RESEARCH ARTICLE

# The welfare culture and the redesign of social eldercare in Finland

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**Abstract**: The welfare culture consists of doctrines and ideologies, beliefs, ideas, values and ideal norms that various groups and actors in the society have concerning the welfare state. The new ways of thinking, which are derived from the cultural turn and paradigm shift in social sciences, is in actual environments influenced and strengthened by economic and social changes, and also by the increasing number of old people. The Nordic welfare model (Denmark, Finland, Norway and Sweden), which is distinct from the other welfare models, is because of its basic ideological foundation, which also pertains to Finland, the general frame for the welfare culture. The characteristics of the environments in which people live, such as risks and uncertainties, impact thoughts and ideas they have about actual and preferred conditions, and influence the interest in renewal of welfare arrangements, schemes and services. Following this lead, we examine the changes in the legislation concerning social eldercare services and changes in provision and use of eldercare services in Finland. We also examine the division of responsibility for social eldercare between the public and private sector. Because the welfare arrangements are embedded in a complex cultural context, the research helps us to understand the shaping of the social eldercare. Great changes in the Finnish eldercare in favour of care at home or in a home-like environment have taken place. The goal "more home care, less institutional care" will serve even in the future as guidance in social eldercare.

**Keywords**: welfare culture, values, social policy, social eldercare, home-like environment

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## 1. Introduction

Relations between culture and welfare can be traced back for decades to early studies on the welfare state (van Oorschot, 2007, p.129). More recent studies on cultural aspects of welfare are guided by observations that culture consists of the beliefs, values and norms of different actors, such as policy-makers, administrators, interest groups, and taxpayers. Despite differences in the value perceptions of an actual or preferred welfare culture, the actors usually look either to design or redesign welfare systems, benefit schemes, and welfare services, or they look at the reverse effects, that actual social policy influences the behavior and values of the actors (Pfau-Effinger, 2005, pp.4–5: van Oorschot, Opielka, and Pfau-Effinger, 2008, p.11; Pfau-Effinger, 2012, p.151). The achieving of changes may thus require a repeated or iterative process of knowledge production and actions (Bäckman and Sharma, 1998; Bäckman and Stenman, 2004, p.62).

The concerns of adequate interpretations and explanations in welfare studies (Freeman and Rustin, 1999, p.10; Freeman *et al.*, 1999, pp.275, 278; van Oorschot, 2007; van Oorschot, Opielka, and Pfau-Effinger, 2008) in connection with new risks (Risk so-

ciety; Beck, 1992) and uncertainties (Runaway world; Giddens, 2000) as consequences of changes in world economy and globalization since the 1970s, has given rise to new thinking about culture, values and norms in welfare and social policy. After the "Golden Age" in 1945–1973, the welfare crisis in the 1980s put pressure on welfare state arrangements, and changes towards a new welfare culture for social policy purposes began to evolve. New ways of thinking about norms, and traditional ways of "doing things" within a process of cultural, especially political culture, and value changes emerged (Zetterholm, 1994, p.2; Inglehart, 1997, p.237; Inglehart and Welzel, 2005, p.134). Social movements or actions for consciousness arising, and group discussion to deliberate on a public issue ("the citizen must have a voice") were examples of efforts made democratically for changes in policies and welfare arrangements (Swedner, 1983, p.3; van Oorschot, Opielka, and Pfau-Effinger, 2008, pp.5, 11; Grönlund, Setälä, and Herne, 2010). All this new thinking originated from the cultural turn and paradigm shift in social sciences, beginning with Kuhn's new view on the meaning of concepts and theories, and Habermas' and Focault's critique of the welfare state and bureaucratic power, as well as from thoughts and ideas in world literature (Ashenden, 1999, p.219; Knowles, 1999, p.240; Sharma, 2010). The cultural turn inspired the new thinking that a culture is constantly contested, (re-) produced and manipulated (van Oorschot, Opielka, and Pfau-Effinger, 2008, p.5). In the 1980s, the new situation in many welfare states was one "where both the goals of social-policy reformers and the context in which they operate have changed dramatically" (Pierson, 1994, p.9), and which would lead to a shift from expansion to how the welfare states cope with permanent austerity (Pierson, 2001, p.411). Public opinions in the 1980s show, however, an increase of support for universal social policy and the elderly (Swallfors, 1991; Timonen, 2003, p.148).

