ELDERCARE IN SWEDEN: AN OVERVIEW

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RESUMEN: Este artículo ofrece una visión general de las políticas y prácticas relacionadas con la ayuda y el apoyo a las personas mayores dependientes en Suecia. El modelo sueco de cuidado de personas mayores dependientes se sitúa dentro del régimen Nórdico de cuidado universal y se describen las características clave de este régimen de Estado de bienestar. El artículo presenta los antecedentes históricos y describe cómo los servicios de ayuda a domicilio se convirtieron en un servicio universal. Asimismo, describe las políticas actuales y las características de la organización y la prestación de servicios de cuidado de personas mayores dependientes. Se identifican tres tendencias, la disminución de los servicios, la re-familiarización y la privatización (a través de la deducción fiscal para los servicios domésticos), y se analizan en términos de los retos que plantean para el universalismo. El artículo también examina los dilemas y las consecuencias relacionados con la mercantilización de los servicios de cuidado de personas mayores dependientes dentro del actual "modelo de elección del cliente" en Suecia. Finalmente, el artículo describe las

condiciones del trabajo de cuidados, particularmente en los servicios de atención domiciliaria, y destaca que una revaluación del trabajo de cuidados sigue siendo una cuestión pendiente en el Estado de bienestar sueco, supuestamente "favorable a las mujeres".

ABSTRACT: This article provides an overview of the policies and practices related to help and support for older dependent people in Sweden. The Swedish model of eldercare is situated within the Nordic universal care regime and the key features of this welfare regime are outlined. The article provides a historical background and describes the development of universal care services as well as current policies and the characteristics of the organization and provision of eldercare services. Three trends, retrenchment, re-familiarization and privatization of care (through the tax deduction for household services) are described and analysed in terms of the challenges they pose for universalism. The article also examines more specifically the dilemmas and consequences related to the marketization of eldercare services within the current so called "customer choice model" in Sweden. Finally, the article describes the conditions of care work for older people, particularly in home care services, and highlights that a revaluation of care work is still a pending issue in the supposedly "women friendly" welfare state of Sweden.

PALABRAS CLAVE: Personas mayores, dependencia, Suecia, modelo Nórdico de cuidado universal, mercantilización.

KEYWORDS: Older people, long-term care, Sweden, Nordic universal care regime, marketization.

1. INTRODUCTION

This article provides an overview of the policies and practices related to help and support for older dependent people in Sweden. To start with, it should be noted that in the Swedish language, the concept 'dependency' is not used, neither is the internationally well-established notion 'long-term care'. Instead, the policies in this field are defined as 'eldercare' (äldreomsorg). In Sweden, there are different policies directed to older people on the one hand, and people with disabilities on the other hand. These are considered two separate fields of social care, rather than health care (Meagher and Szebehely, 2013). Key aspects are certainly common for older dependent people and people with disabilities, such as the principle of universalism. At the same time, there are important dissimilarities given that these groups are dealt with in different legislations. The help and support provided to people with disability under 65 years of age is also framed very differently than the help and support for older people, that is, over 65 years. Hence, while the policies related to the framework of the *Disability Act* is mentioned in the article as a contrast, this overview focuses on the Swedish eldercare system, regulated through the *Social Services Act*. The article pays special attention to the role home care services have played in the development of universal services in Sweden, and the changes that these services have gone through since the emergence in the 1950s. The changing conditions of care work in context of New Public Management, retrenchment and marketization are also outlined.

First, the article situates the Swedish eldercare system within the Nordic universal care regime, explaining the key features of this care regime. Then, the historical background of the Swedish eldercare system is outlined, with particular focus on the development of home care as a universal service for all older people. After that, current policies and the contemporary organization of eldercare are delineated, as well as the implications of the decline in Swedish eldercare services. Marketization is a trend that has substantially shaped Swedish eldercare in the last decades. The article accounts for the policies and practices related to the marketization of care services and discusses some of the challenges involved in this process. Finally, the changing conditions of care work are considered with reference to the prospects for quality care.

