002, Aeldre Sagen 2005). Data on this are very scarce, but in Sweden ca. 40 % of elderly women and 20 % of the men report having ever been carers, mostly for parents or spouses (Socialstyrelsen 2006). Who becomes a care-giver and who does

In Sweden and the other Nordic countries (and elsewhere) caregiving typically climaxes around age 45-54, after that care for parents and other family declines, though caring for a partner remains high and even increases somewhat. Most of the caring is infrequent, with 5 % providing daily care, same for men and women, and the absolute number of spouse-carers are the same for men and women. Daily care is usually for a partner or – less often - other close family and usually in one’s own household (Socialstyrelsen 2006). That equally many men and women provide care for a partner in old age is seemingly inconsistent with the fact that two out of three elderly marriages end with the husband’s death. Yet, when men’s often more ‘abrupt’ deaths and shorter and less severe frailties - when occurring - is accounted for, the total volume of care provided by men and women comes out about the same (Socialstyrelsen 2004a).

The intermittent nature of caregiving also implies that many or maybe even most people will eventually become caregivers, depending on how strict our definition of care. In a national survey in year 2000 34 % of the 75+ living in the community reported one or more incidents of caregiving during their life, higher for women (41 %) than for men (24 %)(Socialstyrelsen 2006). The recipients were almost all a parent or a partner (12 % either) or other close family (9 %). There is no evidence of decreasing care-giving (Lingsom 1997) and, as mentioned above, some recent data indicate *increased* caregiving, and especially for daughters and other female kin during the 1990s. It seems that this has to do with cutbacks in social services for older people in Sweden (Johansson, Sundström & Hassing 2003, Olsson, Svedberg & Jeppsson Grassman 2005). We now proceed to this and services in general for older people.

## PUBLIC SERVICES FOR OLDER PEOPLE

### Beginnings

Up till the late 1940s public old-age care remained poor-relief and authorities were often averse to new ideas. Old people with small or no need were institutionalized – sometimes forcibly – due to poor housing, lack of family or sheer poverty, the municipalities confiscating their possessions, if any. Contemporary photographs graphically depict the conditions of institutions and their residents, often without teeth, subject to rules of order nailed to the wall. Troublemakers were threatened with the work-house. Most old-age homes had tasks of work that residents were expected to perform, like wood-chopping and laundry. (Some places also had pigs or other forms of husbandry.) A certain improvement for old people were the pensions introduced in 1914, although very small and means-tested. In 1937 the program extended to all old people 67+, except those who were institutionalized. In those cases the authorities kept their income, but sometimes paid them pocket-money (ended in 1948).

The poor law of 1918 gave access to the old-age homes also for ‘ordinary’ residents, who paid for their stay in full. By the 1940s, they made up about a tenth of all residents and the fact that institutions began to house ‘ordinary’ citizens may have something to do with the ensuing scandal. During World War II, pensioners began to organize themselves in a pressure group, on initiatives by syndicalists and communists. They fought for housing allowances and higher pensions (Today these organizations – but now non-partisan - recruit about. 40 % of the 65+ population.) They convinced a well-known author, Ivar Lo-Johansson, to embark on a trip through ‘old age Sweden’, visiting many old-age homes and odd quarters of old people on his way. His grandmother was one of the first to receive a pension in 1914, corresponding to one dollar a month, the first money she ever possessed of her own. In a series of reportages he described what he had seen in the most widely circulated weekly, with scarying photographs (also published as a book) and in radio programs in 1949.

There was just one national program being broadcast in those days, that ‘everybody’ listened to. Being the first case of serious questioning of the established wisdom of the authorities – several others surfaced in the 1950s - it caused a major scandal. Followed by a number of mysterious and well-publicized deaths in old-age homes in 1951, the attention forced the government to create a commission on old-age care, which arrived at exactly what the pensioners and Lo-Johansson had demanded: "home-care, not care-homes", as the slogan went (SOU 1956:1).

The time was ripe: earlier proposals and attempts by voluntary organizations to establish home-care had been ignored by the authorities, or seen as valuable but "too expensive" and impracticable on a larger scale. The old-age home was seen as *the* solution. Yet, after the scandals, community care was suddenly not only humane, but also proclaimed as the cheapest way to provide for old people. Home Help, a public service that provides help with household tasks and/or personal care in the community, became the new strategy in old-age care. In 1950, 6 % of old people were institutionalized and in 1954 already 1 % had Home Help, mostly used by poor working-class women. In 1954 3 % still had a maid servant living with them, and many more purchased temporary help with cleaning, laundry etc. This disappeared rapidly, with better work opportunities for women and the competition from inexpensive or free Home Help.

To stimulate municipalities to establish Home Help services, the government for many years gave heavy, earmarked subsidies to these services. Ruling in Sweden is more often done by manipulating economic incentives than by commands or legal procedures. Thus, when the government in the 1970s wanted municipalities to upgrade their institutional care from old-age homes (and nursing-homes) to so-called service-houses, government subsidies for Home Help were officially said to also apply for residents in service-houses. There residents could also get government housing allowances, which the municipalities through the "back-door" could reclaim through rising the rents for the residents... This made investment in traditional institutions (where Home Help was not applicable and no housing allowance could be paid) comparatively very expensive for municipalities.

**Transitions**

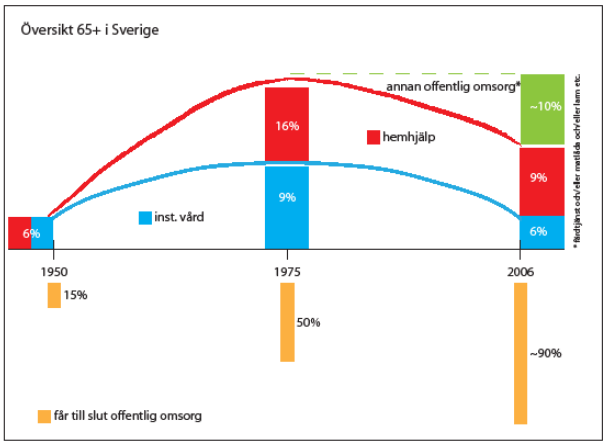
In spite of the new emphasis on community care in the 1950s and 1960s, institutional care also expanded, built by ambitious and resourceful municipalities for old people whose needs were often small, if any at all. Up till this time, institutional care was often an alternative for older people who lived in poor housing or due to ‘causa socialis’. Today it is primarily a

matter of seeking nursing *care*, not an issue of *housing*. The author remembers from his first studies of old-age homes in 1979 residents who lived there only in the winter, left the old-age home during the elk-hunting season, had a motor-car in the parking lot etc. Some observers think that the building of old-age homes or other institutions was - and still is - the result of authorities wanting to show that they *do* something. Institutions – but not Home Help – are visible monuments to political will. Indeed, many municipalities did build old-age homes as a last service for "their" older people, when new municipal reforms were announced in the 1970s (above). Service use of older people since the early 1950s is shown in Figure 3.

The lowest band in the diagram shows institutional care of all kinds, its growth and decline, returning to the 'traditional' level of 6 % in 2006-07. (A rate of 5-6 % was not unusual in the poor-relief era.) Home Help, in the upper band, grew from nothing to 16 % in 1975, and after that declined to the present ca. 9 % (2007). In hindsight it appears that there was 'over-consumption' not only of institutional care but also of Home Help in the 1970s and 1980s. Many used these services – frequently free or very inexpensive – for many years. A photograph in a government publication in the 1960s proudly shows an apparently able-bodied old man who stands onlooking when the Home Helper - a new service by that time - waters his flowers. The Home Helpers also cooked, baked bread and cookies, cleaned windows, took out the dog, and even milked cows in more exceptional cases. In that era, social service departments sometimes had no fixed budget (!) and were more or less free to spend money at their own discretion.

However, we should remind us that still in the 1970s some old people lived in substandard housing, there were not yet any meals-on-wheels, and gender-roles were even more inflexible than today. A close reading of survey questionnaires for old people in Stockholm in 1954 and 1978/79 discloses that married old men did nothing (or next-to) in the household in 1954, but did contribute/help-out more just 25 years later (Skoglund 1984) and a recent study finds that old men and women equally often care for their partner (Socialstyrelsen 2000, 2004).

**Figure 3. Simplified representation of public services for older people, 1950 - 2006**




Source: my own computations on service statistics and government investigations etc.

In the Home Help services a new ideology in the 1980s and 1990s emphasized that staff should not ‘take over’ capacities that the users still had, to be conserved and trained, whenever possible. The catch-words were terms such as integration, normalization, participation and independence. This can, it seems, sometimes be taken too far. A much-publicized case in August 2006 was a 90-year old lady who drowned herself when her application for a room in an old-age home was turned down. Her health was too good to give her eligibility, according to the needs assessment of her municipality, which ran a strict 'stay-in-place' policy.

Some critics argue that the concept of autonomy is sometimes used to camouflage inactivity and leaving old people alone, saving money and allowing them to live in misery. On the other hand, some old people erronously believe that a place in a residence will provide social life and cure loneliness. The tension between general directives from the state and local applications continues; a contemporary example is the practice of keeping doors of dementia units closed with code locks, the code (at best) pasted to the wall nearby. This prevents residents from ‘disappearing’ but is illegal. (Hunting down old persons with dementia is a recurrent job for the police who complain about this waste of their resources.) A commission is set down to find solutions to this dilemma.

An interesting trend in recent years is the growing demand for private retirement housing, usually special apartment houses (often owner-occupied condominiums or cooperatives) that require residents to be 55+. This is mostly a choice for those who like this lifestyle and have the money, somewhat like the Japanese *yuryu rojin homu*, but less luxurious (Kinoshita & Kiefer 1992). The author has studied these settings, and it should be noted that these places are *not* institutions and seldom provide much services (or any at all), although that is likely to change as residents age. They are still entitled to Home Help, like anyone else living in the community. Ca. 1 % of older Swedes live in these settings. Very few old persons want to move to institutional care in the Nordic countries; interest in retirement communities is bigger and also appears to be increasing, according to a Norwegian study (Brevik & Schmidt 2006). It should also be mentioned that some older people live permanently or temporarily in resort communities in Southern countries, so far primarily in Spain.

There are also other signs of privatization, like purchase of private help with household chores. Of course, the big privatization is the growing significance of the family in providing care for old people. Indeed, when talking about "family", it is spouses - men and women - and daughters who increasingly provide this care (below).

Coverage rates of services have shifted somewhat over time, but the decline seems to have ended, although diversification takes plave (below). The greatest worry of older people and their families today is the perceived lack of institutional care. Today's residents in institutional care are very frail and often dementia sufferers already when they enter; about two thirds of the residents are deemed to be in this predicament. A special kind of residence for them, the Group Home (similar institutions are established also in other countries, and in Japan), has gradually been built or converted from previous old-age homes, but most persons with dementia live in ‘ordinary’ institutions. Some programs like day-care for dementia sufferers have had a slow start, and uptake is only a small fraction of potential users.