The well-known typology, consisting of the Nordic, Continental (e.g., Germany) and the Liberal (the US, the UK) as proposed by Esping-Andersen (1990), and Mediterranean (e.g., Greece) and Post-socialist regimes (e.g., Czech Republic, Hungary, Romania) as added later (Fererra, 1996, p.17; Arts and Gelissen, 2002, p.142), which all include an ideological and cultural base, have been useful in understanding social policy models and in the examination of their outcomes (e.g., van Oorschot, Opielka, and Pfau-Effinger, 2008, pp.8–9; Rostila, 2013, pp.279–280; Bäckman, 2015).

The importance of including cultural aspects in the interpretation and explanation of different areas of social policy also in separate countries in different welfare regimes was emphasized in several articles of the book "*Welfare and Culture in Europe*" (Chamberlayne *et al*., 1999). The social model described by the European Commission in terms of values for promoting social justice and solidarity, has been the basis for reducing poverty, a huge social policy problem in some European countries, not only because of "low state and economic capacity" (quality of government) in connection with cultural traditions (Charron, 2013, p.55). In the Nordic countries, the quality of government or governance is high and connected to strong confidence in institutions and thus also to a high level of social capital for promoting welfare (Charron, 2013, pp.56–57; Grönlund and Setälä, 2012; Bäckman, 2015).

Although there are many common features among the Nordic countries referring to a Nordic cultural model, in Finland there are also at least from a historical perspective, cultural and social features, which have set their mark on Finnish welfare culture (Lin, 2005). Finland is a small country in northern Europe with a population of 5.5 million of which 20% is 65 years and over. This share is estimated to be 26% in 2030. The Nordic welfare model or the social democratic model, which is distinct from the other models, is because of its basic ideological foundation, which also pertains to Finland, the general frame for the welfare culture. The characteristics of the environments in which people live, e.g., risks and uncertainties impact thoughts and ideas they have about actual and preferred conditions, and influence the interest in renewal of welfare arrangements. In Finland as a small open economy, the changes in the world economy and fiscal crises have in an actual value and norm context, social policy implications for ways to satisfy current levels of welfare, well-being and opportunities to care for a high number of dependents. In Finland, as in other welfare states, there is wide support for protection of old people (van Oorschot, 2007, p.134; Ervasti and Hjerm, 2012, p.153); the basic ideological foundation of the Nordic welfare model is that the lack of economic resources of a family or individual is not an obstacle to access to care, and also that people are able to maintain a functional ability with well-being and life satisfaction. The early welfare research in the late 1960s and in the beginning of the

1970s, from a Nordic and Finnish perspective on level of living (Erikson, 1993, pp.67–83), and the quality of life (Allardt, 1993, pp.88–94), and current studies on outcomes of the Nordic welfare system (Kvist *et al*., 2012), showing that individual resources such as knowledge, social relations and participation in activities are important for well-being, has stimulated new thinking about equality and social justice in social policy. Empirical welfare studies provide knowledge for functional solutions both in social policy and in eldercare (Bäckman and Sharma, 1998; Bäckman, 2007, p.15; Mohan, 2011, pp.28, 184).

Finnish researchers have been engaged in studies on eldercare, especially on the organization of care, in the changing welfare states since the 1980s (Anttonen, 1988). Later focus has been on the importance of studies on social care, especially from an international perspective, the roots of social care and pattern of social care for older people in a social policy context of universalism and diversities (Sipilä, Anttonen, and Baldock, 2003; Kröger, Anttonen, and Sipilä, 2003; Anttonen *et al.*, 2003). Sipilä (1993) has described the introduction of the informal care allowance in Finland as a new "welfare mix" by giving the household responsibility for the care of a family member with government support. Timonen (2003) has focused on the restructuring of public health and social services, especially on reorganization and privatization during the years of economic recession in Finland in the 1990s, compared to Sweden. Anttonen and Häikiö (2011) evaluated the marketization and its effects on elderly-care policies with statistical data from 1990–2009. Kröger and Leinonen (2011) have analyzed the trends in home care services during the decades from 1990–2010. Karsio and Anttonen (2013) have examined the marketization of eldercare with special regard to legal frames and outsourcing practices. In a publication from 2016, Anttonen and Karsio (2016) give an overview of the redesign of eldercare services completed with interviews among administrators in order to produce information for policies of eldercare. Puthenparambil and Kröger (2016) show how the income of the clients plays a role in the choice of service. A great number of studies on ethical and humane thinking, and psychological views in the eldercare have been conducted, which have also been used for legislative and recommendatory purposes, e.g., in choices of the "right services at the right time" (MSAH 2013; Act on the Care Services for Older Persons 2012).