2. THE NORDIC UNIVERSAL CARE REGIME

The Nordic universal care regime has been characterized by the extensive publicly financed care provision directed to all citizens (Anttonen and Sipilä, 1996; Sipilä, 1997). In Sweden as in the other Nordic countries, care for older people is underpinned by the normative ideal of public responsibility for care (Meagher and Szebehely, 2013). In contrast to many other European countries, grown-up children bear no legal responsibility for older parents (Szebehely and Trydegård, 2011). In the Nordic universal care regime eldercare is not only publicly financed, but also largely publicly provided, and high-quality services are available to all citizens according to need rather than ability to pay (Trydegård, 2012). This means that access to services is not means-tested, although there are a user fees. An important aspect of universalism is that services are affordable for the poor and attractive enough to be preferred by the middle class. Thereby the same services are directed towards and used by all social groups. A central aspect of the Swedish universal care regime is also that municipalities are highly independent, they collect taxes and organize the services. Universalism does not mean uniformity or sameness. In order to be attractive, services must be individualized, that is, adopted to individual situations, needs and preferences.

Universal policies generally aim to reduce gender and class inequalities. Universalism means that all citizens are entitled to the same rights irrespective of their class or labour market situation. By providing a wide range of public social services the Nordic welfare state has been regarded as the most 'de-familializing' (Esping-Andersen, 1999). Universal rights and universal care services have been considered the guarantee of women's right to paid work and to combine employment and care (Anttonen, 2002). Social policy and social care services have therefore been represented as the key to the gender equal social model (Kantola and Dahl, 2005). In a comparative perspective, the Nordic care regime can hence be defined as 'women-friendly' (Hernes, 1987).

Nevertheless, the distribution of resources and responsibility in eldercare - between the state, the family and the market - has changed in Sweden during the last decades. For example, the coverage has decreased, informal family care has increased and care is increasingly provided by private care companies. Scholars have argued that this development is threatening universalism (Brodin, 2005; Szebehely and Trydegård, 2011; Ulmanen, 2012; Vabø and Szebehely, 2012; Meagher and Szebehely, 2013). At the same time, it is important to bear in mind that universalism is a contested concept and it can be seen as an ideal type beyond reach -and as a matter of degree rather than a dichotomy (Anttonen et al., 2012). In this vein, it is possible to discern a trend of 'de-universalization' in the Swedish universal care regime. This trend will be dealt with later on in the article.

3. THE DEVELOPMENT OF ELDERCARE SERVICES: A HISTORICAL BACKDROP

In Sweden, the political discourse of the time after the second World War involved the argument that only public funding and public provision can guarantee equally good services to all social groups according to need and not purchasing power. Formal eligibility was not considered to be not enough, it was stressed that services have to be accessible, affordable and attractive - to gain and keep the support of the middle class. It was emphasized that if the same services are used by all social groups the quality will improve for all.

The development of municipal home care services in the beginning of the 1950s was an important step in the building of the Swedish welfare state. Home care services made it possible for frail older persons to stay at home without being dependent on their children. The initiative of home help for older people came from the voluntary sector: in Sweden the Red Cross started a pioneer project in 1950. A key shift came with the recognition of the 'principle of homecare' in public policy in 1957. Home care services represented individualized alternatives to the more standardized forms of care available in old-age homes and nursing homes. Home care was the first form of eldercare to be offered not only to the poor, but to all social groups. The services were affordable for the poor and attractive enough to be preferred by the middle class and in this sense home care became a universal welfare service. With the expansion of public care provision, the care for older people was no longer constructed as poor relief, but a citizen right. The association of residential care with its legacy of stigmatized poor relief also made home help a welcomed alternative and these services became widely used (Brodin, 2005; Szebehely and Trydegård, 2011).

The 'golden years' of the Swedish welfare state, the 1960s and 1970s, involved a great expansion of social care services and particularly home care services (Anttonen, 2002; Trydegård, 2012). Sweden had achieved a well-developed system of tax-funded eldercare services in 1980s (Meagher and Szebehely, 2013). Public elder care was not articulated as part of gender equality policies in the same way as childcare (Ulmanen, 2013). However, from a historical perspective, the build-up of public eldercare contributed to women's raising labour market participation. The employment rates among middle-aged women increased in Sweden parallel to the expansion of home help: between 1960 and 1996 the employment rate rose from 33 per cent to 80 per cent (Szebehely, 2003). In this perspective, the expansion of home care services clearly shaped middle-aged women's freedom of choice - to care or not to care.

