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A Nordic Model of Elder Care and Neo-liberalism

ハンナ・マレーネ・デール教授

はじめに

菅沼　　隆（立教大学経済学部教授）

本論文は，2014年６月５日，政策プロジェクト研究の研究会にて，デンマーク・ロスキレ大学社会グローバル学部のハンナ・マレーネ・デール教授の報告をもとに，教授に改めて書下ろしていただいたものである。デール教授は2011年３月に立教大学招聘研究員として本学に来校し，本プロジェクト研究で研究報告をされたほか，公開講演会で講演もなされた。しかし，同年３月11日の東日本大震災に遭遇し，予定していた講演の一部を中止して，帰国された。今回は，大阪大学外国語学部の招聘で来日され，同大学で３つの報告・講演をなされた後に，本学に来られた。東京では４泊５日の短期間の滞在であったが，本研究会を含めて２つの研究報告，１つの公開講演会という過密なスケジュールを精力的にこなされた。

デール教授は，現代のデンマークおよび北欧を代表する女性労働，ケア・介護労働研究者であり，“Europeanization, care and gender : global complexities”, (Palgrave Macmillan, 2011)，“Dilemmas of care in the Nordic welfare state : continuity and change”, (Ashgate, 2005)，などの編著がある。今回の研究会の報告もデンマークのケア・介護モデルに関するものである。普遍主義的で地域主権のもと提供されてきたケア・介護であるが，New Public Management（NPM）など新自由主義的な管理手法が導入され，変容しつつあることを報告された。報告は英語で行われ，ディスカッションの一部に通訳を用いた。学外からの参加者も多く，活発な議論が展開された。本論文は，議論を踏まえて書き直されたもので，深い考察に基づいている。

A Nordic Model of Elder Care and Neo-liberalism—Characteristics, Differences, Divisions and Paradoxes

Hanne Marlene Dahl*

Seen from the outside—and from a comparative perspective—it seems often evident that there is a Nordic Model in elder care. In research on elder care the defining characteristics are seen as universalism and local autonomy (Rausch, 2008). In this article I will outline the contours of a Nordic model in elder care with more than these two characteristics. I argue that there exists a Nordic model with six characteristics: *universalism, local autonomy, services in kind, produced by the state, home based care and state engineered professionalization.* These joint characteristics continue to persist along other differences between the countries in elderly care. And they persist despite increasing differences in the model related to the introduction of neo-liberal ideas. Between the four countries: Norway, Sweden, Finland and Denmark, a division between the East and West seems to be developing in relation to universalism and the extent to which the state produces care itself i.e. the extent of marketization. The introduction of neo-liberal ideas not only produces and increases divisions between countries, but it also creates tensions between the original institutionalized values and the new values embedded in neo-liberalism. Paradoxes within the Nordic model of elder care arise.

This article first outlines the two general characteristics of elder care and then moves on to describe the four more specific ones. In the third section a few differences between countries is described, and in the fourth section, I will describe how neo-liberalism meets the Nordic welfare state and increases divisions within the model. In the fifth section paradoxes are described, and finally I conclude.

The two general Characteristics of the Nordic Model of Elder care

It's with some caution that I construct a model in elder care as all models are constructions and create reality in a certain way. One can construct different kinds of models—and models are always abstractions that could have looked different. Mine is just one of many possibilities and created from a (Danish) feminist perspective posi-

＊ Professor, Ph. D., Department of Society and Globalisation, Roskilde University, Denmark

tioning me in a particular way towards the multiple reality (Law, 2004). The two aspects of universalism and local autonomy are well-known in the comparative welfare research literature, but the others are dimensions that I judge specific to the form of elder care as it has historically developed in the five Nordic countries. All models can be deconstructed, but models are in my view heuristic devices that structure reality 'out there', a reality in flux. Models help us make judgments about similarities and differences that are not existing a priori and independent of our conceptual schemes. Models produce—and reproduce—realities and with it characteristics and differences.

One of the most often quoted characteristics of the Nordic model is its universalism. However, it is also a concept that has been taken as self-evident and rarely defined (Anttonen, 2002). Here universalism is defined by five criteria: entitlement as a social right, application to all relevant citizens, tax financed, benefits almost the same for all citizens and benefits are adequate (Andersen, 2012 : 165). To grant social rights have often been closely associated with attempts to avoid stigmatization. In all of the Nordic countries there is a legislated obligation for local authorities to provide care to those deemed in need (Szebehely and Trydegård, 2012 ; Christensen, 2005 ; Rostgaard et al., 2011 : 8). This implies assessments that have to be guided by general guidelines in order to ensure that benefits are similar for citizens (uniform services) with similar needs.

