Chapter 5
Ways of Funding and Organising Elderly Care in Sweden

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Abstract Elderly care in Sweden is an important municipal task and a more specialised care was introduced in 1918. Since then the development of elderly care has evolved in terms of a three stage process and each phase has been characterised by path-dependent processes. Critical junctures have been reached around 1950 and around 1990. Since 1990 the municipalities have been given extended options to organise elderly care and they are now trying to find means of increasing efficiency in elderly care. One possibility has been to privatise parts of the care. The demographic challenge of an ageing population will affect the possibilities to finance elderly care in the future. This will probably lead to a new critical juncture at which the State will take financial responsibility for elderly care and introduce elderly care insurance.

5.1 Introduction

Elderly care has for many decades been an important municipal task in Sweden. Care for the elderly is a social right and regulated in the Swedish Social Services Act. Characterised by a long tradition of extensive local self-government, the 290 local municipalities, to a great extent, decide on issues concerning care of elderly people. Financing of elderly care in Sweden is mainly derived from local taxes and the total cost is ~80 billion SEK, which corresponds to 2.6% of the GDP (Socialstyrelsen 2007). Consumer fees for individual users, limited to a maximum level that is set rather low, finance around 5% of the costs.

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Table 5.1 Elderly people receiving home help in 2007

People in ages	Total	%
65+	153,700	10
65–79	42,700	4
80+	110,700	23

Source: Socialstyrelsen (2008)

Table 5.2 Elderly people in special-housing care in 2007

People in ages	Total	%
65+	95,200	6
65–79	18,800	2
80+	76,100	16

Source: Socialstyrelsen (2008)

Elderly care includes both home help services, i.e. varying forms of assistance in a home environment, and institutional or special-housing care (old people's homes, nursing homes and similar). The number of senior citizens that receive either of the two forms of elderly care is roughly 250,000 persons, which equals 15% of all old-age pensioners (65+). Around 95,000 of these live in some form of institutional facility. Especially for persons above the age of 80 the number of recipients of elderly care is high (Tables 5.1 and 5.2). Their share of home-help services is 72%. Regarding special housing care, they represent ~80% of the recipients.

Local municipal care of the elderly has evolved historically from poor relief. Prior to 1918, no specific care for elderly people existed within the regulated municipal poor relief system. Not until the introduction of the Poor Law of 1918 did local authorities assume responsibility for providing special care for the elderly, albeit restricted to the establishment of old people's homes. The development of elderly care has evolved in terms of a three-stage process.

1. Between 1918 and 1949 municipal elderly care was limited to care in old people's homes
2. From 1950 to ~1990 home help service was introduced and developed
3. From 1990 and onwards the responsibility for home-based nursing has been transferred to the municipalities and these have attained a higher degree of choice when organising elderly care

In essence, public financing and demographic preconditions have defined the frameworks for the development of Swedish elderly care. Each phase in the development is characterised by path-dependent, self-reinforcing processes (David 2001; Pierson 2004). Within each phase, leading public representatives for elderly care have tended to hold on to the past, resulting in restricted and limited choices of action later on. When eventually reaching so-called critical junctures, there has been a shift to a new path, which could prove difficult to leave at a later stage in the process. This chapter commences with an illustration of path dependence and of critical junctures in the history of Swedish elderly care.

5.2 The Establishment of Old People's Homes

Around the turn of the last century, roughly three quarters of the Swedish population lived in the countryside. Most of the numerous municipalities, numbering more than 2,400, were very limited in size. The norm was for adult children to take care of their elderly parents when they no longer could provide for themselves. Elderly people without means of their own or close relatives had to seek help from the local poor relief authority. The municipalities were largely free to decide over poor relief according to their own preferences. Possibilities to appeal did not exist and the recipients of poor relief were under the dominion and authority of the local poor relief board (Edebalk 1991). The unsatisfactory state of affairs within the poor relief system was apparent. The elderly in need of care, especially in rural areas, could be eligible for four different types of support. The first was to offer a person lodging and food in a household paid by the local authority to provide this service. A second option was to auction off the care of the elderly through which the local authority awarded custody to the person demanding the lowest sum for providing this service, which often meant that other poor people became carers for the most destitute. A third alternative was a system of rotating care, in which the person in need constantly had to move from one carer household to another. Yet another possibility was to place the elderly person in special poor relief institutions, such as almshouses or workhouses, which accommodated various sorts of people of different ages under one roof: the young and the old, the chronically sick with the mentally ill, and alcoholics together with orphans.