The needs of older people and people with disabilities were recognized in the *Social Services Act* of 1982, still in force today. The act establishes the legal obligation of municipali-

ties to provide services for all residents according to need. The possibility of older people to stay in their ordinary living environment is a fundamental goal of the Social Services Act. Hence, the principle of homecare has been reinforced as opposed to residential care (Brodin, 2005). Later on, in 1993, the specific needs of people with severe disabilities were recognized in the *Act Concerning Support and Service for Persons with Certain Functional Impairments* (LSS). In contrast to the Social Services Act, the Disability Act focuses on promoting independent living and active participation in society.

The Community Care reform from 1992 (Ädelreform*en*) shifted the responsibility for nursing homes from the health care sector, administered and funded at the county council regional level, to the social care sector, administered and funded at the municipal level. The stated aim was to increase quality of life for older people by 'demedicalizing' care (Brodin, 2005). Nonetheless, the reform was implemented just as Sweden entered in deep recession and the focus shifted to its cost-saving potential. The effects of the retrenchment of the Swedish welfare will be discussed under the title 'decline in eldercare services'.

4. CURRENT POLICIES AND ORGANIZATION OF ELDERCARE

Eldercare services are governed at three levels in Sweden: national, regional and local. The national government governs through legislation, policy plans, state subsidies and supervision through the Health and Social Care Inspectorate (IVO). Responsibility for most health and medical care services lies at the regional level. The overall responsibility for publicly financed eldercare services lies with local public authorities of the 290 municipalities. Municipalities are, hence, responsible for both home care services and nursing homes. As such, the above mentioned Community Care reform was an important turning point since nursing homes shifted from being a responsibility of the county councils to being a responsibility of the municipalities. The local authorities decide on tax rates and budgets, and they establish local objectives and guidelines. Following form this, there are great local variations (Szebehely and Jönsson, 2018).

All forms of eldercare, mainly home care and nursing homes, are covered by the same piece of legislation, the Social Services Act. This law ensures a general right to assistance if the needs cannot be met in any other way. According to this law, the services should be provided in a way that ensures a 'reasonable standard of living'. The legislation does not specify 'needs' but there is a right to appeal to court if the individual is not satisfied with a decision. Eldercare services are granted following needs assessment which is carried out

by the local authorities. The needs assessor officer evaluates the needs and decides if a person is entitled to assistance, and if so, the type and amount of help (i.e. the hours of care in the case of home care). While services are universal they should also be individualized, adopted the individual needs and preferences of the person receiving care. However, the Social Services Act leaves the municipalities to interpret and define who is entitled to services and what their entitlements are. In other words, the right to be cared for is a matter of other's interpretations of the needs, not the older person's own subjective experience (Brodin, 2005; Ulmanen, 2013).

In contrast to the Social Security Act, the Disability Act confers specific and absolute rights to persons with certain extensive functional impairments. Local authorities are obligated to provide help and support to ensure 'good living conditions' - a more ambitious goal than set out for eldercare. Disabled people who qualify for the services under the Disability Act, and who need extensive help with basic needs, may be entitled to personal assistance which is co-funded by the state (Meagher and Szebehely, 2013).

The norm of universalism implies that services are not means-tested, but the older people receiving care services pay user-fees. Users pay the same fee to the municipality, disregarding whether they use publicly and privately run nursing homes or home care services. The fee is related to income (but not assets) and the amount of help provided, and in nursing homes users pay separately for food and housing. There is a maximum fee for care services, approximately €200/month. This is the same for home care and residential care. Low income pensioners are exempted from fees for home care and residential care (Erlandsson et al., 2013). Approximately 85 per cent of eldercare funding comes from municipal taxes, while another 10 per cent comes from national taxes. Hence, users pay only a small fraction of the cost, about 5-6 per cent (Szebehely and Trydegård, 2011).

The main eldercare services are home care and residential care. Home care services include household tasks, personal care, social support and help with medication and rehabilitation. On average, a home care user receives around seven hours of help per week (Szebehely and Trydegård, 2011), but the intensity varies greatly, going from once a month to several times a day and night. Home care is generally appreciated and used by all social groups, but in recent years there has been dissatisfaction with fragmented services for those with largest needs who require help many times a day. This groups of people would previously have been living in nursing homes, but the coverage of residential care has declined sharply in recent decades. Older people who are granted residential care today have greater care needs than before. It has been estimated that an older person in residential care receives on average 100hours of help per month (Ulmanen and Szebehely, 2015). Stays in nursing homes have become shorter and the median is 13 month. The Social Services Act stipulates that home care and residential care staff must have 'adequate skills' and

that the quality has to be good and 'monitored on a regular basis', but there are not specific prescription of staffing ratios (Erlandssson et al., 2013).