Another characteristic is local autonomy where municipalities are responsible for the provision of elderly care (Burau and Dahl, 2012; Rausch, 2008; Szebehely and Meagher, 2013). Municipalities are obliged by law to provide elderly care, but how it is done and the level of services is decided by local politicians. One researcher has aptly described this as developing into specific 'welfare municipalities' (Kröger, 1997). I will now move from these relatively well known characteristics of universalism and local autonomy and into the more specific dimensions in elder care in the Nordic model.

Specific Features of the Nordic Model in Elder Care

To the two already mentioned characteristics, I want to add four features of elder care. In the Nordic countries elder care is typically provided as services in kind, originally it was exclusively produced by the state, it is home based care and the state has typically engineered a professionalization of care. These characteristics will now be outlined briefly. They built upon earlier work in an article co-authored with

Bente Rasmussen (Dahl and Rasmussen, 2012), some of the characteristics are inspired by Marta Szebehely (2005), and these four characteristics are all in a sense comparatively constructed in contrast to what is described as the residual elder care regimes in Continental and southern Europe (Ranzi and Pavolini, 2013).

Services are provided in kind, that is through services such as provided by care workers and professional carers in home care or residential institutions. This is in contrast to the continental European regimes, where cash / transfers are more typical (Ranzi and Pavolini, 2013). It's important here to note, that a basic pension system is in place in all of the Nordic countries where a universal pension is available to all citizens regardless of their participation in labor market or their family status. So services are available and based upon needs assessment on top of the universal pension provided.

Care is seen as a collective responsibility and was typically produced by the state. State responsibility meant that care was regulated in contrast to liberal and continental Europe regime where care was seen as an informal responsibility. Researchers from these regimes state that care has consequently not developed as a professional field characterized by standardization (Ungerson, 1997). This is different from the Nordic welfare model where care has been codified and translated into formal systems of communication about needs and tasks. Neo-liberalism introduces a new societal logic and organizational reforms aiming at 'better and cheaper services' (Dahl, 2012), in short New Public Management reforms (NPM). Marketization was one of the means to produce better and more efficient care. Marketization refers to both the involvement of private actors and private practices and logics in the public sector (Anttonen and Meagher, 2013:16). The state (the public sector) is still responsible legally for services and their financing, but the state is now producing care along with firms and Non Profit organisations (NP's). Despite marketization, the majority of services are still provided publicly i. e. by the municipality in question (Szebehely and Meagher, 2013: 248).

In the Nordic countries we see a policy preference for home based care (Dahl, 2000; Christensen, 2005; Rasmussen, 2004; Szebehely, 2005; Wrede and Henriksson, 2005). Historically family based care and residential care were dominant originating from amongst others poor law, but in the 1970's there was a broad criticism of the state and institutions in public debates. Ideological and economic arguments were advanced seeing residential institutions as limiting personal freedom and as too

expensive (Dahl and Rasmussen, 2013). The preference for home based care implies a relatively small percentage of elderly living in residential institutions / nursing homes. Home based care has traditionally ensured a high level of autonomy for the professional carer (Knijn and Verhagen, 2003).

State engineered professionalization of care is a characteristic often neglected in the international literature. Historically the Nordic welfare states have developed in close relationship with welfare occupations (Brante, 2005 ; Bertilsson, 1990) where the state has played an active role in promoting these professions as well as creating and financing educational institutions (Johansson and Evertsson, 1994; Johansson, 1994; Dahl, 2000; 2010; Simonen, 1991). In this sense it becomes difficult to use the international term 'care worker' as it is more adequate to use the concept of a 'Professional carer'—a concept introduced by Celia Davies (Davies, 1995). In the Nordic model caring for elderly is seen as requiring formalized training.

The Nordic model in elder care consists of services in kind rather than cash, state provided care in primarily the homes of the elderly and historically the state has engineered the professionalization of elder care. However, there are also some differences within the model as we shall see.