The lamentable conditions within the poor relief system drew increasing public attention around 1900 and in the early 1900s. The issue of poor relief had been discussed publicly prior to this when a proposal for introducing a system of old-age pensions had been raised as a solution for taking people out of poor relief and thus cutting costs for the local authorities. The aspect of local economic conditions was essential since the share of elderly in the population had increased substantially and was higher in Sweden than in any comparable country. From constituting 4.8% of the population in 1850, the share of the elderly (65+) almost doubled to 8.4% in 1900 while the percentage of elderly in, for instance, Great Britain and Germany still amounted to no more than 4% of the total population. Due to the financial obligation placed on individual municipalities to pay for local poor relief and to the fact that most recipients of care were old and infirm, many small rural communities found poor relief a heavy burden to bear.

In 1913, the Swedish parliament decided to introduce national pension insurance in Sweden. It was the first of its kind worldwide to embrace the entire population and specific insurance fees financed the pension (Edebalk 2000). Due to this, local governments were partly alleviated from the economic load of poor relief and a modernisation of the system became possible. According to the new Poor Law of 1918, municipalities were obligated to provide housing for elderly in old people's homes. These had to abide by certain quality standards and should resemble a private home in character. The function of old people's homes was to give support,

housing and care to the elderly. Especially the housing aspect was essential as many of the poor lived in dire residential conditions (assuming they had access to some form of dwelling). The function of the old people's home was to offer the elderly a refuge fit for human beings, much in line with bourgeoisie accommodations provided for the so-called "pauvres honteux".

The decision to delegate the care of the elderly to local authorities through the 1918 Poor Law carries more than one possible interpretation. One general assumption was that the national pension insurance to a certain degree would level out the burden of poor relief between municipalities and thereby enable small communities to establish old people's homes. The main argument, however, was that social and geographic proximity between the giver and the receiver of care would facilitate the assessment of which persons were in need of care and support. One also expected cost-efficient incentives for the provision of poor relief to arise from municipal authority. Further, it is likely that restrictions to local governmental autonomy at the time were politically unacceptable, not least with regard to Sweden's long-standing tradition of municipal self-rule on poor relief issues.

The reform of 1918 was a success measured in numbers. One major obstacle, however, was the mix of recipients and the limited size of numerous institutions. As opposed to larger old people's homes, smaller homes had limited resources for separating the different groups of recipients, e.g. specific sections for mentally ill people or for those suffering from chronic diseases. Other obstacles particular to homes with fewer residents, thus mainly occurring in smaller municipalities, also transpired. Problems with recruiting competent staff to old people's homes were common, especially in areas suffering from extensive labour out-migration. Often it was a question of storing the elderly rather than caring for them.

The continuous urbanisation during the interwar period led to further difficulties in the running of old people's homes. In the beginning of the period, a majority of the Swedish population lived in the countryside: in 1940, the rural population had become a minority. Consequently, small communities became more numerous and by 1940 close to half of all Swedish municipalities had less than 1,000 inhabitants (SOU 1942, p. 56). The Swedish parliament decided to change the division into local government areas, partly with the intent to improve the quality standard of old people's homes and the reform came into force in 1952. This was one essential precondition for reforming elderly care. Another was the parliamentary decision in 1946 to introduce a system of old-age pension. The previously implemented national pension financed by insurance fees had only provided meagre support to the elderly, forcing many of them to seek additional help in the form of poor relief. The new system of a tax financed old-age pension, however, provided all those who had reached 67 years of age with a sufficient standard pension while housing allowances for elderly also were introduced. From this point on, elderly people were relieved of poor relief.