5. THE DECLINE IN ELDERCARE SERVICES

In the last decades there has been a marked decline in the coverage of eldercare services in Sweden. In 1980, 16 per cent of people 65 and over received needs assessed home care, compared to 9 per cent in 2012 (Meagher and Szebehely, 2013). During the same period, the coverage of home care services declined among people 80 years and over from 34 per cent to 23 per cent. Moreover, since the year 2000 every fourth residential care bed has disappeared and home care services have not compensated for the decline (Ulmanen and Szebehely, 2015). As the below table shows, the decline of eldercare is far-reaching.

Table 1. *% of population 80+ receiving care services*

	1960	**1960**	**1960**	**1960**	**1960**	**1960**
Home care	10	25	34	26	18	23
Residential care	20	28	28	22	20	14

Source: Ulmanen 2015, pp. 21

Eldercare has achieved lower priority at the municipal level since the 1990s when the government decided to change the structure of state grants to the municipalities, merging earmarked grants for specific activities into a single block grant (Meagher and Szebehely, 2013). Within this framework, the municipalities have been free to decide on the distribution of resources between different types of care (e.g. home-based eldercare or residential care) and between different social groups (e.g. older people, children, and people with disability). The result has been diminishing resources for eldercare. This development can be understood in the light of a stronger legislation in education and disability than in eldercare. A report from 2010 of the National Board of Health and Welfare concluded

that older people's need for care has been sacrificed while other groups' needs have been prioritized (NBHW, 2010). Notably, the decline is not linked to any legislative changes or shift in political intentions of national policy makers. But 'need' is an elastic concept and despite unchanged national universalistic principles there has been a tightened eligibility criteria in most municipalities. As such, in eldercare, the right care has becoming weaker.

Public eldercare is increasingly targeted at those who are most frail, with larger care needs (Rostgaard and Szebehely, 2012). The policy of 'deinstitutionalization' has contributed to the changing needs profile of home care clients; today a smaller proportion of older people receive more intensive care. Many older people who would have had a place in a nursing home before now live at home and get help many times a day and at night. As a result, an increasing proportion of home care workers' time is taken up with personal care rather than domestic tasks and social care (Meagher and Szebehely, 2013). One important change in the health care field, governed at the regional level, which has clearly affected the home care services, is the radical cut in the number of hospital beds since the early 1990s. This was an effect of the before mentioned Community Care reform. This reform resulted in that older people were more likely to be leaving hospitals with remaining care needs, which increased the demand for municipal eldercare services. This influenced the targeting of those with greatest needs (Szebehely and Trydegård, 2011).

Studies reveal that the declining coverage in eldercare services has had consequences in terms of re-familialisation. In contrast to many other European countries Swedish law does not attribute legal responsibility to the family to provide for older people's care needs or to contribute economically paying for services. While grown-up children bear no legal responsibility their contribution to eldercare is still extensive. A study by Ulmanen and Szebehely (2015) shows that family care has increased during the last 15 years among all social groups. However, family care remains more common among older persons with less education, and privately purchased services is more common among those with higher education. The authors argue that the dualisation of care challenges universalism. Additionally, even in Sweden more daughters than sons provide intensive as well as sporadic support, and working class daughters are the most affected by the cutbacks in eldercare and subsequent re-familialisation. At the same time, it is important to highlight that informal help and support provided by the family tends to be less intensive and more equally distributed in the family than in other European care regimes (Rodrigues et al., 2012). Even though coverage has diminished to the level of mid 1960s, eldercare is still generous in an international comparative perspective (Meagher and Szebehely, 2013). On the other hand, it should be underlined that the cutbacks in Swedish eldercare services have taken place in spite of the strong preference for public eldercare services over family care (Ulmanen, 2015).

6. MARKETIZATION: A TREND IN SWEDISH ELDERCARE

In Sweden as well as in other welfare states, the provision of eldercare services has been greatly influenced by the global wave of New Public Management (NPM) since the 1980s (Blomberg, 2004). This reform movement has favoured practices of the private business sector as a solution to a wide range of perceived problems of public sector service provision. NPM replaces the 'old' public administration model by models from the private sector. To increase efficiency and productivity, market inspired logics are introduced. Public organizations become 'business-like'. On example of the influence of NMP in Swedish eldercare is the shift from public to private providers (funding is still public). In contrast to the retrenchment, marketization was an intended political change. Legislative changes have opened up for private provision in both the home care sector and in residential care (Szebehely and Trydegård, 2011).