It is misleading to compare contemporary Home Help with the service provided in, say, the 1970s. Today’s users can get help many times a day, during evenings, in the night-time and

in week-ends, features unavailable just a couple of decades ago. Yet, Home Help now tries to minimize household chores (offering meals-on-wheels etc. instead) and concentrate on providing personal care. On average clients use about 30 hours/month, but the distribution is very skewed, with most users getting much less and a few using up to 200 hours or more. In practice this will often be the minority that is mentally alert but with severe physical dysfunctions and/or with a family that know their rights.

Although support volumes – from the Home Help *and* from family – typically do increase with rising needs, longitudinal studies show that most users die or are institutionalized before they attain those very high volumes of community care. Importantly, there is a single-entry with all social services for old people (usually) handled by the same agency and by the same needs assessor, the 'gate-keeper'. Services are charged according to income, and Home Help fees is sometimes structured so as to make use for 'small' needs quite costly, whereas the very frail find it relatively less expensive. The incentive in this is not always felicitous. A cap on fees protect users against being impoverished. Capital and real estate does not count in calculating the fees, although income from capital does.

Surveys demonstrate that needs-assessments have become stricter, and municipalities tend to reinterpret the letter of the law. According to the Social Service Act of 1982, the municipality shall provide services when needs can not be seen to by other means. This has sometimes – without legal justification - been taken as having family in the neighboorhood or having money enough to buy the service commercially.

Cutbacks in services in the 1990s and after coincided with improved functional capacity of older people. In 1988/89 30 % of the 65+ living in the community needed help with one or more ADLs. In 2002/03 only 21 % needed such help and local outreach to non-users of services (persons who do not use *any* service) rarely finds people with unmet needs. Notwithstanding, it is an established fact that fewer old people on average get/use Home Help now than before and that they (have to) wait longer before asking for it. Their frailty is greater and they increasingly need help with personal care when they become Home Help clients. They will also get fewer hours of help relative to their needs today than previously (Socialstyrelsen 2000).

Social administrations in the municipalities often attempt to change the image of the Home Help service by emphasizing personal care - not house-keeping - and often symbolically change the name to Home Care. For staff, this means a job where many clients display frailty and illnesses, and not seldom loneliness, depression and dementia. The only group of older people who often get Home Help and who have benefited from a *rise* in service provision are persons who live alone and are childless (below, Table 13). This group of elderly, incidentally, constituted a large proportion of the traditional poor relief clients about half a century ago. Yet, public services of today has a different social profile. It is now a service for everybody, regardless of social class, although as we shall see utilization may still differ due to better health of higher social classes.

**International comparisons of service provision: Europe and Spain-Sweden**

To give some relief to the Swedish data, I show coverage rates of Home Help and institutional care in several European countries in Table 6. Sweden has the lowest rates of all the Nordic countries, but as we shall see later, these other countries have little of other services than the ones shown here, whereas Sweden has very extensive provision of transportation services, alarm-systems etc. (below). High rates of Home Help in Denmark

and Norway is partly due to their including home nursing, raising coverage rates. (Their Home Help only does household chores, while in Sweden it does also personal care, dispenses medications and sometimes even insulin, eye-drops etc.)

Targeting of Home Help and other services differs: in some countries these services are means-tested, in others they are for anyone in need, but with fees graded by income, for example in the Nordic countries (or free: Denmark, so far). Users are often old people who live alone (80 – 90 % of the users in Nordic countries), and it is not uncommon to focus services on people on low income and without a family to care for them. In southern Europe users sometimes live with or near family, who are busy in the daytime (explicit policy in Slovenia). A criterion of very severe dependence may also apply.

The rates shown in Table 6 are national averages, estimated as best we can. It should be observed that there seems to be great variations in local coverage of thee services in every country, an issue I will return to below. Coverage rates also have to be related to *needs.* The definition of need may vary both between countries and inside one country. Therefore it is problematic to compare crude coverage rates.

To assess the impact of the needs factor, I will use a comparison of Spain and Sweden, as we happen to have access to good data for these two countries. They are also quite different in their social make-up, with many old people who live alone in Sweden, but few in Spain etc.

**Table 6. Home Help use and institutionalisation rates of older (65+) people in selected European countries around year 2000.**

| | Coverage rates (%) of Home Help[a] | Institutiona-nalization | Year |
|---|---|---|---|
| ***Nordic*** | | | |
| Denmark | 15 | 8 | 2005 |
| Finland | 11 | 4 | 2002 |
| Iceland | 20 | 9 | 2001 |
| Norway | 13 | 6 | 2004 |
| Sweden | 9 | 6 | 2005 |
| ***Northern*** | | | |
| Belgium/Flanders/ | 10 | 6 | 2004 |
| Britain | 5 | 5 | 2003 |
| France | 5 | 7 | 1998, 1996 |
| Germany | 7 | 4 | 2003 |
| Luxembourg | 5 | 7 | 2003 |
| Netherlands | 14 | 7 | 1999 |
| ***Southern*** | | | |
| Austria | 15 | 4 | 2000 |
| Greece | <1 | <1 | 'present' |
| Ireland | 5 | 5 | 2000 |
| Italy | c. 1 | c. 1 | 'present' |
| Portugal | n.a. but low | 4 | 2001 |
| Spain | 4 | 4 | 2005 |
| ***Non-Categ.*** | | | |
| Bulgaria | n.a. but low | n.a. | no info. |
| Czechiya | n.a. but low | n.a. | no info. |
| Estonia | c:a 3 | c:a 2 | 2005 |
| Hungary | c:a 5 | n.a. | 2000 |

| | | | |
|---|---|---|---|
| Poland | <1 | n.a. but low | 'present' |
| Slovenia | c. 1 | 4 | 'present' |
| Switzerland | 5 | 7 | 2000 |
| Israel | 16 | 4 | 2004 |

a. Public(ly financed) services with household tasks and/or personal care.

Note: In spite of our attempt to cover the whole panorama of care and services in the community, variations may often reflect organisational as much as substantial differences. For example, Norwegian Home Help mostly provides household help and an independent organisation helps with personal care (and also more or less regular home health care etc.). This is likely to 'blow up' public services for the elderly in Norway, as compared to Sweden, where one single organization provides both household help and personal care. On the other hand, many old people in Sweden only use transportation services or some other service, but *not* Home Help. In Denmark, with more extensive Home Help, few old people seem to rely *only* on these 'other' services.

*Sources:* see Appendix.

We use old persons who *live alone and need help with their ADL* (activities of daily life) to compare targeting of Home Help services in Spain and Sweden in Table 7. Firstly we note that 3 % of all old persons in Spain use public Home Help (this was in 2004) as against 8 % in Sweden. In both countries persons who live alone are more likely to be service users, 7 % and 15 % respectively in Spain and Sweden. Among co-resident old people only 2-3 % use Home Help in either country. Needs for help with ADL as measured here (as similarly as possible with our data) are about as common in Spain as in Sweden (20 % and 21 % respectively). Old persons who need help more often use Home Help, 9 % in Spain and 37 % in Sweden. Even among co-resident persons, their use rates are higher: 6 % and 19 % respectively. The service use of *frail persons who live alone* is as expected still higher: 18 % of old people in need of help and who live alone get Home Help in Spain, as against 54 % of a similar group in Sweden.

**Table 7. Use of public services (Home Help) among old people 65+ living in the community in Spain (2004) and Sweden (2002-03), by household structure and by need. Per cent**

| | Living alone | | Co-resident* | | All | |
|---|---|---|---|---|---|---|
| | Spain | Sweden | Spain | Sweden | Spain | Sweden |
| All | 22 | 39 | 78 | 61 | 100 | 100 |
| Percent who use Home Help | 7 | 15 | 2 | 3 | 3 | 8 |
| Percent who need ADL**help | 19 | 28 | 21 | 17 | 20 | 21 |
| *Whereof use Home Help %* | *18* | *54* | *6* | *19* | *9* | *37* |
| *N* | *83* | *392* | *323* | *349* | *406* | *741* |

* any relationship

**Ns refer to those who need help with ADL, defined as needs help with one or more of the following ADL-tasks:

Spain - shopping, cooking, bath/shower, outdoor mobility, (un)dressing, indoor mobility

Sweden - shopping, cooking, cleaning, laundry, bath/shower, (un)dressing, get into/out of bed.
Sources: our own computations on Encuesta de Condiciones de Vida de los Mayores 2004 for Spain, and on Statistics Sweden Level of Living Surveys 2002-03 for Sweden

In other words, after correcting for living arrangements and frailty, it emerges that public services target many more old people than we can deduce from the raw national averages, in both Spain and Sweden. In Spain it is much less common than in Sweden for old people to live alone to begin with. They will also much less often suffer from some frailty *and* live alone. Persons who live alone are typically healthier than other old people, and frequently more affluent. (Similar patterns are reported for France.) Yet, for the most critical group, those who live alone and need help, the service still reaches out to just a minority in Spain and they often report that they need more help (analysis not shown here). In Sweden public Home Help targets a little over half of the eligible recipients. This implies that most of them will need help from other sources both in Spain and Sweden. A special analysis of the data for Sweden verifies that most eligible persons who live alone but do not use Home Help, have rather small needs and usually get help from their families. Persons with big needs for help much more often use Home Help. Few report unmet needs (analyses not shown).

**Averages and the longitudinal risks of public service use**

A problem with all cross-sectional rates like the above coverage rates for services is that they do not give us a clue as to the historical (longitudinal) risk or chance to be subject to something. This is an acute problem with coverage rates of Home Help and other public services in Sweden. To interpret empirical data on use of services we should follow old persons from the day of retirement till their death, to find out about how well the state – and the family – eventually attends to their needs. If coverage rates are high, but 'occupied' by the same people for a very long time, the services will still reach out to just a small segment of the needy, whereas shorter use will allow for more rapid 'turnover' and seeing to the needs of more people, even if coverage rates are low. Basically it is the problem of rationing: if it works well, everyone will get the desired goods, although a little less.

Evidence of this kind for old-age care is rare, but the little data we have on this for Sweden indicates that the historical chance to get public support has indeed risen dramatically, as shown in Figure 2. Around 1950, some 15 % of older persons eventually ended up in institutional care (here and below excluding acute care hospitals), nothing else existed in the way of care. The rest died at home or in hospitals which did not at all provide dignified care of the kind these persons needed. A study in the 1970s in a rural area found that 30 % eventually ended up in an institution; another 20 % used Home Help, but died elsewhere. Analysis of an urban sample of 70 year olds followed from 1970 (the H70 in Gothenburg) found that 50 % of them ended their life in institutional settings (personal communication from Marie Ernsth Bravell). Contemporary evidence indicates that about 90 % of the 80+ eventually use Home Help and/or institutional care.