Differences Between countries

Many differences between the four countries can be stated. Here I will only focus upon two: the role of non-profit organizations and the role of targeting. Historically the Finnish slot machine association has played a strong role in residential institutions for elderly by financing them giving NP's a major role in contrast to for-profit providers (Szebehely and Meagher, 2013 : 253). However, this situation changed drastically in 2001 with EU legislation on procurement. The Finnish government interpreted the EU legislation as demanding a competition between FP's and NP's providers changing fundamentally the conditions for non-profit organizations in elder care. Now actors for residential care in Finland are exclusively for-profit providers (Szebehely and Meagher, 2013 : 249). In Denmark the role of non-profit organizations in residential care has historically and currently remained strong, although larger international companies like Aleris have now entered the market (ibid ; Bertelsen and Rostgaard, 2013).

During the 1990's Sweden has targeted its services to the frailest and poorest elderly (Szebehely , 2005; Meagher and Szebehely , 2013) simultaneously with a

retrenchment. Retrenchment and targeting seems to results of an unintentionally created situation. According to Meagher and Sezebehely (2013: 65-66) the introduction of the Disability act (1993) in Sweden has been crowding out resources for elderly care in the municipalities. Given a certain level of social expenditures in each municipality, increasing costs for people with disabilities have been directly related to declining resources for elderly. Some of the care previously provided by the municipality now has moved back to families, primarily daughters (Szebehely and Trydegård, 2012) and to the market with user payments. The key question becomes whether targeting is compatible with universalism and this depends, ultimately upon the definition of universalism. If Universalism is understood as consisting of the five criteria I introduced in the beginning (social rights, applicable to all relevant citizen, tax financed, almost the same for all citizens and benefits adequate), then I believe universalism is under attack in Sweden. Although elder care is still a social right it is no longer exclusively tax financed as user fees have grown, and they are no longer the same for all citizens as a differentiation has taken place in relation to need, financial and family situation.

Within the so called Nordic model of elder care there are differences relating to the role of the third sector. Whereas the role of NP's in Denmark has remained strong for residential care, this has changed dramatically in Finland where the third sector no longer plays a major role in residential care. Instead international firms have entered this field. Also in relation to universalism there are differences as Sweden is moving away from one of the core principles of the model, not caused by direct change of legislation in elderly care. From these differences within we will know have a look at divisions created by neo-liberalism, especially marketization.

Neo-liberalism and Divisions

Neo-liberalism is a global discourse travelling and being translated in various ways in different welfare regimes (Sahlin-Andersson, 2002; Newman and Tonkens, 2011) and as I have noted previously, both refers to organizational reforms within the state and to changes in the societal logic (Dahl, 2012). Reforms shaped by NPM i.e. a form of governance inspired by the market and leadership in private enterprise containing a focus upon marketization in different ways and new forms of leadership in the state (Hood, 1991). Despite an obituary (Dunleavy et al, 2007) NPM is still alive and a dominant as a form of governance, although now supplemented by new forms

of governance stressing networks and partnerships (Christensen, 2012; Osborne, 2010). NPM has entered its second phase and paradoxes are increasing (Hood and Peters, 2004). Here I will mostly consider one part of NPM, namely marketization, although I also briefly will consider its self-responsibilizing features in the end.

Marketization means a cultural revolution in public services concerning professional and elder identities and the way care is provided (Dahl, 2012). Often this change is envisioned as new logics replacing old ones. However, whether this is the case is a question for research for respond to. Recent Danish research has shown that a NPM inspired logic seem to co-exist with logics prior to the introduction of NPM (Dahl, Eskelinen and Hansen, 2015) i.e. that these logics are translated in a way reducing possibilities for conflict implying a layering of logics in the specific practices of elder care.

Marketization within the Nordic countries differs in relation to its year of introduction and the pace of change (Szebehely and Meagher, 2013: 242). Different paths within the Nordic welfare model of elder care can be identified. Frontrunners of marketization have been Sweden and Finland, where Finland was the first to introduce outsourcing in 1984, whereas Denmark introduced it nearly two decades later in 2003. The timing and rate of change has created a division between East and the West within the model concerning marketization (ibid). Most generally, marketization has mostly affected Finland and Sweden with a large and increasing role of international corporations in elder care. However, whereas marketization for municipalities in Sweden, Finland and Norway is optional, Denmark has been the only country to make marketization of care services obligatory (Szebehely and Meagher, 2013).