Out-sourcing through public procurement

The *Local Government Act* of 1991 made it possible for municipalities to out-source the provision eldercare services to non-governmental actors, both for-profit and non-profit. Further, the *Public Procurement Act* (LOU), introduced in 1992 and emended in 2007, regulates the process of outsourcing through competitive tendering. Over the two last decades there has been a marked increase in privately provided eldercare in the main two services; home care and residential care. For instance, statistics show that today 24 per cent of all provided home care hours are privately provided, while 3 per cent were privately provided in 1993 (Erlandsson et al., 2013). In contrast to private for-profit providers, the growth in care provision by non-profit organizations has been very modest (Meagher and Szebehely, 2010). Outsourcing of eldercare services according to LOU has tended to favour larger companies (Meagher and Szebehely, 2013).

The customer choice model

Customer choice is today one of the most widely used political tools for spreading market practices in Swedish eldercare. It allows older people who have been granted the right to social services through needs-assessment to choose their provider of care services from a list of approved providers. All the providers that fulfil the requirements set out in the market entry requirements shall be approved. At the same time, the care providers are not guaranteed clients. Authorized private care providers compete with other public and pri-

vate eldercare units to provide care to individual 'consumers'. The legislation introducing customer choice in Swedish eldercare, the *Act on System of Choice* of 2009 (LOV), was founded on strong hopes that older people's right to choose service provider - and change if not satisfied - would strengthen the users' voice and increase the quality of eldercare. The law also promoted a diversification of services adapted to the individual needs of all older people, for example different profiles such as languages directed to different groups of immigrant people, focus on people with dementia, etc. (Brodin and Peterson, 2018; Erlandsson et al. 2013).

The Act on System of Choice is also an attempt to break the oligopoly of the Swedish homecare market; a few large corporations dominate the private homecare sector, which makes it difficult for small private providers to enter the market (Meagher and Szebehely, 2013). With this new system small providers would then be able to take up the competition with large providers, for example by creating distinctive profiles of the services to attract specific group of clients. Customer choice has been represented as a way to increase gender equality as it was anticipated that more women would be encouraged to become 'care entrepreneurs' as the legislation would make it easier for small providers to obtain a foothold on the eldercare market (SOU, 2008). Many small companies have indeed entered the market. For example, in Stockholm 25 per cent of the providers had less than 15 clients in 2013. At the same time, studies indicate that small companies owned by women have problems surviving at the home care market (Brodin and Peterson, 2018)

The emergence of choice models has been an ideological decision rather than demanded by older people or their representative organizations (Szebehely and Trydegård, 2011). Consistent with the principle of local self-government, the LOV does not force the local authorities to implement customer choice in publicly funded eldercare. However, they have been encouraged to introduce customer choice through financial initiatives.

When it comes to marketization, there are great variations across the country. Customer choice is in use or will be implemented in approximately 61 % of Swedish municipalities (SALAR, 2016). The free choice system is used mainly in home care; only a few local authorities have introduced customer choice in residential care. While there are still many municipalities that do not have any private providers, Stockholm has been a forerunner in marketization and customer choice. For example, 72 per cent of all homecare hours in the city are provided by private provider (Socialstyrelsen, 2017).

Tax deduction for household services

A law relevant in the context of marketization is the *Act on Tax Deduction on Household Services* of 2007, often referred to as RUT in Swedish. The tax deduction was intensively

debated by social and political actors during many years before it was adopted by the centre-right government (Peterson, 2007). According to this reform, taxpayers under the age of 65 are entitled to deduct 50 per cent of the price of domestic services up to 25 000 SEK (approximately 2 500 EUR) per person per year, and tax payers over the age of 65 are entitled to deduct 50 per cent of the price of domestic services up to 50 000 SEK (approximately 5 000 EUR) per person per year. In both cases, the provider has to have a business tax certificate. The services can be provided in the purchaser's home or in a parents home and can include both household tasks and personal care. Access to the services covered by this legislation is not subject to needs assessment and hence all citizens can claim the tax deduction. However, the tax deduction intersects with needs assessed home care services as private home care providers can offer 'extra services'. In other words, private home care providers may offer users both needs assessed care and privately purchase but subsidized household services. Hence, users can buy supplementary services at the market to 'top up' the subsidised eldercare services they receive (Meagher and Szebehely, 2013; Erlandsson et al., 2013; Brodin and Anderson, 2017).