In the historical past, older people who used poor relief were short on (functional) family and/or lived alone and/or were poor. It was exceptional, when in the poor-house in Mulseryd (near Jönköping) the widow of the previous county governor languished in the 1840s and 1850s. Her aristocratic husband had lost his job for mismanaging public funds and abandoned his family. To some extent it is still true that the less well-off and persons short in social networks more often use public services in the Nordic countries. In particular this holds for use of institutional care, where for example the never-married (and consequently often childless) still are over-represented. In the Nordic countries institutionalization rates were

somewhat higher than in most other Western countries at about 5-6 % of the elderly in the 1950s, typically rising in the following decades, to later retreat. Rates at this level were not unusual already in earlier centuries, but could vary a good deal locally. Swedish regions with many large estates and proletarized farm-workers had more poor-houses to accommodate them in their old age. Yet, averages gave and give an incomplete image of institutionalization, as the cumulative risk of institutionalization varied locally and also has shifted historically. In 1950 about 15 % of old Swedes sooner or later were institutionalized, in the 1970s about 30 % and today most likely a higher fraction, as the duration of institutionalization has declined (Gaunt 1987, Sundström 1995).

Institutions refer to permanent residences for old people, excluding acute health care. An alternative are the Home Help services that expanded rapidly in the 1960s. They had and have a much less visible class bias. Old workers use Home Help services more often than middle- and upper-class elderly, but a Norwegian study (by Kari Waerness; unpublished) and Swedish analyses indicate that this is mostly due to class differences in functional capacity and living arrangements. It was also found that persons who used Home Help often were helped by their family as well and vice-versa (Socialstyrelsen 2000, 2006). These patterns will be dealt with in more detail below.

It seems that class gradients may have become attenuated, with public services focusing on the oldest and frailest, often suffering from dementia. The Nordic elderly now manage longer at home, thanks to better housing, informal care provided by family and others, and the public Home Help services. In particular, as we have seen, old people stay married longer and marriage protects against institutionalization and use of other services: few husbands or wives send their partners to institutional care. This goes a long way to explain risks of institutionalization, but usually we have access only to ‘snapshots’ of marital status etc. for institutionalized persons. It is rare to find the trajectories from onset of retirement or thereabout till the end of life that describes geographical moves, institutionalization etc. A few studies that capture these aspects longitudinally have been done, in France (Cribier, Duffau & Kych 1999) and in Norway (Romören 2003), both reporting that well over half of the subjects ended their lives in institutional care.

Longitudinal data from age 67 (retirement age in 1969-70) for a Swedish locality are used in Table 8 to analyze how gender, marital status and social class interact with risks of institutionalization. Altogether, 32 % ended their life in an institution, but working class elderly ran a greater risk of ending their lives there. Married middle class men ran a 10 % risk of eventually being institutionalized, working class spinsters 70 % risk (or chance). Indeed, using class, marital status and gender one may already at age 40 predict the subjects’ much later risk of institutionalization (analysis not shown here). Noteworthy is the rather high risk for the single elderly. In the Finnish census in 1990, 9 % of single old women and 11 % of single men were institutionalized, and many at relatively low ages (Sundström 2009).

**Table 8. Longitudinal patterns of institutionalization of old people in Dalby, Sweden, 1969-1995. Percent institutionalized before death**

| | All | Workers | Mdl-class | Single* | Married** | Single worker | Marr. worker | Single mdlcl | Married mdlcl |
|---|---|---|---|---|---|---|---|---|---|
| Men | 20 | 27 | 14 | (40) | 16 | (40) | 23 | (40) | 10 |
| Women | 48 | 58 | 32 | (58) | 45 | (70) | 53 | (0) | 35 |
| Total | 32 | 41 | 20 | (48) | 28 | (55) | 37 | (29) | 19 |
| N men | 89 | 45 | 44 | 15 | 74 | 10 | 35 | 5 | 39 |
| women | 65 | 40 | 25 | 12 | 53 | 10 | 30 | 2 | 23 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| N total | 154 | 85 | 69 | 27 | 127 | 20 | 65 | 7 | 62 |

* Never-married ** Ever-married, incl. widowed and divorced persons and co-habitational units (3 %). Source: computations on the Dalby-study. Subjects were all aged 67 when the study began.

Most of these institutionalizations took place in the 1970s in a rural area. Analysis of an urban sample of 70 year olds followed from 1970 (the H70 in Gothenburg) found that 50 % of them ended their life in an institution, with risk gradients about the same as in Dalby (personal communication from Marie Ernsth Bravell). More recent data indicate that ca. 90 % will use public services before they die (Larsson, Kåreholt & Thorslund 2008).

The rather dramatic risk differences of Table 8 may be a thing of the past. The risk of institutionalization used to be primarily a matter of demography and social class but less a matter of health. The age of entry into institutions is now higher on average and placements rationed to provide for very old, frail and frequently demented persons. Also, housing of old people is much improved and community services are now more extensive and better targeted. And, as we have seen, more of the elderly are married into late life. We therefore expect the demographical differences to be smaller if we analyze the trajectories of very old persons, as in Table 7. They and their spouses (if any) are frailer and illnesses more severe and debilitating and of longer duration, especially for the women (Romören 2003).

An analogous analysis in Table 9 for persons 80+, confirms that their greater frailty and higher rates of solitary living tend to equalize social differences and gender distinctions. In Norwegian Larvik the final rate of institutionalization was double as high as in Swedish Dalby for the 67 year olds (Table 6), totally and for the same sub-groups. Social differences have shrunk, as have gender variations and the significance of marital status. It might be noted that both studies took place in municipalities with abundant supply of institutional care, fairly typical of that era.

There are obvious social differences in risks of institutionalization. Higher risks of working class elderly than of the middle class probably mirrors the better health of the latter. A British study found that partner care was more common in working-class elder-marriages for that very reason (Glaser & Grundy 2002).

**Table 9. Longitudinal patterns of institutionalization of older people in Larvik, Norway, 1981-2000. Percent institutionalized before death***

| | All | Workers | Mdl-class | Single** | Married | Single worker | Marr. * worker | Single mdlcl | Married mdlcl |
|---|---|---|---|---|---|---|---|---|---|
| Men | 52 | 49 | 60 | (50) | 53 | (40) | 50 | (67) | 59 |
| Women | 73 | 73 | 75 | 75 | 72 | (64) | 74 | 78 | 73 |
| Total | 67 | 65 | 71 | 72 | 66 | (58) | 66 | 77 | 69 |
| N men | 124 | 75 | 47 | 8 | 116 | 5 | 70 | 3 | 44 |
| women | 309 | 151 | 142 | 60 | 249 | 14 | 137 | 45 | 97 |
| | | | | | | | | | |
| N total | 433 | 226 | 189 | 68 | 365 | 19 | 207 | 48 | 141 |

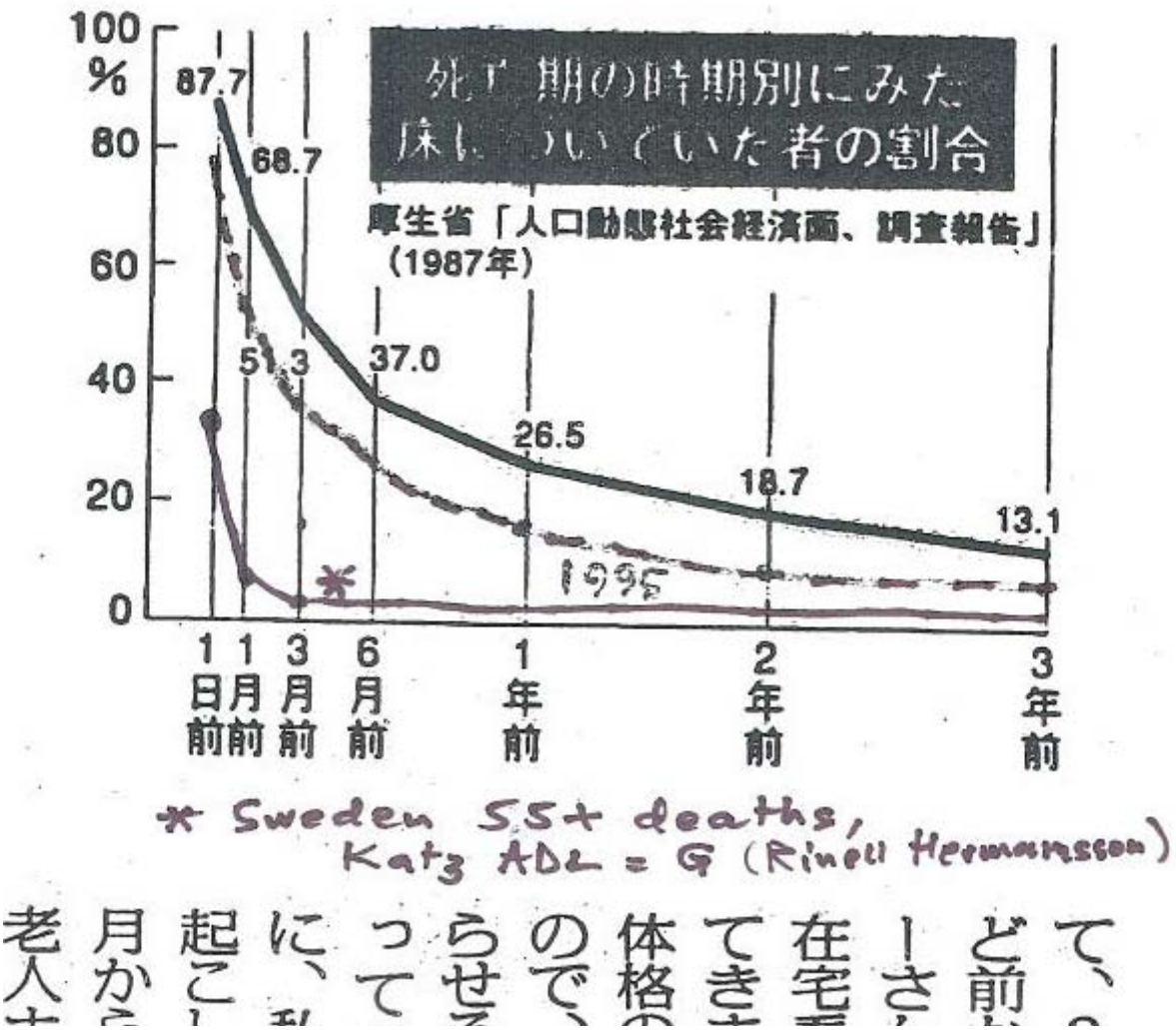
* The study followed all 434 persons in the municipality who were 80+ in 1981 until they were all dead. (See Romören 2003 for details.) Source: computations on Larvik-data kindly provided by Tor Inge Romören.