In 1947, the parliament approved new guidelines for old people's homes. The decisions to introduce the old-age pension and to create larger municipalities acted as important preconditions for the implementation of these guidelines. It meant that old people's homes would no longer be institutions for the poor but homes for all

elderly people in need of care regardless of their private economic status. Instead of being recipients of public relief, the residents would become full-time boarders, and most of them would have access to single rooms. Changing the recommended size of old people's homes was another essential enhancement of the standard as the minimum number of places was set to 25. This also meant improved working conditions and thus facilitated recruitment of competent staff. The parliament further stated that care of the chronically ill was no longer a local municipal responsibility but fell to the county councils to provide.

One might ask why the new guidelines in 1947 did not also embrace the issue of home help service to the elderly. Albeit no explicit discussion occurred at the time, several likely reasons behind the one-sided emphasis on elderly care through old people's homes can be identified. In Swedish agrarian society, caring for the elderly in special homes was a deeply rooted ideology. The de-population of rural regions rapidly progressed in the interwar years, especially from the mid-1930 onwards. The outcome was twofold; a surplus of elderly in the countryside combined with a female shortage in the rural population. Not only did the majority of old people continue to reside in the countryside but their housing conditions were often hopelessly dated and lacked modern conveniences such as electricity and water supply. Under such preconditions, it would have been impossible to recruit home help staff. The geographical distances were large (considering that motoring was still undeveloped) and a substantial amount of practical work had to be performed in inferior dwellings. It would simply have required hoards of home help staff. The generations of youths that were expected to enter the labour market after the war were small as consequence of low birth rates in the 1920s and 1930s. Thus, the positive post-war labour market situation created a fierce competition for new entrants on the labour market and the prospects for rurally based home help work would not have been attractive. Such working environments would not be competitive in comparison with urban positions within trade, commerce and business sectors and home help service was never brought up as an issue in the discussions on reforming the elderly care.

To implement the guidelines of 1947 would entail huge building programmes since available demographic prognoses predicted rising numbers of elderly people. As the Swedish economy in the post-war years started to become over-heated, this would turn out to be a tangible obstacle to the reform plans. There was a halt to social reforms in 1948 and prospects for the 1950s were not looking bright. For the increasing group of elderly people in need of care, the municipalities could only provide old people's homes built in the 1920s and 1930s. At that point, the author Ivar Lo-Johansson undertook an investigating tour to old people's homes throughout Sweden that came to receive much attention (Gaunt 1995). He wrote articles on what he saw, filled with indignation, and his involvement had a strong effect on the public opinion. One aspect that caused debate was the system of mixing different groups of care recipients but what raised most attention, nevertheless, was the general morale, the lack of spirit within the care of the elderly. A sense of passiveness and gloominess prevailed, even a feeling of deprivation of old people's human value and will to live. It was the own home that gave meaning to life and that

was where old people should be offered help and support. Lo-Johansson's slogan was "home-care instead of care-homes".

5.3 The Development of Home Help Services

Around the late 1940s, Swedish elderly care had plunged into a state of crisis. The local Red Cross organisation in Uppsala initiated home help services for the elderly in 1950 (Edebalk 1991). Experienced housewives were recruited for this purpose and the successful outcome was threefold; the elderly were pleased, the demand for places in old people's homes went down, and recruiting predominantly middle-aged housewives who were not normally at the disposal of the labour market turned out to be fairly easy. This became a turning point and the same development quickly followed suit in other municipalities. Often initiated by voluntary organisations, home help services after some time shifted over to the local authorities due to the increase in the number of recipients of care.

From the start, home help services grew in urban settings and the preconditions for this form of elderly care differed from previous ones. The old-age pension reduced the supportive function that old people's homes had filled. The building of better and more modern housing, in particular in densely populated areas, enabled old people to stay in their home and constituted a better-suited working environment for home help staff. The question is then, how was the recruitment of home help employees possible in the early 1950s? The answer can primarily be found in improved housing standards and in the progress that took place within household and domestic appliance technology. This development paved the way for part-time work in elderly care for housewives, which meant that a large and previously hidden labour reserve was unveiled. Home help services expanded substantially and, in contrast to the old people's home system, the stigma of being associated with poor relief was never present.