7. DILEMMAS AND CONSEQUENCES OF MARKETIZATION

With the marketization of eldercare services, older dependent people have become constructed not as 'citizens' but as 'consumers'. The policies have become more focused on individual freedom and individual choice, and hence older people are represented as rational consumers who can chose the best care services on the market. In this vein, eldercare also tends to be framed as a commodity rather than a public good. In a system where older people can 'top-up' the needs-assessed eldercare through subsidized household services bought at the market, older people with more economic resources are benefited. In contrast, older people with less resources will not be able to supplement the publicly financed eldercare. The choice model together with the tax deduction risk creating dual care systems, when older people with more economic resources get 'good care' by complementing with private services and other people only get the more restrictive and time-limited needs-assessed care. A study by Szebehely and Trydegård (2011) point out that a consequence of declining tax-funded home care services is that older persons with lower education increasingly receive family care, while those with higher education are more likely to buy private services. Further, the combination of income-related user fees, customer choice models and the tax deduction for household services has created

an incentive for high-income older persons to turn to the market instead of using public home care services. In this context, the Swedish home care, as a universal welfare service, is under threat. If public home care becomes dominated by groups with less education and lower incomes this can also jeopardise the quality of care in the future. Swedish home care services are still universal in an international comparative perspective, but in view of the changes in the most recent decades a de-universalization has taken place.

The implementation of customer choice model in Stockholm has led to new problems in terms of monitoring and control. Since this tool for marketization does not delimit the number of private home care providers in the system, there is over 130 home care companies to choose between in Stockholm (Brodin and Peterson, 2018). In this context, a deliberate choice is very difficult, not the least considering the situation of the older person who is in the situation of needing care. The older person is generally in a vulnerable position and often need care after an acute situation and hospitalization. The choice, however, can also be complicated for family members considering the number of providers and the often similar ways of marketing the care services. Continuity (the same personnel coming) is a central aspect of quality, and therefore very few actually chose to change providers (Erlandsson, et al., 2013). Although many people appreciate the possibility to choose providers, many would prefer to be able to influence the content of help (e.g. time, tasks etc.).

When services are outsourced, the municipalities must still monitor and control the care services and the management of the providers. The responsibility for the quality of care ultimately lies with the public authorities. With generous funding and a tradition of trust there has been very little regulation and control. Recent government policies have strengthened regulation and control and the scope of profit-making is being revised in a government commission. However, there is a dilemma here related to the tension between the control of the providers and the autonomy of care work. Extensive Nordic and international care research shows that care workers' decision latitude in order to meet the users' varying needs is crucial for quality care (Meagher and Szebehely, 2013). Stricter regulation may therefore be a threat to the quality of care. Experience from Anglo-Saxon countries points at several unintended consequences of stricter regulation (Braithwaite et al., 2007). One is that regulation becomes ritualised and therefore less effective: politicians respond to scandals by creating more and more rules so that they appear tough to the electorate; and managers and administrators learn how to get good results by managing the paperwork rather than the care process. Also Nordic studies stress the risk that stricter regulation focus on what is easy and possible to measure. Then, social aspects of care which are difficult to measure, like care relationships, are ignored and undervalued (Meagher and Szebehely, 2013). Additionally, while increased control and regulation has

become necessary this is both costly and time-consuming. Increased documentation and compliance demands can lead to more time spent on other tasks than care.

8. CHANGING CONDITIONS OF CARE WORK

As mentioned in the beginning, the Nordic universal care regime has often been defined as 'women-friendly'. Extensive care provision for children and older people has been central to the Nordic model, and universal care services have been considered the guarantee of women's right to take on paid work and to combine employment and care (Anttonen, 2002). However, this women-friendliness is challenged when it comes to women working in the public care sector. Studies demonstrate that when care goes public women still predominate in care work - now paid care work- and that eldercare is low paid and undervalued work (Trydegård, 2012; Stranz, 2013).