Importantly, a high longitudinal risk does not necessarily imply high prevalence rates, or vice versa. Indeed, the little evidence there is on these aspects in the Nordic countries, indicates rising long-term risks (chances) of using public services before death, while cross-sectional user data at the same time indicate declining rates of use. The explanation seems to be that these services are now used for much shorter time than before. It is noteworthy that most old people will have used public Home Help before they move to an institution or before they die.

**A comparison with Japan**

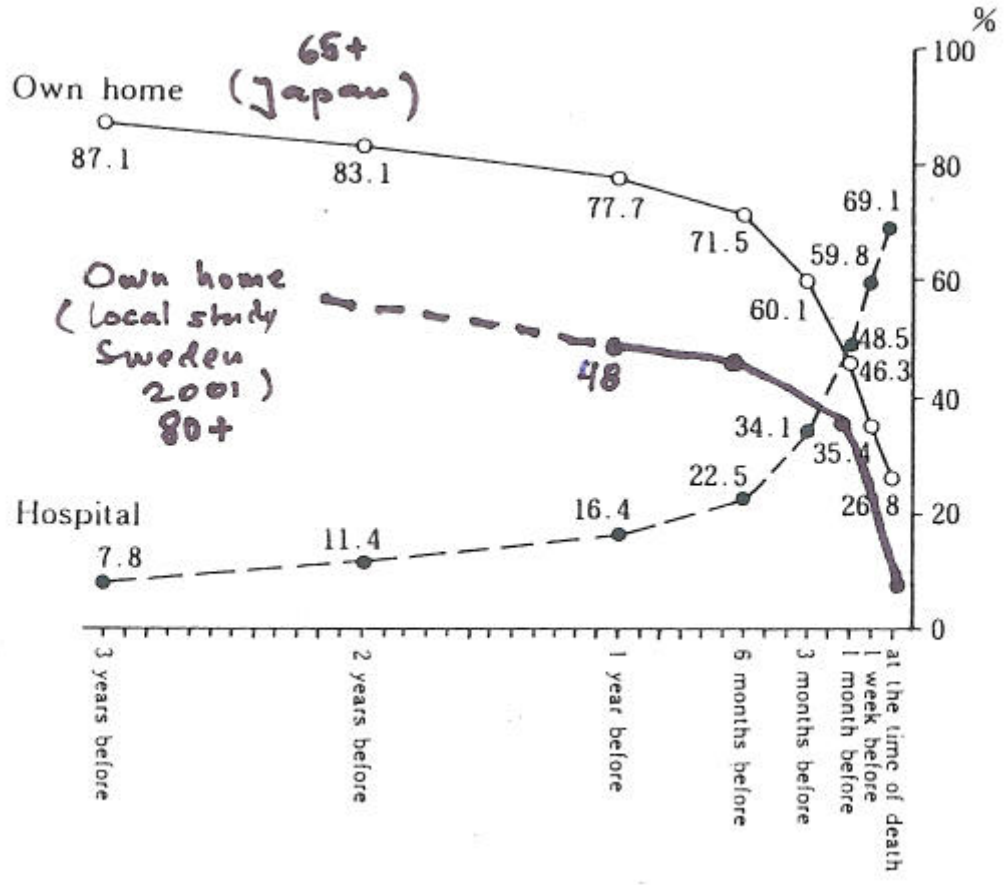
I will pursue a somewhat crude comparison of Japan and Sweden, utilizing information on patterns of care in the last year of life of older people. This obviously is not the same as comparing averages of care patterns, nor the type of longitudinal data used above. In 1987 and in 1995 a Japanese government agency surveyed families of deceased older persons to gather information on their trajectories of frailty and care before they died, their place of death, institutionalization and preferences. It emerges from these surveys that remarkably many were bed-bound for a long time before they died; this declined a good deal between these surveys - see Figure 4 - but was in 1995 still much higher than in Sweden (curve marked with *). In 1987 37 % were bed-bound already 6 months before their death, in 1995 "only" a quarter of them, to compare with just 1-2 % in Sweden. I am not aware of any later survey of this kind, but these patterns may illustrate an important cultural difference in care and attitudes to care, both among older people and their families. Interestingly, patterns have changed in Japan, with fewer old persons bed-bound for a long time before they die. The survey also covered carers and their efforts: 27 % of male carers gave up work or took leave from it to provide care, while 35 % of female carers did this. Some 2 % changed their work schedule. It was also found that just a third of older people who preferred to die at home did so.

**Figure 4. Duration of bed-bound status before death of older people, Japan and Sweden**




We may also use the 1995 Japanese source to assess and compare "final" rates of institutionalization in Japan and Sweden in Figure 5. They are higher in Sweden - probably partly due to the sample being 80+ in Sweden, but 65+ in Japan - but in both countries much higher than the averages usually referred to in comparisons. Probably many or most places termed "hospitals" in the Japanese statistics correspond to nursing-homes and similar long-stay institutions in Western countries.

**Figure 5. Place of residence before death, Japan 1995 and Sweden 2001***




* Sample of deceased 80+ 2001, hospital catchment area Jönköping County (Andersson, Sundström & Thulin 2003).
For Japan 1995 I relied on "Deaths of Aged Fiscal Year 1995". Vital Statistics Division. Statistics and Information Department. Minister's Secretariat. Ministry of Health and Welfare.

**Family care and the public services: symbiosis, collaboration or co-existence?**
An important aspect of old-age care in Sweden is the high degree of overlap between family care and public services, which we have seen also occurred in poor-relief. Just as sometimes happened in the era of old poor-relief, many old people who are helped by their families today *also* receive public help. This is a significant feature of Nordic welfare and also the preferred arrangement, both by old people and by their families: they don't want total dependence on the family, nor on public services. With a combination of the two, there is some room for choice and maneuvering for both ageing parents and their off-spring. International research shows this to be the preferred pattern also in continental and southern European countries (Daatland & Lowenstein 2005). Yet, for example in Spain, most support to old people has so far been forthcoming from the family (mostly) *or* the state, with much less overlap between these actors than in northern Europe (Walker 1993, Sundström et al. 2007).

Everything else equal, we may expect that family ties in general and informal care in particular to be at least partly determined by the sheer size of the family, acknowledging that 'access' to a partner and off-spring may be of primary importance. Of course, being in the context of a network means not only that one may receive help, but also that one may have to

provide it. If networks expand or contract, one might find a corresponding change in these risks (chances). These dynamic aspects are hard to assess, but some evidence on the effects of network character and size can be deduced from survey data. There is thus a clear social profile to the pattern of help old people receive when they live alone in the community and need help, as shown for Sweden with two different data sets in Tables 10 and 11.

**Table 10. Older people aged 65 or more years living in the community, by family situation, need for help and help sources, Sweden 2002-03. Per cent**

| | Married/co-habiting[1] | | Lives alone | | |
|---|---|---|---|---|---|
| | Has child | No child | Has child | No child | All |
| | *Percentages* | | | | |
| **Needs help**[2] | 16 | 20 | 27 | 25 | 21 |
| **Sources of help**: | | | | | |
| Family only[3] | 80 | 69 | 42 | 24 | 58 |
| Home-help only | 5 | 8 | 18 | 47 | 15 |
| Both | 14 | 18 | 32 | 20 | 23 |
| Neither[4] | 2 | 5 | 7 | 9 | 5 |
| Sum | 100 | 100 | 100 | 100 | 100 |
| **Sample sizes** | (1,711) | (194) | (1,078) | (277) | (3,260) |

*Notes:* 1. About 97 percent lived with spouse only, but including those also living with children, siblings and others. 2. Needs help with one or more ADLs: help received refers to the same ADLs. 3. Or other informal care. 4. But may have had other sources of support
Source: Statistics Sweden ULF 2002-03, our own computations.

In Table 10 we highlight the division of labour between family and state, in Table 11 we take a closer look at who the helpers are. It emerges from Table 10 that older people who need help, but who are married and have children mostly (80 %) rely on family only. Those who lack both of these cardinal relations tend to rely exclusively on the state.

This is not surprising, but also old people who live alone and who have off-spring often use public Home Help, but rarely alone: for them the typical situation is to be helped by family alone or to have a combination of family support and public help. As mentioned, adult children of old people often live in the vicinity, and in this group we have seen the greatest increase in family care in the 1990s, parallelling a cutback in public Home Help (Johansson, Sundström & Hassing 2003).

The ‘access’ to a partner and/or child and its consequence for who the carers are can be gleaned in some detail from Table 10, which describes various combinations of informal and formal (public Home Help) care in Sweden for older people in need of help. It verifies that public services (Home Help) are used mostly by older persons lacking close family, but in Table 11 we also see a characteristic pattern of *who* in the family that is relied upon.

Those who have a partner rarely rely upon help from others; other evidence indicates that ‘outside help’ is used primarily when the partner also is frail or otherwise not able to give the support needed, regardless of whether they have off-spring or not. (Also, when public help is given to these persons, relatively few hours of help are granted.) Partnered persons who do not have children use Home Help somewhat more often than when a child is demographically

available. As mentioned, geographic proximity of off-spring is a deterrent to use of public support in old age.

**Table 11. Support patterns for old Swedes in need of help*, by family situation and help constellations, 2000, 75+. Per cent**

| | Has spouse/partner | | No spouse/partner | |
|---|---|---|---|---|
| | Has off-spring | No off-spring | Has off-spring | No off-spring |
| | (N=313) | (N=37) | (N=320) | (N=100) |
| **TOTAL** | | | | |
| % women | 22 | 24 | 66 | 69 |
| Help given only by Spouse/partner | 70 | 70 | - | - |
| Child(ren)** | 3 | 3 | 30 | - |
| Other kin | - | 3 | 4 | 13 |
| Other household member | - | - | 2 | - |
| Friend/neighbour | 1 | 3 | 6 | 14 |
| Home Help | 5 | 3 | 21 | 34 |
| Combinations of Spouse+child** | 6 | - | - | - |
| Spouse+HomeHelp | 5 | 11 | - | - |
| Spouse+other(s)** | 1 | 5 | - | - |
| Child+HomeHelp** | 1 | - | 19 | - |
| Child+other(s)** | 1 | - | 4 | - |
| Home Help+ | - | - | 3 | 19 |
| other(s) | | | | |
| No one | 6 | 5 | 12 | 19 |
| **Total** | **100** | **100** | **100** | **100** |

*Need help with one or more ADL-tasks **Children include potential inlaws
Source: our own computations on HPAD survey 2000 (Socialstyrelsen 2000).