A special governmental subsidy for home help services was issued in the mid-1960s. The expansion was prolonged and peaked in 1978 (Szebehely 1995), see Table 5.3. The notion of home help service as a cheap form of elderly care had

Table 5.3 Recipients of home help 1969–1992

Year	Numbers
1969	230,557
1972	292,448
1975	328,552
1978	352,466
1981	346,543
1984	313,453
1987	314,204
1990	302,385
1992	271,316

Source: Statistisk årsbok 1972, 1980, 1987, 1994

prevailed from its initial phase when housewives, paid only symbolic wages, had constituted the majority of voluntary workers in home-based care. From the mid-1970s, however, full-time housewives had more or less disappeared in Sweden and it became vital to recruit care staff based on competitive market wages. At the same time, the demand for care per recipient increased, which elevated the required level of competence and education of the care staff. Hence, costs for home help services went up.

The cost rise in the provision of home help service was made less obvious by several means. Governmental subsidies were given to municipal home help services but not to old people's homes. For recipients of care living in their own home, the fee was low and a housing allowance could be provided to cover the rent. Residents in old people's homes had to pay a full-time boarding fee, which amounted to 70% of the old-age pension and 80% of all other income on top of that. Hence, for both the elderly and the local authorities, it seemed cheaper to provide home help services in private homes. In reality, the costs could turn out to be exceedingly high in comparison with elderly care given in an old people's home or nursing home for those in need of extensive care.

Home-based elderly service was considered the superior alternative and during the 1980s, a final discontinuation of homes for old people came to the fore. Some municipalities went so far as to move their elderly in need of care from care in nursing homes to care in their own home.

Those who received care in nursing homes run by the county councils only paid a small standard fee for the care. In relation to old people's homes, the economic advantage of having elderly persons admitted to nursing homes was substantial, both for the local authorities and for the individuals themselves (and, not least, for any potential heirs). Nevertheless, even though nursing homes appeared to be an economically attractive alternative, they were (and still are) considerably more expensive than old people's homes when all aspects are taken into account. Particularly the density of staff in nursing homes, and thereby labour costs, are high.

5.4 Times of Reappraisal Around 1990

Home help services for the elderly had become more expensive, and the change had come about at the same time as public finances were under pressure and demands for elderly care increased. In the 1980s, home help services became increasingly oriented towards more extensive and heavier forms of care and the total number of recipients decreased. At the end of the decade, it became increasingly apparent that Swedish elderly care was suffering from severe system failures. By way of illustration, only one new home for old people was built in the 1980s in Sweden as a whole. Calculations of public expenses for elderly care provided through this new modern home for old people, showed that total costs would have increased by 35% had the care recipients lived in their own homes and instead been given home help services

(Edebalk and Persson 1988). Home help services for elderly with great care demands could thus be a very costly alternative.

Problems with sharing the responsibility for elderly care between the local municipalities and the county councils also occurred regarding who should pay for what. Medical treatment was the responsibility of county councils but elderly patients who, in effect, did not require more medical treatment came to occupy expensive hospital beds. This shift in cost allocation was of course beneficial to the local municipalities.

Problems within the elderly care system were politically addressed seriously in the late 1980s. The first step was a governmental decision to allow national subsidies and housing allowances to apply also to residents in old people's homes. The State would hence take a neutral stance with regard to homes for old people and home help services and the local authorities were given more extended options of choosing how they wished to organise their services. A noteworthy change was also the ending of municipal monopoly of elderly care; in contrast to previous regulations, the municipalities were now free to engage private companies to provide care for their elderly.