The nature of care work has changed since the introduction of home care as a universal service, moving towards a professionalization of care. In the 1950s the housewife served as a role model for homecare workers (Szebehely 1995; Szebehely, 2003; Trydegård 2005). Workers were not expected to have any formal training in care, but to have a 'housewife's commonsense' and a will to help other people. The payment was based on the logic that home helpers were housewives complementing their husbands' salaries with 'pin money'. Hence, the work as home helper caring for older people was not considered a real profession. In the 1980s the issues of training and professionalization of care work emerged on the political agenda of public eldercare. Since then, there have been some efforts to professionalize home helpers through formal training programs. This became a means to improve the status of the workers and, in turn, increase the possibilities to recruit workers in this sector. The issue of educational training is still on the political agenda, as a strategy to higher the status and make the work more attractive, but also as a means to adapt the care workers' skills to attending very and sick frail older people with great care needs.

At the same time, the organization of care work has changed during the last decades. Under the influence of New Public Management, the day-to-day care work has shifted from a more person-centred organizational model, under which each care worker was responsible for a small number of clients, toward a Taylorized 'assembly-line' model, under which a number of care workers jointly provide specific tasks to a larger number of clients. In this context, the work has become more focused on the specific tasks to be performed

within specific timeframes and the everyday care work is steered in advance by detailed schedules. The work tasks are laid down in contracts with tight timeframes and instructions as to how meet the quality criteria. As such, care work has become increasingly standardized, with rules laid down in manuals and regulated at an organizational level at a distance from both the care worker and the care recipient. These organizational changes have made more difficult the adaptation of the work to specific situations and needs that emerge. The influence of the care recipient and the care worker on what tasks should be done and how the help should be provided is being delimited. This rationalization of care has resulted in that a larger proportion of working time is required for tasks other than helping, such as planning and coordinating the work (Szebehely, 1995; Meagher and Szebehely, 2013).

Swedish studies have revealed various challenges when it comes to care work in the current eldercare system (Stranz, 2013; Szebehely, Stranz and Strandell, 2017). Key shifts have been pointed out as problematic for both care workers and care recipients, such as are the following:

More challenging mental and physical working conditions. The older people receiving help in their homes today have much greater care needs than before.

Detailed regulation, monitoring and minute-steered care undermine the professionalization of the care workers

Discrepancy between the needs of the care recipients and the help the caregivers are able to offer, given the strict time frames.

Likewise, Nordic research on care workers' experiences shows that when care work is split into small, time-limited units, this makes it very hard for care workers to adjust the care to the older persons' different and shifting needs. Additionally, care workers experience time pressures and constraints, an increased work-load and reduced opportunities to use their skills and knowledge (Trydegård, 2012). The current organization of the care work undermines workers' autonomy and possibility to give care according to their professional values.

Nordic research on everyday care has explored the preconditions for 'good care'. Three elements have been showed to be crucial for good quality care adapted to the older person's changing needs: 1) sufficient time; 2) continuity in the care relationship (limited number of recipients/worker) and; 3) discretion for care worker and care receivers, meaning power over one's own work or situation (Szebehely, 1995). Nordic research also stress the relationship between good working conditions for care worker and good care. As expressed by Trydegård (2012: 120): *The quality of care is closely related to the quality of work; care workers cannot provide good quality care unless they have reasonable working conditions*.

9. IN CONCLUSION

Care research carried out in the Swedish context has highlighted that social services for older people are important for society as a whole, not only for those using care services here and now, because care policies deal with risks related to both needing and giving care. In this perspective, Szebehely's (1995) research within the field of social work defines care services as a 'social infrastructure'. As Szebehely argues, three parties are involved in care for older people: a) the persons in need of care; b) their families and; c) paid care workers (in the formal or informal economy). These three groups, of whom the majority are women, live the consequences of changing public policies. In this vein, policies should be evaluated from an equality perspective regarding all three groups. In Sweden, the general decline of eldercare services, the marketization and the shifting organization of care work affect older people who need care, their families and paid care workers. The changes in the Swedish welfare state has implied a de-universalization, related to retrenchment, re-familiarization and privatization of care (through the tax deduction for household services). At the same time, Swedish eldercare continues to be generous and universal in an international comparative perspective. Overall, Swedish researchers continue to underline the importance of universal care services for gender and class equality. Care research on the dilemmas and challenges encountered in the Swedish eldercare system can hopefully inspire studies focusing on the possibilities and obstacles in advancing towards universal care services for older people in different contexts. Swedish care research also point at the importance of analysing the prospect of good care from the perspectives of older people, their families and care workers. Definitively, policy-makers need to start taking the issue of quality care and its links with good working conditions seriously.

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