Following the lead from the cultural approach to welfare and social policy, according to which the value and norm climate influence actions for changes, we examine the renewal of legislation and the use of social eldercare services and the outsourcing of different services from the 1990s to 2014. The focus is on the formal and informal social care of people aged 65 and over who need help in their everyday lives because of illness, disability or other conditions, and who have a valid service and care plan according to the new *Social Welfare Act* (1301/2014). The social eldercare consists of (i) regular home care services, (ii) informal care (informal care allowance is paid to a registered informal care-giver), (iii) residential care services (service housing with/without 24-hour assistance), and (iv) long-term care in nursing homes and in long-term wards in health centers. This classification is used in the official statistics on clients in social care (OSF, 2014; Sotkanet, 2014).

## 2. Legislation Paving the Way for Redesign of Social Eldercare

There is a long tradition since the 19th century of institutional care of old people when "poorhouses" or "workhouses" were constructed by municipalities with loans from the central government on the model of the English Poor Laws. The "workhouses" or "poorhouses" which, according to the *Act of Poor Relief* (145/1922), became "municipal homes" in 1922 (the *Act of Poor Relief*), together with the existing voluntary activities, formed the beginning of a welfare mix in the care of old people (Anttonen *et al*., 2003, p.28). After the concern about the "population question" in the 1930s, and after the interruption of the WW II period 1939-45, the *Social Assistance Act* (116/1956), in the era of the rebuilding and changing value thinking, made it possible for the municipalities' homes to be opened also for "self-paying" clients.

The global economic changes since the end of the 1970s, and the new value and norm climate, which e.g., in the UK gave rise to a radical change in the care of older people, paved the way for new ideas and plans to adjust and reorganize the social eldercare services (Anttonen, 1988, p.2; Walker, 1993, p.67). A new situation and ideas of diversity began to challenge universalism, and the development towards plurality and informalization began (Anttonen *et al*., 2012, p.190). The Finnish *Social Welfare Act* (710/1982) abandoned the old poor relief thinking, and laid down

the general obligation and principles for the provision of eldercare services. The municipalities (464 in 1980 and 313 in 2016), either alone or as a joint municipality authority, were permitted to use state grants to purchase social services from voluntary (non-profit) and other service providers (for-profit firms), and also to pay an informal care allowance to a care-giver who takes care of a person close to the care-giver (Timonen, 2003, pp.113–115; Karsio and Anttonen, 2013, p.92). The roots of the system of informal care allowance have their origin in California and Sweden in the 1950s (Sipilä, 1993, pp.255–256). The municipal taxes on income from the inhabitants and local enterprises and the received state grants, are the main revenues for financing the publicly provided health and social services. The user's fees in public (municipal) residential care for old people have since the 1990s accounted for about a fifth of the total expenditure (Karsio and Anttonen, 2013, p.104).

The recession years of the beginning of the1990s' economic crisis ended the expansion of the Finnish welfare state. The GDP fell almost 12% in the years from 1990 to 1993, unemployment increased from 3.2% in 1990 to 16.3% in 1993, and welfare benefits were cut (Kautto, 2001, p.7; Kosonen, 2011, p.219). People were more than earlier forced to apply for social assistance to cope with the everyday life. The risks and need of help pushed social expenditure as a percentage of GDP from 24.7 in 1990 up to the exceptionally high level 34.2 in 1993 (Bäckman and Dallmer, 2000, p.22; Bäckman, 2007, p.12). The features of a risk society (Beck, 1992) and a runaway world (Giddens, 2000) forced new thinking in the Finnish policies of inclusion (Laurinkari, 2014, p.52) and of a new culture of welfare as it was emerging in the research (Chamberlayne *et al.*, 1999; Pfau-Effinger, 2005; van Oorschot, 2007). In the implementation of the earlier planned outsourcing of some state owned companies or "services of general interest", the government wanted to use the sales revenues to reduce public sector debt to maintain an acceptable level of welfare according to the Nordic welfare model (Willner and Grönblom, 2016, p.8). The financial stress of the municipalities increased significantly, because in the weak economic circumstances, the state partly freed itself from responsibility for financing municipality services (Timonen, 2003, p.115). The *Act on Planning and Government Grants for Social Welfare and Health Care* (733/1992), gave the municipalities freedom to allocate the earlier earmarked state grants for the outsourcing of nearly all services (Karsio and Anttonen, 2013, p.92).