In 1992, a Community Care Reform (in Swedish *Ädelreformen*, Ds 1989, p. 27) was enacted, by which the municipalities were appointed the sole authority for all care and home-based nursing for the elderly. In addition, the local authorities were made liable for payment of costs for elderly who were in hospital but not in need of further medical treatment. The municipalities could thereby no longer evade the economic responsibility by throwing over costs to the county councils. The Community Care Reform in 1992 was a wide-ranging reform; ~55,000 former county council staff became municipality employees as a consequence thereof.

The reappraisal meant that Swedish elderly care entered a new path. In effect, the local governments were given more responsibility but also more freedom.

5.5 Elderly Care of Today and Future Challenges

The recent demographic development with a growing share of elderly has created a new sense of crisis awareness. Today the elderly (aged 65+) constitute around 18% of the population and prognoses indicate that the figure will rise to 25% in the year 2030 (see, Chap. 2). The share of very old people will increase but still comparatively little over the next 15 years; the major rise will come when the large generation born in the 1940s reach old age in the 2020s.

Those producing prognoses agree that the remaining years of life will increase in the future for those over the age of 65. The large and difficult question is what will happen to the general health, and therefore with the need for nursing and care, during these increased years. Two competing hypotheses are commonly put forward (Fries 1986; Batljan 2007; Meinow 2008):

1. A better general health leads to postponed illness and periods of illness are pushed forward towards a higher age as the years of life increase.

2. The period of illness and reduced functional capacity is increased. This increase in illness is due to more people surviving acute cases of illness but with permanently reduced functional capacity.

Many studies lend certain support to the first hypotheses. Some recent studies, however, show a degree of support for the second one. One factor that is also considered is that the prevalence of reductions in cognitive capacity increases with age. Even changes in life style of the population (e.g. increase in the number of overweight people or increase in alcohol consumption) will affect the future pattern of morbidity. Another factor is that people with an immigrant background have, on average, poorer general health than others and an increasing number of immigrants will be ageing in Sweden.

A recent Swedish study based on two representative samples of the Swedish population aged 77 and older (1992 and 2002) suggests a worsening of health during the 10-year period measured (Meinow et al. 2006). According to the study, serious health problems increased significantly during this period and the increase was highest for multiple diseases and symptoms. The number of old people in the future will be higher and, as the oldest old represent a large majority of recipients of elderly care, this will have implications for the future demand for care and nursing.

Since 1990 when the new path was embarked upon, the economic situation for local governments has been rather difficult. Elderly care has largely become concentrated on pensioners with extended care demands. Municipalities have made adjustments by cutting down on the supply of care (reducing certain services) and applying more strict needs-assessments and thereby excluding persons with more limited needs from municipal elderly care. This has resulted in elderly people purchasing market-based care services to a greater extent and voluntary organisations becoming increasingly involved in elderly care. In the last few years, local governments have made extensive reductions in institutional care and instead focused on home help service, which in essence is an expensive alternative for those with great care needs. The substantial public costs for home help services are concealed by the augmented tendency to shove the costs over onto relatives as providers of care. The carer in question is most often an elderly husband or wife. In recent years, there has been an increased awareness of the difficulties that many elderly carers face when having to take care of their partner in their own home (Socialstyrelsen 2007).

Due to the fact that municipal responsibility creates certain problems, several other conditions that are linked to municipal elderly care will be discussed.

One problem relates to the lack of interest from municipalities to accept care-demanding elderly people from other communities. It is likely that old people wish to live closer to their children but with the present local municipal financing, elderly persons with care demands only represent a cost to the receiving municipality. One might go so far as to say that municipalities that keep a very high standard in their elderly care, and hence are attractive to elderly movers, are punished economically.

Insufficient consumer influence on decisions made within elderly care has also been addressed in several contexts. Future recipients of care will probably express

higher demands on influence in comparison to those receiving care today. On top of this, Sweden has become a multicultural society. The number of elderly immigrants (aged 65+) today totals 170,000 and the number will increase. In the future, elderly care-consumers will be increasingly heterogeneous with regards to language as well as ethnic, cultural and religious characteristics. Elderly services provided by the municipalities must be adapted to these conditions and become more pluralistic.