What are the reasons for this new division between the countries at the introduction of marketization? Several explanations can be listed. One is the economic situation at the time of the introduction of marketization, where Finland and Sweden were financially hit very hard. Secondly, the discursive context where the leading party in Sweden was unambiguously in favor of marketization, whereas the Danish social democratic party was split. Other reasons are potentially the role of non-profit providers, the different interpretation of EU legislation on procurement in the four countries (Szebehely and Meagher, 2013) as well as resistance to outsourcing (Burau and Dahl, 2013).

There are major divisions between countries but also within each country. Whereas there is a majority of private, for profit providers in Stockholm, 65% of

Swedish municipalities have no private providers. So there are large divisions between the larger cities and rural areas in regard to marketization, where marketization has proliferated mostly in the major cities.

But marketization is not just about importation of market like mechanisms, competitive tendering, choice models and tax rebates such as mentioned by Szebeheley and Meagher (2013). It is also about the prevalence of a 'thin' concept of care (Dahl, 2012). In such an understanding of care more and more elements of care gets offloaded to the market and family (Szebehely and Trydegård, 2012) and an increasing self-responsibilization of the elderly takes place requiring the elderly to change and take responsibility (Dahl, 2010). Self-responsibilizing is about creating a will and motivation for change thereby creating an active citizen doing more of the care him / herself (Kofoed, 2012; Dahl, 2005; Dahl, 2012).

With the divisions in mind, one question becomes whether there still is one model in elder care or whether marketization is pulling the regimes apart? Of the six characteristics, two of them seem under attack. Universalism and local autonomy seem under pressure in respectively Sweden and Denmark. Targeting and retrenchment in the Swedish case has put universalism and the tax financing of care under pressure, introducing user fees and stronger differentiation between elderly. In the Danish case, the obligatory marketization has reduced local autonomy—a key aspect of the Nordic model. But also another of the six characteristics is being undermined by marketization as we shall see in the next section about the paradoxes arising with neo-liberalism.

One key Paradox

Neo-liberal changes in policy such as marketization are not only translated and taken up in various ways in the different Nordic regimes, but it also creates paradoxes within the model. Marketisation meets a hostile institutional ground in the Nordic welfare regimes, although the countries differ in this respect as just described.

Some view paradoxes as immanent and as arising within NPM and liberalism as it becomes middle aged (Hood and Peters, 2004). This is not my perspective here as I will consider paradoxes as something created when neo-liberalism translates into the Nordic Welfare States and meets existing institutional values and practices. Consume rism, choice and self-responsibilizing processes meet welfare regimes stressing equality. Although a few paradoxes can be identified, I am exclusively concerned with one

paradox relating to the sixth characteristic i. e. professionalization of care as I have also outlined elsewhere (Dahl and Rasmussen, 2012). This commitment for education for all is both linked to social democratic thinking, state feminism (Hernes, 1987) and has been carried out by parts of the state concerned with education and adult education. It has also recently been related to recruitment problems and seeing these as being solved by increasing training and status of the profession (Dahl and Rasmussen, 2012). However, other parts of the state e.g. the treasury have been pushing for a marketization and standardization in order to improve efficiency and quality. However, standardization is reducing autonomy of the care professional and thereby contributing to a process of de-professionalizing. Similarly marketization could have an impact upon the level of educational standards in the care market, where there would be an economic incentive to lover educational standards and expenses in private firms if educational standards are not regulated and part of formal marketization processes.

Conclusion

Despite differences and divisions the general contours of a Nordic model in elder care is still tenable. Of the six characteristics, three of them are untouched: local autonomy for the municipality to make decisions on elder care (except in Denmark), to provide services in kind and primarily home based care are mutual and stable characteristics. The three other characteristics are still viable, although under pressure. Services are still mainly publicly funded and still mainly publicly provided, although in Finland and Sweden an increasing amount of home care and residential care is provided by large, international care companies. In this sense we witness an increasing divide between Norway and Denmark on one side, and Sweden and Finland on the other. This divide seems to be related to neo-liberalism and the origin, pace and form of marketization used. Neo-liberalism also challenges a sixth feature of the model, namely the state engineered process of professionalizing care—this commitment is under pressure in a competitive environment and creates a paradox for the model.

But there are also other challenges to the model such as migration and the integrationist model of residential care. With more ethnically and religiously diverse societies, the question becomes whether to have multicultural residential home or have residential homes exclusively for religious or ethnic minorities.

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