New stipulations on the informal care allowance are included in the *Act on Support for Informal Care* (937/2005) also called the *Act on Informal Care Allowance.* According to the Act, the municipalities have the possibility to pay an informal care allowance to a registered care-giver for informal home care. An informal care-giver is a family member or another person who is close to the care receiver, who gives help and support to a person not in need of professional care, and who has signed a care agreement with the care receiver's municipality of residence. In 2014, about 43 000 informal care-givers had an agreement with the municipal social and health authorities; they received a monthly informal care allowance, which varies depending on the "burden" of the care.

The main goal of the *Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons* (980/ 2012), also known as the *Act on the Care Services for Older Persons* is, also in the future, that the long-term care for the elderly should mainly be provided at home or in home-like environments. According to the Act, the local authorities are obliged to consult other authorities and organizations, and to cooperate with them in issues concerning the planning and organization of services and care for the elderly. Partnership between actors in social policy is a new trend in social policy, aspiring to efficiency in policy-making, increased confidence in institutions, and thus to social capital for promoting welfare.

## 3. A New Policy — Regular Home Care and Informal Care

The liberal ideas and values in the 1980s, in connection with the climate of "new politics", and other factors such as the critique of formal care, financial stress, changing age structure of the population and improved health, have contributed to a new policy in Finnish eldercare in favor of home care (Sipilä, 1993, p.255; Pierson, 2001, p.411; Kröger, Anttonen, and Sipilä, 2003, p.31). Because an informal care-giver can receive an informal care allowance for taking care of e.g., an old relative, the informal care become an integrated part of home care (Kröger and Leinonen, 2011). The registered informal care-givers, who take care of those persons who do not need professional help and care, receive economic support, which in 2015 varied between 385 euro per month, and 769 euro in the

case of a burdensome short-term care situation or transition period (e.g., recovery from serious surgery).

The high costs of institutional and professional home care, facts about the health and functional ability of the old people, and values on humane thinking in eldercare, have resulted in policies in favor of informal care. The availability of informal care has impact on reducing public expenditure in the eldercare (Kehusmaa *et al.*, 2013). The increased medical treatment and changes in lifestyles, and behavior, have postponed chronic diseases and related disability to older ages as shown by the increased life expectancy at age 65, as well as a great number of health indicators. Since 2000 the life expectancy for women and men aged 65 in Finland has increased by more than two years for women to 21.5 years, and for men to 18.0 years in 2014. The health and functional ability of old people have improved since the 1970s. Many conditions for health and functional ability have improved (changes in ways of living, increased medical care, prevention, and rehabilitation), and the positive trend seems to continue (Koskinen, Manderbacka and Aromaa, 2012, pp.7–9, 78). The number of people aged 75 and over living at home has increased (Sotkanet, 2014).

In Table 1, regular home care includes clients living at home who receive home-help, home-nursing as part of a valid service and a care plan (OSF, 2014, p.15). Table 1 also shows the recipients of informal care. The concept of regular home care has been in use in the statistics since 1995. Before that, the municipal home-help service system, as a universal service, developed especially after 1966 by the introduction of the *Municipal Home Help Act*, provided home-help services for the old population. The Act was a sign of a new way of thinking influenced by urbanization and by women's work intensity (Henriksson and Wrede, 2012, p.172). The main service idea in regular home care is to make it possible for the elderly to live in their own homes, and to provide services on the grounds of impaired functional capacity or illness, or to persons in need of assistance in coping with functions and activities (*Social Welfare Act* (1301/2014); Karsio and Anttonen, 2013, p.91). Support services, like meals-on-wheels, washing and bathing, help with shopping, transportation etc. that support independent and daily living, can thereto be provided. The coverage of support services has declined since the middle of the 1990s (Karsio and Anttonen, 2013, p.90). This is, at least partly connected to the greater supply and demand of sheltered service housing with 24-hour assistance.