Elderly care in Sweden is a social right. The outcome of this right, however, is dependent on, for example, financial and political conditions prevailing at municipal level. It is at that level that the efforts directed towards elderly care are weighed against other requirements from, for instance, the schooling and child-care systems. The rights are therefore obscure and seemingly arbitrary in a national perspective. The differences between municipalities are considerable, illustrated by the following numerical examples. The overall cost for municipal elderly care per inhabitant above 65 years of age is more than twice as high in the municipality with the highest cost compared to the one with the lowest cost (Socialstyrelsen 2007). The cost for a person receiving home help service only is, based on the same comparison, five times as high in the highest-cost community and three times as high for a person in special-housing care. It has been said that when it comes to elderly care, Sweden is not a welfare state but 290 welfare municipalities (Trydegård 2000). The local variations can only to a minor part be explained by structural or geographical factors. Variation seems to depend more on historical factors (i.e. previous costs or coverage rates) than on local differences in levels of need or economic and political conditions.

Within municipalities, different means of raising the efficiency within elderly care are sought after. One possibility has been to privatise parts of the elderly care by inviting tenders from private care providers. This implies that a number of providers compete for time-limited contracts, often 3-year agreements, for running a special-housing unit or for providing home help services in a specific area by sending in tenders. The tender that, according to municipal criteria, offers the agreed services to the lowest cost is awarded the contract. The incentive of this tender procedure has primarily been to lower costs. Presently, slightly more than 10% of the consumers of elderly care in Sweden receive help from a private provider. However, this form of elderly care is showing signs of stagnation, mainly due to risks of impairing the quality of care as a result of cost cuts.

In ~30 of Sweden's municipalities, a more radical change has been introduced in the form of a consumer-choice system (Konkurrensverket 2007). Consumer-choice means that the user is free to choose a care provider other than the municipal one. The financing of a consumer-choice system does not differ from elderly care in more traditional forms. In essence, it is thus local taxes that are used and the local government still exercises its municipal authority and the responsibility for, among other things, assessments of care needs.

One motive for introducing consumer-choice has been to enhance freedom of choice for the care recipients. Not least is it likely that future receivers of care will have stronger preferences than present ones regarding which provider they prefer. There is also a competitive aspect as the presence of more care providers is assumed

to stimulate market competition. This competition is not based on price, since the municipality decides on the same payment per hour to all providers, but on the quality of supplied services. In order to gain new customers and retain already existing ones, the care providing companies must meet care recipients with kind treatment and have competent and involved co-workers. The care providers have to respect agreed time schedules and produce well-performed work efforts, thereby establishing a good reputation.

A quasi-market is thus created through the system of consumer-choice. The competition can improve the development of new methods and, as a consequence, the productivity and cost efficiency in the care sector. There are incentives for care providers to produce the total number of approved care hours since they are paid per hour for provided home help services. Without consumer-choice, many approved hours will not be produced for different reasons, so with consumer-choice the care recipients can receive more hours of home help care. Hence, productivity as well as quality can be increased.

5.6 Financing of Elderly Care

Historically, the main source of financing has been local taxes. A continuation of tax-based financing presumes that tax revenues can be channelled to elderly care in pace with an increasing demand for care. However, to increase tax pressure in the future could turn out to be problematic considering that the basis for taxation has become more flexible. People, capital, products and services nowadays easily move across national boundaries. The more extended these flows are, the more restricted the level of taxation will be.

The challenges presently facing elderly care could result in a more substantial degree of financing through fees. Bearing in mind that the real costs for elderly care services are very high, it will only be possible to finance a small share of future elderly care with fees. If high-income earners have to pay huge fees, the likelihood that they will quit the public system and instead opt for private solutions increases. In that case, elderly care will run the risk of coming to resemble poor relief once again. Furthermore, higher fees could lead to an amplification of the marginal taxation effect. The outcome could be a lowered level of savings.

In recent years, insurance has been discussed as a possible source of financing (Söderström et al. 2001). Elderly care insurance may be compulsory or voluntary. Could voluntary insurance positively contribute to a strengthening of elderly care? Three advantages with voluntary insurance are often given. One is the added resources to elderly care that it could give. Another is the improved security in old age that such insurance may provide certain groups with. Thirdly, competition between insurance companies might also stimulate a development of elderly care as an effect of customer demands for differentiation of services.