For unpartnered older persons, having a child or not thus makes a big difference. Unmarried persons with children tend to receive help from them, alone or in combination with Home Help, though 21 % are helped by public services alone. The small – a tenth of this age-group – category that has neither partner nor children does make use of help from more distant kin and/or neighbours/others. They also more often (53 %) rely on the public Home Help, though we note that even among them a minority is dependent solely (34 %) on the public service.

We may use our data to explore at some depth the degree of interplay and overlap between what the family and the state is doing respectively for old people in need, again using the examples of Spain and Sweden. This is described in Table 12.

Once again we in Table 12 discern differences, but also some similarities. The family is the main resource for help both in Spain and - though somewhat less often – also in Sweden: 73 % and 58 % respectively of old people who need help rely on their family *only*. In Spain just one per cent rely on Home Help *only*, in Sweden a substantial minority of 15 %. To get help *both* from family *and* from Home Help is more common than relying on Home Help only in both countries: 5 % in Spain and 23 % in Sweden benefit from overlapping care. Noteworthy is the large group (20 %) in Spain who use neither family care nor Home Help.

Most of them (17 %) hire private help: there are an estimated 1 million care givers for old people in Spain and about 100 000 private helpers, often immigrants (IMSERSO 2005b). In total, help from family is forthcoming about equally often in Spain and Sweden: 78 % and 81 % respectively. The important difference is the degree of overlap with public services, which is much bigger in Sweden, and the use of private help, much bigger in Spain.

**Table 12. Home Help and family care among old people 65+ living in the community and who need help, Spain (2004) and Sweden (2002-03), by household structure. Per cent**

| | Living alone | | Co-resident | | All | |
|---|---|---|---|---|---|---|
| | Spain | Sweden | Spain | Sweden | Spain | Sweden |
| Old people who need help*% | 19 | 28 | 21 | 17 | 20 | 21 |
| *Thereof helpd by* | | | | | | |
| Family only** | 65 | 38 | 76 | 78 | 73 | 58 |
| Home Help only | 5 | 24 | -- | 5 | 1 | 15 |
| Both | 6 | 30 | 3 | 15 | 5 | 23 |
| Neither*** | -- | 8 | 19 | 2 | 20 | 5 |
| Sum | 100 | 100 | 100 | 100 | 100 | 100 |
| *N* | *83* | *392* | *323* | *349* | *406* | *741* |

*Need help with one or more ADL-tasks, help received refers to the same ADLs as in Table 5.
**or other informal care
***but may have other sources of support: in the Spanish case in total 3 % report having no one to help and 17 % "others" (mostly a private live-in helper or other private arrangement)
Sources: our own computations on Encuesta de Condiciones de Vida de los Mayores 2004 for Spain, and on Statistics Sweden Level of Living Surveys 2002-03 for Sweden

A closer look at Table 12 reveals that relying on help from family only, is the biggest single provider even among old Swedes who live alone (38 %). For them off-spring – mostly daughters – are the main providers of help. Yet, this is more clearly the case in Spain, where family dominates the panorama absolutely with their 65 %. For co-resident old Swedes the carer is usually a partner, and there are in absolute numbers equally many male and female spouse carers in Sweden. In comparison, Spanish wives are about two times more likely than husbands to care for their partner. (Also in couples only households wives are more likely than husbands to be carers, when the partner needs care.) Other family than the spouse may be more active in these cases in Spain, reflecting that more old people there live with their off-spring or other family (above and analyses not shown).

Access to kin clearly influences both the chance to receive and to give care, evidenced both by the character of the relation and the sheer number of kin. In recent (2002-03) Swedish national data for the 55+, 45 % are care-givers (any person, regardless of relation and location) if the have both a partner, parent(s) and siblings(s), in contrast to 24 % of those who have two of them, 20 % when one of them remains and 16 % for those who lack all these near relations. Of course, the biggest difference makes the presence of a parent, and it is rare

to have all three of them: 12 % have them all, 47 % have two of these relations, 33 % just one of them and 8 % none of them. Clearly, there is a good deal of care being exchanged inside the family, but there is also substantial care being given to more distant kin and to non-kin (Socialstyrelsen 2006).

The degree of division of labour between family and Home Help is typically nebulous, though some countries report that there may indeed be agreements between family carers and the public services as to who does what, hence producing a significant overlap between these providers. In the Nordic countries the issue has surfaced in recent years of cutbacks in public services. A systematic comparison of care patterns for the 75+ in the international OASIS-project found - consistent with our analysis - that the overlap between formal and informal care was largest for frail persons in Norway and England and rather small in Germany, Israel and Spain, where more old people had help *either* from their family *or* from the state. In Israel and Spain proportionally many used relatively inexpensive, private paid help (Daatland & Lowenstein 2005). This is rarely available in the Nordic countries. Again, we remind the reader that these are averages, the longitudinal risks may show a different picture.

It is difficult to compare services between countries, even in the best of situations. As an example of this, I may mention one type of service where Spain has higher coverage - and a better service - than Sweden, namely in day-care. Spain provides this for well one per cent of older persons, whereas Sweden lags at less than one per cent, and also provides a rather inferior service. (Which may be the reason why demand is small.) In Spain this is a 08-18 service 5 days/week, in Sweden it is a 09-15 service 2-3 days/week.

## POLITICAL AND FINANCIAL ASPECTS

As hinted at already, Swedish public old-age care rests on a long tradtion, but also is shaped by political and financial factors. Already in 1912 did a Swedish government commission on pensions point to the significance of (supposedly) weakened informal care for public spending (in 1914 we got the first general pension program). This has remained an ingredient of most Nordic white books on pensions and old-age care. Even if no assumption of a decrease in care is made, the availability of family care is considered, the latest examples being econometric analyses of consequences of increased needs for old-age care in Norway of 2050 (Statistics Norway 2006) and a similar Swedish analysis with a rather ‘optimistic’ perspective on future needs for care (Lagergren & Batljan 2000). In contrast to at least one officious European Community document (Council of Europe 1998), official Nordic publications do not propose that families shoulder bigger commitments in old-age care.

A Swedish government commission on old-age care published a report in 1977, where it planned for high service rates to expand even farther, but financial problems of the municipalities soon led to stagnation and decrease in coverage rates. In 1950 and 1960 Sweden spent c. 5 % of its GDP on older people, in 1965 6 %, in 1970 7 % and in 1975 10 %. The government white paper that did these calculations found that expenses per retired person had trebled in fix prices (SOU 1977:98 Table 7.12). In the early 1990s the rate had reached c. 14 %. It has not risen after that, notwithstanding repeated government declarations to raise spending on older people and budget forecasts do not indicate any future rise either. About three quarters of these expenses are on pensions and housing-allowances. The latter benefit nearly 40 % of older persons, enabling them to demand modern and adequate housing. A recent overhaul of the pension programs means that they will be less generous in the future,

safe-guarding actuarial soundness, but limiting pensioners' purchasing power (some 85 % of their incomes derive from pensions).

The conclusion is of course that any further rise in standards of living or services has to be financed by older people themselves, or by their families. This has also been hinted in government publications, but has not been well received. It is likely that we have reached the limit of what the welfare state can allocate to older people. Henceforth the problem for the service providers will rather be how to best use these resources, in other words a more efficient use of them. This is often the explicit motive of reforms of the services. We will below try and assess how authorities allocate the armory of services available to them.

The stagnation in resource allocation on older persons coincided with a general trend in the 1980s and 1990s of rehabilitation and care in the community, such as de-institutionalization of the mentally sick and developmentally impaired. So-called bed-blockers that plagued hospital wards in the past were made away with through a reform in 1992: when a hospital can not do more for patients and wants to discharge them, their municipality has to provide care for them or foot the hospital bill. This quickly solved this problem, but has instead made unsatisfactory rehabilitation and gaps in the chain of health care after discharge from hospital a burning issue. Sweden, like most other countries, strives to bridge the gap between social services and health care, but has not been wholly succesful at this.

It can be noted that the law does not prescribe the *right* of the needy citizens for support, only the *duty* of municipalities to provide a service, but not how much, or what kind of service and in what manner. The Social Service Act, that is supposed to steer municipal provision, only dictates that there must be Home Help services and institutional care, without specifying their levels. The whole law is a ‘framework’ law, the intention was that the vague formulations should allow for local solutions and initiatives, and potential conflicts be solved through prejudicates created after appeals to the administrative courts (above). This has not always worked the way legislators thought when they formulated the law in the affluent 1970s (the act is from 1982) and it has been necessary with a number of revisions of the law.

One such amendment was the prescription that municipalities ‘ought’ to support family carers, when feasible (1998), reflecting increased awareness of the significance of family care, now revised to be mandatory for the municipalities (in 2009). There are no uniform procedures of needs assessments in Sweden; each municipality has its own routines. This contrasts with mainstreamed procedures in Germany (Pflegeversicherung), France (APA), Spain (Ley de dependencia), and Japan (care insurance Kaigo Hoken). A comparison of needs assessments and service allocation in one area in Japan and one in Sweden did show better and more systematic procedures in Japan, but also that they disregard some important aspects of care (Lagergren & Korube 2008). Proposals in Sweden to introduce better assesments or even a care-insurance have so far met with little interest.

Several European countries are now experimenting with various ways to provide the public with quality indicators of services. The Swedish Association of Municipalities just published "Open Comparisons" which uses many indicators of quantities and qualities of the local services. Another, somewhat different type of "Ageing Guide" is published by the National Board of Social Welfare. The intention is that service users and/or their families use these to assess the quality of services, and to put pressure on local authorities through the publicity. Differences are big also for these quality indicators. They vary from standard indicators of residences to aspects of staff training, whether people die alone, and if people in terminal care

were told that they were going to die. Also, launched in 2008, questionnaires are sent out nation-wide to nearly all users of institutional care and Home Help. A first report of findings shows that most users are relatively satisfied, which has been found also by previous, smaller studies.

Sweden also now introduces a Law of Freedom of Choice: municipalities will have to offer some choice in providers of services. This is done with a procedure of legal tender, where the reimbursement for the providers is fixed and they are invited to compete with quality. Just being launched (compulsory from 2009) the outcome is still uncertain.

One reason for Nordic reserve as to family care is the official wish to keep labour force participation high and also gender aspects: provision of informal care is seen as a mostly female undertaking, and it is often assumed that this is hard to combine with paid work. Yet, it is estimated that two thirds of *all* care for older Swedes is provided by family, whereof in turn two thirds is provided by women (Szebehely 2005). Analyses of both cross-sectional and longitudinal data fail to find any major effects of informal care-giving on gainful employment of either men or women in general, except in - the less common - cases of very heavy informal care (Socialstyrelsen 2006). Indeed, analysis of a period in the 1990s of shrinking public services for old people and a simultaneous increase in informal care coincided with an era of consistently high labour force participation.