**Table 1**. Clients 65 years old and over in regular home care and informal care, during the year, 1990–2014 as a percentage of the population of the same age group.

| | 1990 | 1995 | 2000 | 2005 | 2010 | 2014 |
|---|---|---|---|---|---|---|
| Regular home care | .. | 7.1 | 6.5 | 6.3 | 6.4 | 6.0 |
| Informal care allowance | 2.0 | 1.5 | 1.8 | 2.4 | 2.6 | 2.6 |

Source: Sotkanet, 2014; Karsio and Anttonen, 2013, p.90.

The number of clients in regular home care aged 65 and over as percentage of the population of the same age has decreased since 1995 from 7.1 in 1995 to 6.0 in 2014 (Table 1). It is notable, that the introduction of the informal care allowance scheme, included already in the *Social Welfare Act* (710/1982), also impacted on the use of regular home care and the popularity of housing with 24-hour assistance (Table 2). The new informal care allowance is associated with the high use of informal care in the beginning of the 1990s. Finland was, however, at that time in a severe recession which makes the statistical interpretation difficult (e.g., Kröger, Anttonen, and Sipilä, 2003, pp. 34). On the whole a contrary trend in Table 1 can be seen in the informal care sector. This pattern of development has been suggested to be a sign that "care is going market" (Anttonen and Häikiö, 2011).

Statistics also show that the coverage of the regular home care services among the 75+ and 85+ population has been significantly higher than among the whole 65+ population because of greater need of support and help. Since 2010 the coverage has been at the level of 12% and 22%, respectively (OSF, 2014, Appendix Table 10), compared to 6.0 for all those aged 65 or over (Table 1).

In social policies favoring care at home, ethical and humane thinking, and psychological views on personal goal engagements are also important guiding principles in the eldercare (Bäckman, 2007, p.15; Saajanajo, 2016, p.76). The social environment and culture in which people live and function are in general important for maintaining social relations and for receiving and strengthening social support, as well as social capital (Bäckman, 2013, pp.74–75). Attachment to their own home is usually strong among old people, relating to persons, memories and experiences, and contacts with family members and friends. Opportunities for an eventful life, meaningfulness and strong goal engagement (Antonovsky, 1987, pp.16–19; Saajanajo, 2016, p.76), life satisfaction and happiness (Layard, 2005, pp.23–24; Lyubomirsky, 2008, pp.21–23), are all important for maintaining health and well-

ness. There are no obligations, based on cultural values and norms, on the younger generation to take care of the older generation. Work and family life of relatives and friends, as well as geographical separation can, however, be limitations to taking part of the life of old people (Jolkkonen, Kilpeläinen, and Koistinen, 2009, p.75).

## 4. Great Changes in Residential Care

The residential care of old people has much changed since the days when the first "workhouses" or "poorhouses" were built on the model of the English Poor Laws. Service housing with 24-hour assistance is preferred and used more in care and services than service housing without 24-hour assistance, traditional nursing homes, and long-term care in wards of the health centers. The number of intensive service units with 24-hour assistance has grown markedly, and their clients over 65 years as percentage of the 65+ population has increased from 1.2 in 2001 to 3.3 in 2014 (Table 2). The use of the other forms of care (housing service without 24-hour assistance, nursing homes and health centers) has decreased. In the nursing homes, the clients pay a fixed monthly means-tested fee, including in principle everything (care, meals, medication). In the service housing with 24-hour assistance, the most outsourced service in the for-profit sector, the client pays for all services and medication (Karsio and Anttonen, 2013, p.92). The costs for medical care inclusive of medicines and housing are to a certain extent reimbursed through the Social Insurance Institution (SII/Kela), and through the pensioner's housing allowance which has been a target for cuts in government policy.

According to the recommendations of the Ministry of Social Affairs and Health (MSAH 2013:19), the national target was that by 2017, only 2–3 per cent of persons aged 75 and over will be cared for in residential homes for older people or in long-term wards in health centers. This percentage was 1.3 for persons aged 65 and over in 2014 (Table 2), and 2.6 for persons aged 75 or over. The aim for intensive service housing with 24-hour assistance was 6–7 per cent for those aged 75 or over (6.7 in 2014). For regular home care, the aim was 13–14 per cent (11.8 in 2014), and for informal care 6-7 per cent (4.5 in 2014).