Several problematic issues linked to voluntary insurance for elderly care can be identified (Kumar et al. 1995; Edebalk and Svensson 2003). One specific obstacle is

the implication of the long-time perspective. Since the need for care probably will arise first at a distant point in the future, there is uncertainty as regards the care needs and supply of care one might experience ahead. When signing up for insurance, it is essential to have knowledge concerning what the insurance will provide. Hence, it must be difficult to convince a young person to pay insurance for care that will be needed and offered 50–60 years from now. Elderly people will instead constitute the majority of voluntary insurance holders; consequently, the fees will be very high.

One vital question is which forms of service that could be eligible for voluntary insurance. Today, domestic services such as laundry, cleaning and gardening, are to a lesser extent than before supplied within the framework of Swedish elderly care. It is likely that such services would be interesting to offer through voluntary insurances. Less probable is a form of insurance that solely provides domestic services, as most elderly people at some point in time can be expected to need household services. In case the probability for an event to occur is high, the most reasonable and cheapest strategy is to increase savings rather than to buy insurance.

It is furthermore complicated to define the coverage of elderly care insurance. Presuppose that coverage is independent of needs assessments made by municipal authorities. If the insurance in question is to provide domestic services and minor care service for relatively healthy old people, a problem of moral hazard will arise. A large group of insurance holders, who might have been paying for elderly care insurance for years, can claim they have a need and demand compensation from the insurance company. The higher the required degree of disability is, the more limited the problem of moral hazard will be.

Alternatively, the municipal needs assessment could be made decisive. Only if the local authority deems that a person is in need of care will that individual receive help from the insurance company and then only with services, or monetary subsidies for services, that are not included in the municipal elderly care. Due to the existing discrepancy between municipalities with regards to both assessment of care needs and the supply of services, this system could cause major problems. What would be covered by insurance in one municipality would not be covered in another, and the insurance holders would most definitely consider this as profoundly unfair.

The presence of asymmetric information poses another problem; insured persons benefit from having knowledge of their health status and functional capacities, insights that are better than any insurance company can expect to gain. Thus, there is a risk of adverse selection. People with relatively high risks (e.g. those suffering from certain diseases) will perceive of an insurance alternative as attractive and be willing to pay the premium while those with low risks (e.g. young and fit individuals) will decline to enter the insurance system as they will not consider it worth the money. For the insurance business, this is a problematic outcome that could lead to even higher premiums, since there is an increase in the number of high-risk customers.

In addition, the insurance companies might face political risks that are difficult to predict, illustrated by the following example. In the late-1990s, a proposal for private and voluntary insurance that partly would protect the individual care

recipient from high fees for elderly care was discussed (Fölster 1998). At the time, most municipalities applied earnings-related fees, i.e. the higher the income a person had, the higher the fee was. Hence, there was motivation for some high-earners to sign up for insurance that could bring a certain degree of economic security in old age. Today, this form of insurance is ineffective due to a national decision taken in 2002 to introduce a maximum "ceiling" for the fee. User fees within Swedish elderly care are nowadays very low.

Strong arguments indicate that potential voluntary insurance for elderly care would exert only limited influence on the elderly care in Sweden. A compulsory insurance for elderly care has been initiated in a few countries, for example in Germany and Japan (Sato 2006; Ikegami 2007). The insurance system in these two countries differs with regard to organisation, financing and levels of compensation. The German system links the elderly care insurance to existing national sickness funds whereas the municipalities are responsible for the insurance in Japan. Also, with regard to the level of the insurance premium there is a distinction between the two; while constituting a certain percent of the income in Germany, it is strongly subsidised through taxes in Japan. An interesting difference is that only Japanese income earners above 40 years of age contribute financially to the insurance. This can be interpreted as a positive family policy effort aimed at young families with children and as a method of mitigating possible generational conflicts.