**Table 13. Care for older people 75+ who live alone, help from children and from public Home Help, Sweden 1994 and 2000. Percent**

| | All | | Has off-spring, all elders | | Off-spring within 15 km | | Childless | |
|---|---|---|---|---|---|---|---|---|
| *Year* | 1994 | 2000 | 1994 | 2000 | 1994 | 2000 | 1994 | 2000 |
| *Help from* | | | | | | | | |
| Children | 12 | 22 | 16 | 28 | 16 | 36 | -- | -- |
| Home Help | 25 | 20 | 24 | 18 | 23 | 19 | 27 | 29 |
| N (weighted) | 716 | 843 | 547 | 670 | 371 | 414 | 170 | 173 |

Note: Home Help is a needs-assessed public service that in Sweden provides help with *household tasks* (primarily shopping, cooking, cleaning and laundry) and/or with *personal care* (getting into/out-of bed, bathing, toileting, eating, un/dressing, outdoor walks etc.). Both for Home Help and children help refers to aid with one or more of these aspects. Home Help clients pay a fee, according to income and number of hours used, up to a ceiling. The average client uses 32 hrs/month, with large variations and no upper limit but only about 4 % of them use more than 120 hrs/month.
Source: here after Johansson, Sundström & Hassing 2003.

The increase in care, we have noticed, fell nearly all on daughters and other female family members (Sundström, Johansson & Hassing 2003), as shown in Table 13: "children" here are mostly daughters. They help more in general, and especially if the live near their parents.

Yet, common assumptions about (female) employment and capacity to provide help and care for ageing family mebers (parents) may be overly mechanistic. There is no rational link between high co-residence - and presumably more informal caregiving - between old people

and their children in Finland and Norway on the one hand, and high labour force participation rates in full-time jobs for men and women in Finland and low rates for women in Norway on the other hand. Denmark and Sweden have little co-residence and high employment rates, with many women in part-time jobs, but the reason for the part-time choice is rarely any need to provide care to ageing family members (Socialstyrelsen 2006).

Interestingly, these patterns contrast with what is observed in Southern Europe in the SHARE-database, where many carers of old family members report that they have had to refrain from work, stop working and so on (ibid.). A plausible explanation for these divergent patterns is the access to relatively abundant and affordable public services for elderly people in the Nordic countries, both in the community and institutional care. This is also what carers ask for in surveys like a large representative Spanish study of carers in 2004 (IMSERSO 2005) and in international comparative studies like the OASIS-project covering Norway, Germany, Britain, Spain and Israel (Daatland & Herlofson 2004, Daatland & Lowenstein 2005).

Families in general and carers in particular do not ask for the state to 'take over' altogether, but desire a *shared* commitment, where *both* parties contribute (ibid., Socialstyrelsen 2004a). Quite often this is also the case in care for old people in the Nordic countries, both in the short and the long run, and much more often than in, for example, Spain (Sundström et al. 2007).

Norms on responsibility for old people have been probed in a few international studies. In the OASIS-project, representative samples of old people in Norway, Germany, Britain, Spain and Israel varied somewhat in their definition of responsibility, but everywhere the large majority wanted responsibility to be shared between family and state. Preferences vary, as may be expected, by actual availability of government support. Half or more was for 'mainly state' responsibility for financial support, domestic help and personal care in Israel and Norway. Much the same held for opinions on who should be responsible for increasing, future needs (Daatland & Herlofson 2004). Another international study found similar patterns, shown in Table 14.

**Table 14. Desired division of responsibility between family and state among carers of the elderly in selected European countries 2005. Per cent**

| *Desired responsibility* | *SWEDEN* | *ENGLAND* | *POLAND* | *GERMANY* | *ITALY* | *GREECE* |
|---|---|---|---|---|---|---|
| Family all | 3 | 3 | 36 | 4 | 12 | 15 |
| Mainly family, state contributes | 22 | 65 | 57 | 71 | 77 | 78 |
| Mainly state, family contributes | 57 | 12 | 5 | 11 | 6 | 3 |
| State all | 6 | 2 | 1 | 0 | 1 | 0 |
| Don't know, No answer | 12 | 18 | 1 | 14 | 4 | 4 |
| Sum | 100 | 100 | 100 | 100 | 100 | 100 |
| N | 581 | 320 | 875 | 451 | 863 | 290 |

Source: EUROFAMCARE, by permission

In Sweden a quarter of carers endorse main responsibility for family, as against three quarters or more in the other countries. Yet, only in Poland (36 %) a large fraction accepts total family responsibility. (A couple of national studies confirm the pattern; see the concluding comparison of Spain and Sweden.) The OASIS-study is nearly exceptional in considering both family and state support simultaneously (Daatland & Lowenstein 2005). It is very unusual to find a conscious discourse on this in official publications. A rare exception is a French analysis of the APA, with systematic consideration of network configurations of old people at different levels of need and the interaction of family and public support (DREES 2006b). These aspects are likely to be more important in coming years.

A survey in Flanders (Belgium) found that most 55+ are negative towards legal filial responsibility for residential care (Vanden Boer & Vanderleyden 2003). As mentioned above, a recent opinion poll in Denmark by the central pensioner organization AeldreSagen revealed the same pattern. Still, we rarely encounter discussions of the ambivalence and conflicts that may be inherent for both provider and recipient in obligatory care for a dependent old relative. Without entering a discussion of the complexities of these aspects, it appears that strict application of legal responsibility may not guarantee adequate care for dependent (old) persons. The individual family history, with emotional ties but also conflicts, may make for abuse in situations of enforced care, documented both scientifically and in fiction.

As care of older people is a public responsibility in Sweden there are no legal filial obligations for family, but also no rights. If a family prefers to care for a family member, they often get little recognition and support. The underlying philosophy has been to promote maximum independence from the family and next of kin, even if you need support for your daily living. For example, if a person wants information about his/her spouse's' illness, treatment and prognosis, informed consent from the sick person is required. In Swedish Civil law, expectations on family support exist only for spouses, although officially not including 'heavy' personal care. Persons who take care of an sick family member in a terminal care situation, can receive payment from the Social Insurance under the programme Care Leave. It gives the right (for persons in gainful employment, i.e. under 67 years of age) to take time off work, with compensation for up to a total of 60 days per person-cared-for. The compensation is ca. 80% of the income before taxes. (There is no general right to take time off work to care for family members.)

In the 1990s Sweden 're-discovered' the important role of the family in supporting older people. First was the realisation that the success of a policy of home-based community care was largely dependent on extensive family input. Second, as a result of economic recession, there was a growing interest in the informal care sector and its potential to substitute for costly formal service provision. Third, there was increasing research evidence pointing to the crucial role of families, their care burdens and their need for support. And, in the 1990s there was a growth of carer organisations, lobbying the authorities and seeking public recognition and support.

In order to underpin and sustain the new legislation on support for carers and to stimulate service development, the Swedish government allocated 300 million crowns (~40 million dollars) to be distributed amongst municipalities 1999-2001. This first wave of state grants was subsequently followed by similar initiatives during 2001-2004 and during 2005-2008. Carers are now somewhat more visible and recognised, but there are still vast problems of targeting, of coverage, and the quality of supportive services. Additional challenges exist in

reaching working carers, the diversity of carers and harmonizing support for carers in health care and social services.

Cutbacks in pulic services has had negative repercussions on carers. This has further triggered the 'carers' movement' to increase their lobbying of local and national governments to provide easily accessible, flexible and tailored support for carers. Policy initiatives to meet demands of carers also reflects an ambition to make support to carers an integrated part of the "ageing-in-place policy" in Sweden. Several decades of neglect of the families now changes, and the new law on family support can be seen an historic turning point.

**Local variations in public services: a threat to equity? /with Dolores Puga, CSIC/**
As already hinted at, countries can vary as much internally as between themselves. This also holds for needs of care and for services for older people meant to see to those needs. There are substantial local variations in public services (Home Help) for the elderly in all the Nordic countries. As hinted at above, this is not a new feature of the public provision for the needy. It could be seen in the 1829 inventory of poor-relief (Skoglund 1992) and was recognized by the first modern government white papers on social services.

The lack of analyses of local variations in needs and services can partly be excused by a serious shortage of the kind of data needed. Exceptions nearly always are studies, also rare, of individual countries. As far as we know, only the Nordic countries (excepting Iceland), France, the United Kingdom and Spain have reasonably easy-to-access data on service variations. In some other countries it is possible to use survey-data with information on where residents live, to construe rough coverage data, but they will by necessity be less precise than administrative statistics. (The latter may suffer from other kinds of imprecisions.) Creative use of survey data is for example found in a study of Japanese intergenerational care and attitudes (Takagi, Silverstein & Crimmins 2007). A few studies of this kind have also been undertaken in the United States.

The problem has been to connect coverage rates of public services with *needs*, information on which is typically derived from surveys. In the UK both the 1991 and the 2001 census asked about impairments and in 2001 even whether one was an informal carer! Yet, incompatibility between regional divisions makes it hard or impossible to connect this information with service statistics (pers. comm. Emily Grundy). In France, thanks to the common use of départements as the statistical unit, these connections can be done. The one French study of this kind that we know about showed a convincing connection between rurality and class factors - responsible for poor health - on the one hand, and service coverage (APA) on the other (DREES 2005). Many and good surveys in Spain have provided data on living conditions of older people and on informal care and services. No study that I know of has scrutinized local variations in service allocation, but a few studies have analysed regional differences in the supply of health care (e.g. Lopez-Casasnovas, Costa-Font & Planas 2005).

In Sweden, a couple of studies have analysed service variations, although using other types of data. Studies that only used macro level indicators of demography, economy and political structure failed to explain variations (Berg et al. 1993, Trydegård 2000). When these analyses failed to find any 'rational' demographical, political or financial explanation (at the macro-level) of these local variations, it was tempting to conclude that the reason behind the local differences was local incompetence and ignorance.

Yet, a recent study that used individual data disclosed that the patterns may indeed be more rational – and quite equitable - than previously thought. It was previously unknown that needs differ considerably between the municipalities in Sweden, needs defined as living alone and needing help. When survey data on individuals are connected with local coverage statistics it was shown that variations in service coverage vanish when local differences in needs are accounted for. Frail older people who live alone all receive Home Help to about the same extent (ca. 54 %) wherever they live. This implies a surprising degree of equity, which can not be inferred from 'raw' variations in service coverage, as seen in a study by the author and colleagues (Davey, Malmberg & Sundström 2006). /We now continue with work on similar analyses of service variations in Denmark, France and Spain, possibly also in the United States where some states have usable statistical sources on services./ The pattern in the Swedish case is shown in Table 15.