**Table 2**. Clients aged 65 and over in residential care units as a percentage of population of same age 2001–2014 (year-end).

| | 2001 | 2005 | 2010 | 2014 |
|---|---|---|---|---|
| Service housing, 24-hour assistance | 1.2 | 1.9 | 2.9 | 3.3 |
| Service housing, without assistance | 1.3 | 1.2 | 0.7 | 0.5 |
| Nursing homes | 2.6 | 2.2 | 1.7 | 1.0 |
| Health centers | 1.5 | 1.3 | 0.8 | 0.3 |

Source: OSF 2014, Appendix table 10. Note: Statistics not available before 2001.

Table 2 confirms the great changes, or deinstitutionalization, that have taken place in the social eldercare in Finland because of the new policy that the care of the elderly should be provided in the person's own home or in a home-like environment. The changes in Finland are in line with international trends (Anttonen and Karsio, 2016). According to research on welfare culture, the new ways of thinking about values and norms and traditional ways of "doing things", influence the interest in consciousness raising and claims for renewal and redesign. A principle is that "the citizen must have a voice" (van Oorschot, Opielka, and Pfau-Effinger, 2008, p.5). The importance of a "voice" and a "choice" in the process of deinstitutionalization has been emphasized in studies on social eldercare in Finland in comparison with other countries (Yeandle, Kröger, and Cass, 2012; Anttonen and Karsio, 2016; Puthenparambil and Kröger, 2016). Voices can either be a collective voice, raised by organizations representing the elderly and care-givers or an individual voice initiated by service users and care-givers (Yeandle, Kröger, and Cass, 2012, p.438). The work of the organizations for promoting health and welfare and thus also beneficial for aging policy cannot be underestimated (Bäckman, 2014, p.85). Partnership between authorities and organizations in or with an interest in eldercare or group discussion on an important issue of care (democratic deliberation), may facilitate the readiness for policy-making (Grönlund *et al.*, 2010). The user's influence on the provision of care may, however, be limited (Yeandle, Kröger, and Cass, 2012).

## 5. The Outsourcing of Services

The development of the Finnish eldercare consists of two phases of which the first has been described as "care going public", i.e., a changeover from family or household responsibility for the care of old family members (e.g., the contract that secured the livelihood of the old farmer when the young farmer took over the farm) to the domain of the municipalities and the state by the construction of "poorhouses" which later became "municipal homes", complemented by the voluntary sector and the market (Anttonen *et al.*, 2003, p.172; Kröger, Anttonen, and Sipilä, 2003, p.28). The

second phase, when the outsourcing of services began to strengthen in the years of economic recession in the beginning of the 1990s, has been described as "care going market" or "care going private" (Anttonen and Häikiö, 2011, p.77). The legal reforms in the 1980s and 1990s, paved the way for the outsourcing of social care (Anttonen and Häikiö, 2011, p.75; Karsio and Anttonen, 2013, p.92). New norms, values and ideologies, e.g., the liberalist market ideology, embedded in the changing welfare culture, which strengthened during the welfare state crisis and economic recession, contributed to changes in the provision of eldercare services. The role of the public sector is changing towards a supportive guiding policy and control policy.

In the new value and norm climate, the government began the implementation of the earlier planned outsourcing of some state owned companies or "services of general interest" with social policy motives. The government wanted to use the sales revenues to reduce public sector debt in order to maintain an acceptable level of welfare according to the Nordic welfare model (Willner and Grönblom, 2016, p.8). As in the whole social service sector, including services for children, adults and the elderly, marketization in the social eldercare has increased (OSF, 2012; Karsio and Anttonen, 2013, p.107). Already before 1992, when the *Act on Planning and Government Grants* gave the municipalities freedom to outsource services, Finland's Slot Machine Association, which was obliged to use its received profit for public good, gave financial support in the 1980s and also in the 1990s to build service housing apartments (Kröger, Anttonen, and Sipilä, 2003, p.35; Karsio and Anttonen, 2013, p.93). The share of the personnel employed by providers of private services has increased from 26 in 2000 to 35 in 2012; especially marked in the growth of personnel in the private for-profit sector (firms) from 7% in 2000 to 19% in 2012 (Table 3).