The German insurance does not normally guarantee full compensation of costs. It provides a partial contribution for the financing of care cost; remaining costs are expected to be covered by the elderly care recipient him/herself or relatives, or by the social services. In Japan, the insurance will cover 90% of the care costs. One important distinction is that family or relative carers can receive monetary compensation in Germany but not in Japan. The level of payment is, however, much lower for this group of carers than for professional ones. The Japanese system has instead opted for a shift away from the traditional family system by encouraging women to participate in the labour market.

In recent years, the issue of Swedish compulsory elderly care insurance has been debated. There are four feasible pros for introducing such insurance.

1. Elderly care insurance can facilitate the financing of elderly care. This presupposes a switch from municipal taxes to insurance premiums. A compulsory insurance premium could be seen as an earmarked form of taxation that would be used solely for elderly care. It is likely that such a specific tax more readily than a municipal general tax would meet with civic acceptance. If need be, it would probably also be less difficult to increase that sort of insurance premium at a later time, compared to raising the level of a general tax.
2. Elderly care insurance is a means of rewarding good quality in elderly care. In Sweden, a care recipient that arrives in a community is regarded as a municipal cost only. In case the arriving care recipient brings along insurance money, he/she will also represent a source of revenue to the municipality. This

could in turn lead to rewards for communities that offer elderly care of high quality.
3. Compared to the current situation, the status of elderly people could be strengthened and their influence could increase. Care providing companies, both private and municipal, could develop and the tendency towards consumer-choice would be enhanced. As a consequence, a system of pluralistic care provision may be created in which companies with diverse care services could emerge.
4. Preconditions for the elderly care throughout Sweden to become fair and equal could improve through a system with national elderly care insurance. The result could be that discrepancies between local communities, and consequently perceived injustices, are reduced.

These are hence the principal pros that are referred to when discussing compulsory elderly care insurance. What about the possible cons for such insurance then? A compulsory insurance premium, such as this form of earmarked tax, could encroach on the flexibility of budget alternatives as it creates obligations for certain future priorities. In the future, priorities other than elderly care might become more relevant. How important is municipal democracy for elderly care? What influence would different competing interests in the various municipal sectors exert on the development of elderly care? Questions like these must be addressed and answered before deciding on the financing of elderly care in the future.

5.7 Conclusion

Since a more specialised care of the elderly was introduced in Sweden in 1918, there has been distinct dominance of specific care ideologies. The prevailing ideology has been based on conceptions of what constitutes good care for the elderly but not seldom have these conceptions led to situations where one has held on to the past too firmly. During the period 1918–1949, homes for old people were the obvious alternative and the development of elderly care came about through the establishment of old people's homes. The guidelines for modern homes for old people that were approved by the parliament in 1947, rested on ideas formulated in the early 1900s. In turn, these ideas can be linked to dire living and housing conditions for the elderly, especially in the poor and rural segments of the population.

Around 1950 a critical juncture was reached and after that point, the home help service system developed. The growth of home help services was mainly founded on urban conditions in which the standard of housing had become decent and where a surplus reserve of labour existed in the form of housewives willing to work for symbolic payment. This circumstance was completely excluded from the overall picture when the guidelines for modern old people's homes were enacted in 1947. The emergence of home help services was further based on the assumption that home help service was cheap and that elderly people as a rule preferred to reside in

their own home. That conception, as it eventually would turn out, resulted in system failures and unnecessarily high costs. One was, once again, "stuck in the past".

The next critical juncture took place around 1990. The national government support for home help services was replaced by a neutral attitude from the State; the municipalities were given increased freedom to organise elderly care locally and took over the responsibility for home-based nursing. That is the path presently being developed and along which the local authorities are trying to find means of increasing efficiency within elderly care. What is left of the introduction of specialised elderly care in 1918 is the municipal responsibility. It remains to be seen whether the demographic challenge of an ageing population and the observed problems arising from the system of municipal authority will lead to another critical juncture, at which the State will take financial responsibility for Swedish elderly care and introduce elderly care insurance.

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