**Table 15. Patterns of family and public support for frail older persons by coverage rate of public Home Help, Sweden 2002-03. Per cent**

Level of Municipal Support (Home Help)

| | Low | Moderate | High | Total |
|---|---|---|---|---|
| *In need** | 21 | 27 | 31 | 27 |
| Informal Only | 37 | 44 | 35 | 39 |
| Home Help only | 29 | 24 | 20 | 24 |
| Both | 25 | 28 | 36 | 30 |
| Neither | 9 | 5 | 9 | 8 |
| Total (N) | 97 | 136 | 159 | 392 |

Source: after Malmberg & Sundström 2005

Low-providing municipalities have on average proportionally fewer old people who are frail *and* live alone, high-providing ones many more old people in this predicament. The latter are typically rural municipalities with many working-class elderly of poor health. When focussing only on persons in need, as in Table 15, these influences tend to vanish. Interestingly, informal care varies in the same manner as public services in these regional analyses, that is, the higher the need, the more help *both* from family *and* from the public services (Davey et al. 2006). In other words, for coverage rates to be equitable, they have to be unequal, as needs are unequally distributed in the country.

It is likely that the one-point entry system of welfare in Sweden and the old tradition from the poor-relief era explains why social workers manage relatively well to target needy old people in their catchment areas, as older people in need help with their ADL receive Home Help equally often, regardless of where they live. The rest are usually receiving the help they need from their family. As mentioned above, surveys or local outreach activities find very few older people who need help but do not get it, in general and in comparison with, for example, the United States (Shea et al. 2003).

Older people in regions with low coverage rates of public services more often are helped by their families, implying not only parallelisms but also a degree of substitutability between these sources of support. In municipalities that have low coverage of Home Help 25 % of older people in need have both family and Home Help to support them, in high coverage areas 36 % (national average 30 %). But there is also less overlap between family care and

public services in these regions, probably reflecting stricter needs assessments that primarily allocate support to persons without family. The greater overlap of family and state in regions with greater coverage means there is more of *indirect* support to carers in these regions as more frail old people enjoy support from *both*; in regions with low coverage the choice is family *or* state.

Indeed a similar tendency is seen in provisional data for Spain, although levels of public support are generally lower, as shown in Table 16. In Spain, coverage rates have expanded remarkably, deviating from other Southern European countries (and Sweden) over the past one-two decades, but with noticeable local variations. The national Plan Gérontologico in the 1990s encouraged some seven thousand municipios and 17 autonomous authorities to provide both residential services and home care, although the locus of responsibility was not exactly defined (??). Up till now, services have been means-tested and therefore primarily used by the poorer segments of the population.

**Table 16. Family care and public services for older people in Spain, by coverage rate of region, 2006. Per cent PROVISIONAL**

*Coverage rate**

| | LOW | MEDIUM | HIGH | ALL |
|---|---|---|---|---|
| Home Help** | 3 | 4 | 8 | 4 |
| Any service | 8 | 11 | 19 | 12 |
| Family help | 33 | 29 | 27 | 30 |
| Overlap**** | 5 | 7 | 14 | 8 |

*Coverage rate total of any service: residential, Home Help and/or "other servces", excluding vacation programs and similar services.
LOW: Cantabria, C. Valenciana, Murcia, Canarias, Galicia.
MEDIUM: Castilla-León, Asturias, La Rioja, Cataluna, Andalucia, Baleares.
HIGH: Madrid, Castilla-La Mancha, Extremadura, P. Vasco, Navarra, Aragón.
** Servicios a Domicilio, corresponds to Swedish Home Help
****Calculated as the percentage of persons who get helped by their family who also use Home Help.

Financing was previously a barrier to service growth, but the new Ley de dependencia (2008) is meant to alleviate the economic burden of the local providers when it is gradually phased in. An interesting feature of Spain are the many private domestic aids, part- or full-time, who are hired by older people or by their families. A government survey estimates them to number at least one hundred thousand (IMSERSO 2006).

Another important aspect is the efficiency of services; are they allocated in a way that will target older people in need, or at least as many as possible of them? Most countries with reasonable rates of public (publicly financed) services tend to provide different services for different needs, with more or less degrees of superimposition (overlap) between them, affecting how large a proportion of all older people that are covered. A degree of substitution was already seen above in the analyses that used data at the national level.

**How efficient is service allocation?/with Dolores Puga, CSIC/**

Many countries strive to make their services more efficient. This seems usually to mean not to provide unnecessary help, and avoid duplication: to give the right kind of input for a specific need, but no more, and the right amount, for example the number of Home Help

hours . A general conclusion, then, is that the more different services we have, the better. The reason is of course that needs differ, and they also change over time. To add some crude insight into this issue, we can draw on scattered data on public service use. Talking about efficiency, I obviously do not imply efficiency in the strict economic sense, but a more loosely conceived concept.

The above-mentioned OASIS-survey, that used a sample of persons living in the community in big urban centers (100,000 or more) in five countries, provides information on use of a number of (usually) public services. This is shown in Table 17.

Israel and Norway have the highest rates of Home Help use, with England, Germany and Spain providing their older people (in year 2000) considerably less. When the whole (or near-whole) panorama of services is considered, some of the discrepancies disappear, and coverage is about two-three times higher than for Home Help solely. One of the implications is of course that many old people don't use Home Help, but manage at home with just meals-on-wheels and/or some other service(s).

**Table 17. Service use among older persons 75+ in OASIS, 2000. Per cent**
**PROVISIONAL DATA**

| *Country* | *Home Help use* | *Uses any service** |
|---|---|---|
| Norway | 33 | 53 |
| England | 15 | 46 |
| Germany | 6 | 19 |
| Spain | 8 | 22 |
| Israel | 33 | 73 |

*Home Help and Home Care and/or Home Nursing, Alarm system, Day Care, Pensioner club, Meals-on-wheels, Transportation services, others. (England did not ask about meals-on-wheels). N total = 2626.
Source: courtesy Svein-Olav Daatland
Note: rates refer to use during last 12 months, which may exaggerate coverage compared to cross-sectionall data
Source: courtesy Svein-Olav Daatland and Katharina Herlofson, NOVA.

To disentangle the degree of ’overlap’ between various forms of services is statistically tricky, and has been reported systematically only in Britain. There 5 % use Home Help and 5 % some other service, but not Home Help (2001). We continue with a presentation of Swedish data on the 'overlap' (superimposition) of different services, to try to grasp one important aspect of efficiency, that is how the arsenal of services is used, and whether the whole panorama of services target more older people than just the individual services by themselves.

The most common Swedish service beyond Home Help for older persons, and often their first contact with the helping bureaucracy, is transportation services. In total some 18 % of older people use transportation services, which are very extensive in Sweden. (Persons entitled to use the service just call an ordinary taxi and pay the same fee as if they had been able to take the local bus/tram. If they are severly handicapped, there are also special vehicles that take wheel-chairs etc.) Somewhat less common are meals-on-wheels, alarm systems etc. None of these services were available in the 1970s. As sketchily indicated in Diagram 2, there was no or little decline in over-all coverage, if the whole panorama of services is considered. Since the culmination of Home Help and institutionalization in the 1970s, there has rather been a

diversification of public services, in a sense responding to the diversity of needs among old people.

Regrettably there is no routine monitoring of all services, and I will therefore first use information on service statistics for a single municipality - Jönköping (122,000 inhab.) - which has provided me with data from their computerized records on clients in the social services. The outcome and a comparison with similar data for 1999 is shown in Table 18. It shows the concrete changes, and over-all continuity, in provision of the different kinds of services. As it gets very complicated to account for all variations, I have simplified the data into a few categories.

**Table 18. Use of public services for older people in the municipality of Jönköping, November 1999 and 2008, by age. Percent PROVISIONAL DATA**

| *Age* | *Any kind of service** | *Home Help* | *Institutional care* | *Only "other" service* | *No service* |
|---|---|---|---|---|---|
| *65-74* | *7* | *2* | *1* | *4* | *93* |
| *75-79* | *18* | *6* | *3* | *9* | *82* |
| *80-84* | *37* | *12* | *9* | *16* | *63* |
| 85-89 | 62 | 23 | 17 | 32 | 38 |
| 90-94 | 80 | 27 | 34 | 19 | 20 |
| 95+ | 82 | 24 | 47 | 11 | 18 |
| **2008** | | | | | |
| *65+* | *23* | *8* | *6* | *9* | *77* |
| *80+* | *53* | *18* | *17* | *19* | *47* |
| ***1999*** | | | | | |
| *65+* | *24* | *7* | *8* | *9* | *76* |
| *80+* | *54* | *16* | *22* | *16* | *46* |

*Institutional care, Home Help, Day care, Alarm system, Transportation service and/or meals-on-wheels or any other public service provided under the Social Service Act.
Calculated on
Information provided in November 2008 by Pia Kopp, Jönköping Municipality.
** Information provided in November 1999 by Anette Elver, Jönköping Municipality.

There was a remarkable stability in targeting *at large* in this municipality between 1999 and 2008, but shifts took place *in the kinds of services* that were provided. The trend over time is that the more "heavy" - and expensive - kinds of services were replaced by lesser and less costly ones: institutional care by Home Help, and Home Help in turn by transportation services, meals-on-wheels and/or alarm systems etc. Up to ca. age 75-79 these 'other' services are *the* most common ones in total, and they are more common than either Home Help or institutional care up ca. age 85-89. This is not to say that these 'other' services are inferior, they may even be more adequate. It may for example be better for some older persons suffering from (mainly) insecurity or dizziness to have an (inexpensive) alarm system than to get an infrequent visit by a Home Helper. It emerges from Table 18 that "other" support indeed is more common than Home Help and institutional care together up to ca. age 80, and it is more common than each of the latter up to ca. age 90.

The issue of the *quality* of the services can not be answered with these data, but analyses of survey data show that persons who only use these "other" services mostly have quite small needs for help, and rarely express that they need more help (below Table 21, Socialstyrelsen 2000). It is also worth noting that "small" services that reach out to many older people may be better than targeting fewer people with "heavy" support, and giving the rest nothing (Clark, Dyer, Horwood 1998).

Another noteworthy aspect, already mentioned, is that statistics on Home Help and institutional care - the only ones routinely available in Sweden and - give a very limited representation of public support to older people. Services reach out to about double as many as we can deduce from the official statistics. It is hard to say whether this is representative, but results from a few other Swedish municipalities and national survey data that collected information on use of these services indicate that that these patterns may be rather typical, at least for the years around 2000 (Socialstyrelsen 2000).

At the national level, the only and most representative data we have for Sweden are shown in Table 19. It can be deduced from Table 19 that most users of Home Help also use transportation services, but the opposite is not the case. The majority of persons using transportation services do not use Home Help, confirming that many of them have (so far) rather small needs for support. Many, of course, have a combination of the two.
In Middle- and High-coverage municipalities, older people get more of both kinds of services, and there is a bigger overlap of the two.