Until 2010 the number of clients was higher in both the private service housing with 24-hour assistance and in ordinary service housing than in the corresponding care provided by public (municipality) providers (Figure 1). Since 2010 the number of clients in public-provided service housing with 24-hour assistance has increased significantly and the number of clients in ordinary service housing has not changed. There are nowadays fewer clients than earlier in traditional nursing homes (Table 2) because the municipalities have begun to convert the traditional nursing homes into service housing units with 24-hour assistance. In 2014 half of the clients were in public service housing units, the other half in private units (Figure 1).

According to a study on the choice and use of private social care services (Puthenparambil and Kröger, 2016), based on a sample of people aged 75 or over living independently at home or in sheltered housing in two cities in Finland, nonusers of private services considered private support too expensive. The income statistics show, that the at-risk-of-poverty rate (disposable income below 60 per cent of the national median income) of persons aged 75 or more, was 22% in 2014 (OSF, 2016; Fritzell *et al.*, 2012, pp.176, 180). Already in 2010, the percentage of at-risk-of-poverty was 15% among all pensioners and 3% among wage-earners (Mikkonen, 2013, p.28). Although old people receive much help and support from their relatives, they, however, prefer public services as a primary source of help, while especially for their children, public and private services are equally preferred (Anttonen and Karsio, 2016, p.155).

The outsourcing and informalization of eldercare services has continued, but not in the way that the Big Society program was proclaimed as a huge culture change in the UK comprising ideas about decentralization, voluntary work rather than state action and

**Table 3**. The personnel in public and private social eldercare 2000 and 2012, %.

| | 2000 | 2012 |
|---|---|---|
| Public | 74 | 65 |
| Private | 26 | 35 |
| -non-profit | 19 | 16 |
| -for-profit | 7 | 19 |
| Total staff | 57 075 | 78 511 |

Source: OSF, 2012, Appendix Table 1B; Karsio and Anttonen, 2013, Table 5.

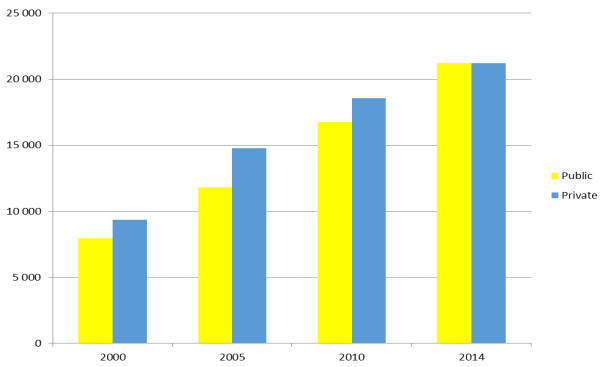


**Figure 1**. Clients in service housing with 24-hour assistance and service housing by provider type 2000–2014 (year-end).
Source: Sotkanet 2014; Note: A small number of clients under 65 years included in the service housing with 24-hour service.

empowerment, and choice in the public sector (Cameron, 2010). Although there is a strong support for universal service programs in the Nordic countries, and although the popularity of the welfare state, according to data from European countries, remains high, diversity is challenging universalism (Anttonen, 1988, p.2; Anttonen *et al.*, 2012, p.190–191; Ervasti and Hjerm, 2012, p.168).

## 6. Conclusion

The welfare culture, consisting of ideas, values and norms of actors in different social environments of the society, in connection with economic slowdown has influenced the redesign of social eldercare in Finland. The changes were observable in the 1980s, when the municipalities, either alone or as a joint municipal board, were permitted to purchase services from non-profit providers (organizations) and from for-profit providers (firms). The new legislation made it possible for the local authorities to pay an informal care allowance to an informal care-giver, who takes care of a person in his/her home, e.g., an old person, close to the care-giver. A reform of social and health care provision, called "sote" — an abbreviation from the Finnish words "sosiaali" and "terveys" meaning social and health — is in progress. The aim is that a number of large regions of groupings of the existing municipalities, 18 "sote" regions, have the responsibility to provide health and social services. The "sote" regions will provide the entire chain of social welfare and health care, from doctors taking care of patients to homecare workers caring for the elderly. The increase in the number of clients who have received informal care in their homes (Table 1) is in line with the national guidelines (MSAH, 2013; the *Act on the Care Services for Older Persons;* 2012), stipulating that the care and especially the long-term care for the elderly should be provided in the person's own home or other home-like environment, where the individual can be taken into consideration. According to the current "sote" plans, this policy will not change. Because of this prioritizing of care at home or in a home-like environment, and also because of the cost, it is suggested that the number of informal care-givers should be increased from today's 43 000 to 60 000 in 2020. The number of intensive service units with 24-hour assistance has grown markedly, and their clients over 65 years as a percentage of the 65+ population has increased from 1.2 in 2001 to 3.3 in 2014 (Table 2). This is a result of a longstanding social policy, which has also contributed to the municipalities having begun to change the traditional nursing homes into service homes with 24-hour assistance.

In the new value and norm climate in the beginning of the 1990s, the Finnish government began to outsource state-owned companies or "services of general interest", as was the case in the whole social service sector, including services for children, adults and the elderly. The outsourcing of services in the social eldercare has increased, especially in the for-profit sector (Table 3). Until 2010, the number of clients has been higher in both the private service housing with 24-hour assistance and in the ordinary service housing than in the corresponding care provided by public (municipality) providers. In 2014, half of the clients were in public service housing units, the other half in private units (Figure 1). Freedom of choice will be one part of the "sote" reform; the customers can choose among public, private or third sector service providers.

The effects of social policies or of a certain welfare arrangement are perhaps not always interpreted in the same way by all individuals and social groups. In such situations, the basic culture of the community has, according to research, a significant modifying influence on the behavior of individuals and social groups. Consciousness raising, so that all interested parts in different environments where they live and function will be aware of the importance of opinions and ideas in policy-making, therefore becomes important in the redesign of services ("the citizen must have a voice"). By interviewing old people or their relatives, and also representatives of the service providers, important information for evaluation of both policy solutions and practical care arrangements can be gathered. Although old people usually receive help and support from their relatives, research findings show that old people themselves prefer public services as a primary source of help, while for their relatives, especially their children, public and private services are equally preferred (Anttonen and Karsio, 2016). In that study, data from interviews with municipal administrators and managers were used to get their opinions on the eldercare at the local level and reflect the "voices from the managerial side" on the development; this can be considered important information for evaluation of the organization of social eldercare. Many non-users of private services considered private support too expensive, especially for low income groups (Puthenparambil and Kröger, 2016). The findings reflect "the old citizen's voice" in the Finnish welfare state. The at-

risk-of-poverty rate (disposable income below 60 per cent of the national median income) of persons aged 75 or more, is high, 22% in 2014 (OSF, 2016).

We must, however, take into consideration the fact that the redesign of the social eldercare in Finland is based on comprehensive legislation, which is already influenced by existing values and norms in different social groups and environments of the society. The *Act on Care Services for Older Persons* (2012) has opened new possibilities for partnership between the local authorities and organizations in issues concerning the planning and organization of services and care for the elderly, in order to support the well-being, health, functional capacity and independent living of the older population. Partnership between actors in social policy and in eldercare contributes new information for policy-making. Consciousness-raising through group discussion to deliberate on a public issue like eldercare may help to increase our knowledge and preparedness for actions and renewal. The democratic deliberation experiment in Finland in 2006 (Grönlund *et al.*, 2010), which tried to enhance knowledge of a public issue through group discussions, has shown positive effects on political trust and readiness for collective actions. The new thinking can also be seen in the new *Social Welfare Act* of 2014. Finland has not been subjected to such great inefficiencies and functional problems as the welfare system in Greece, where research-based policy proposals on the "necessity of a new welfare culture" have been suggested (Kotroyannos *et al.*, 2014). Nor has Finland experienced radical shifting of the welfare mix in the care of older people, as in the UK in 1979, there called a "cultural revolution", primarily because of ideological change.

The great changes in the Finnish social eldercare are in line with international trends. The reform of health and social care provision, which is planned to come into force at the earliest in 2019, involves a redesign of the service system. According to the government, the reform seeks to guarantee that its ageing population will continue to receive all of the services it needs in the future, and also mitigate the rising costs of Finland's social welfare and health care services. The goal and motto "more home care, less institutional care" will serve even in the future as guidance in social eldercare, and it is important that the whole chain of care and treatment — from home care to hospital care — functions well to ensure high quality in all aspects of ageing policy. This is also a challenge for future research. The cultural approach to welfare has contributed to our understanding of the great changes that have taken place in the social eldercare.

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