In Table 15 we saw that difference between areas with unlike regimes of coverage disappeared when we looked at family-Home Help interactions for older people in need . For the panorama in Table 19 of Home Help and transportation services, the two largest services in Sweden for older people, a good deal of the variations remain even when we look at older persons in need. Medium- and High-coverage areas do provide a higher fraction of needy older people with some kind of service than Low-coverage areas, but the differences are not dramatic. There is also a tendency to provide more older people with *both* services, when coverage rates are higher. Transportation services are typically allocated to persons in the early stages of frailty, as a first service. Therefore many of them don't use Home Help. In later stages, when they use Home Help, many of them will also have Transportation service. In other words, it seems that a bigger arsenal of services does meet needs better than a few, but also that some administrations are better at discriminating between users with specific needs, implying some variations in efficiency of resource allocation.

Over time there has been diversification of services in both countries, but earlier and more extensively in Sweden. For Spain we don't have access to exactly comparable data, but it is possible to give some insight into the same issue. This is done in Table 20. Although coverage rates are lower, and differences greater between areas, the over-all tendency is similar to the Swedish one in Table 19.

In both countries regions with lower coverage rates of their services use their diversified services differently. The seem to try to target more older persons by spreading their graces in a more discriminating way, but can still not reach as many . Regions with higher coverage rates tend to allocate more of their more abundant services on the same clients. Spain - alone among Southern countries as seen in Table 6 - at present expands all these services very ambitiously, although financiation remains a problem.

**Table 19. Substitution and complementarity in public services for older people in Sweden, by coverage rate of municipality, 2002-03. Per cent**

*Coverage rate of Home Help services*

| | LOW | MEDIUM | HIGH | ALL | |
|---|---|---|---|---|---|
| | | | | | Population *1000s* |
| No service use* | 86 | 85 | 80 | 84 | 1190 |
| Only Home Help | 2 | 2 | 3 | 2 | 31 |
| Only Transportation service | 8 | 8 | 10 | 9 | 124 |
| Both | 4 | 5 | 8 | 6 | 80 |
| Sum | 100 | 100 | 100 | 100 | 100 |
| N | (1023 | 1085 | 1118 | 3226) | |

*Older persons who live alone and need help*

| | | | | | |
|---|---|---|---|---|---|
| No service | 29 | 24 | 19 | 23 | 36 |
| Only Home Help | 16 | 12 | 14 | 14 | 22 |
| Only Transportation service | 18 | 25 | 24 | 23 | 35 |
| Both | 38 | 39 | 42 | 40 | 62 |
| Sum | 100 | 100 | 100 | 100 | 100 |
| N | (97 | 136 | 159 | 392) | |

*Neither Home Help or transportation services, but may use other service(s).

**Table 20. Substitution and complementarity in public services for older people in Spain, by coverage rate of region, 2006. Per cent PROVISIONAL DATA**

*Coverage rate**

| | LOW | MEDIUM | HIGH | ALL |
|---|---|---|---|---|
| Residential care | 1 | 2 | 5 | 4 |
| Home Help** | 3 | 4 | 8 | 4 |
| Tele-alarm, meals-on-wheels and/or laundry service | 2 | 4 | 8 | 5 |
| Other services*** | 2 | 4 | 8 | 4 |
| Any of these services | 8 | 11 | 19 | 12 |
| Overlap**** | 15 | 31 | 39 | 35 |

*Coverage rate total of any service: residential, Home Help and/or "other services".
LOW: Cantabria, C. Valenciana, Murcia, Canarias, Galicia.
MEDIUM: Castilla-León, Asturias, La Rioja, Cataluna, Andalucia, Baleares.
HIGH: Madrid, Castilla-La Mancha, Extremadura, P. Vasco, Navarra, Aragón.
** Servicios a Domicilio, corresponds to Swedish Home Help
*** Help for mobility and Technical adaptations
****Calculated as the percentage of users of "other services" that *also* use Home Help

As already indicated, these analyses have only touched on quantities of services, not on their quality, although some observers might feel that a large quantity (high coverage rates) is indeed a quality in itself. We may superficially assess how well these more or less overlapping services target persons in need. As shown for a national average of older Swedes in Table 21, older persons with no kind of public help tend to be in very good health ADL-wise, and the more services they use (receive), the poorer their health. Closer scrutiny of the data also reveals that persons who use Home Help get more hours of help, the lower their ADL (analyses not shown). Yet, about a fifth of the users found the Home Help insufficient.

**Table 21. Older persons (75+) by support and ADL-index. Sweden 2000. Per cent**

| *Type of public support for older persons living in the community* | *ADL-inex, average** |
|---|---|
| No support | 8.3 |
| Only transportation service | 7.5 |
| Only alarm system | 7.5 |
| Transportation service and alarm system | 7.2 |
| Home Help only | 6.9 |
| Home Help and transportation service | 5.8 |
| Home Help, transportation service and alarm system | 5.5 |
| Home Help, transportation service, alarm system and meals-on-wheels | 3.8 |

* Here defined as number of activities of daily life (ADL) that a person can do without help, of the following: shopping, cooking, cleaning, laundry, (un)dress, get into/out of bed, shower/bath, toileting, go outdoors without personal help. The index can thus vary from 0 to 9. It may be mentioned that 51 % managed all nine activities without problems

**Discussion**

We are at risk of painting an overly rosy picture of Swedish social services, if we are satisfied with the above empirical data. Public services need to be critically assessed, as to their quality and meaning to the users and their families. The fact is that Swedish old-age care has been haunted by scandals all along in the post-war era. Many people, young and old, are quite critical of these services, although persons who have their parents in institutional care are less negative than others, and most old people who use them find little to complain of. It is possible that some of the critique should be seen as a sign of the health of the system. If it keeps a critical vein alive that is a good thing; in a less generous system users may have to keep silent and show gratitude, although they did not always do that even in the poor relief era, as we have seen. Still, it remains that there are few exit options in Swedish old-age care, beyond the family. In this context it should be noted that public services in Sweden are used to the same extent by citizens of all social classes, when in need. Less use by the upper classes is mainly due to their better health.

After stagnating public finances and continuous cutbacks of the two major services in the 1990s and after (Home Help and institutional care), there was a growth of family care. This is to be expected also for the reason that more old people today have close family, and more adults have ageing parents. But their increased support for ageing family members is likely also a response to the shortage of public services. As mentioned, more old people are married and more also have children and/or other relatives than before. In the early 1900s nearly a quarter of the elderly had never been married and childlessness was high. Even with

unchanged propensity of caregiving this would entail more family help, everything else being equal, although we know little about the implications of increased caregiving for the carers.

There has been a diversification of services through the expansion of *other* services for older people. The growth in transportation services, alarm systems etc. has in a way offset cutbacks in Home help and institutional care. This can be interpreted as a means to save resources and raise efficiency, but can also - when used in the right way for the right clients - be more adequate than the rigid choice between nothing, Home Help or institutional care. We may indeed already see early evidence of the future scenario sketched in micro simulations of the prospects for older people in Sweden. Rising numbers of older people in need of care, some but not all of them well-off, may require re-allocation of public expenditures, raised taxes and/or fees-for-services, alone or in combination with less public services and more family care (Klevmarken & Lindgren 2008).

We have in this vein observed that regions with lower coverage rates of their services, in Spain and in Sweden, use their diversified services differently and more sparingly, attempting to cover more older people with what they have. They target more older persons by spreading their graces in a more discriminating way. Regions with higher coverage rates tend to allocate more of their more abundant services on the same clients. Spain at present expands all services very ambitiously, although finances and political cleavages remain a problem.

Spreading the jam thinner also holds for overlap between family care and public services. Areas with higher coverage rates of public services have more older people who benefit from both. In the less covered regions, older people have to choose between family *or* state.

Both in Spain and in Sweden authorities attempt to ration services, by eligibility criteria, restrictive needs assessments and/or raised fees (Sundström & Tortosa 1999). This has lead to a postponement of the use of institutional care. Instead, older people use Home Help, and groups who previously used Home Help now make do with less costly 'other' services. Paradoxically, faster turnover of clients in Home Help and institutional care has at the same time meant that more people than ever will eventually use these services.

Some local authorities in Sweden are experimenting with voucher systems that allow users – still needs-assessed by the municipality – to choose between different providers, which will all be paid for by the tax-payers (the municipality and various private firms, cooperatives etc.). Similar arrangements are now (2009) mandated for all municipalities. It also seems that raised fees for services have kept some people from using them altogether, finding better value for money in the private market. This may often be so-called ‘black work’, untaxed work that provides no protection for either user of provider, no social security benefits etc. Contrasting with practices on the continent, the Nordic tradition has been to primarily support clients in kind. Hence many old people receive services, but very few family carers are remunerated in cash. In other words, support to carers is indirect, through giving some relief from what had else to be done by the family, or not be done at all. As mentioned, public services tend to provide personal care, leaving household chores to the family or others.

Elderly persons without a partner increasingly rely on their offspring, mostly daughters (Sundström, Johansson & Hassing 2003). The ancient fear that state support would lead to impoverished relations within the family seems groundless. Although family ties may appear weak at times, these ties have proved more viable than government programs.

An important feature of Nordic societies is the far-reaching overlap of what is done informally, mostly in the family, and what is done by public bodies. Public support is mostly seen in positive terms, although there is a constant risk of more or less benign paternalism. Opinion polls continue to show that the large majority wants the state to shoulder the responsibility in one's own old age and for one's frail parents, and indeed not just in Sweden and the other Nordic countries (Daatland & Lowenstein 2005). The administration of poor-relief in the parishes created a mentality and routines for the management of care for older people, and other frail, sick and/or destitute persons. This generated local identity and social cohesion. Later affluence made for a vast and important difference: today's social services provide for everybody (in principle), not just for the poor.

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**Appendix**

Sources of Table 6:

Denmark, Norway and Sweden: our own computations on national social service statistics
Finland: communication from professor Marja Vaarama, University of Lapland, Rovaniemi
Iceland: TemaNord 2005

Flanders: Benedicte de Koker, University of Antwerpen
Britain: personal communication from Care Equation, Britain
France: Home Help - DREES 2000 own computations; institutional care – Rostgaard & Fridberg 1998
Germany: OECD 2005
Luxembourg: Home Help - OECD 2005; institutional care - EUROFAMCARE
The Netherlands: Social and Cultural Planning Office 2001
Austria: OECD 2005
Greece: EUROFAMCARE
Ireland: OECD 2005
Italy: EUROFAMCARE
Portugal: C. Goncalvez INE
Spain: M. Sancho Castiello, IMSERSO
Bulgaria and Czechia: EUROFAMCARE
Estonia: Dr. Kai Saks, Tarttu University, pers. comm.
Hungary: OECD 2005
Poland and Slovenia: EUROFAMCARE
Switzerland: OECD 2005
Israel: after Lowenstein 2006 and personal communication