issued guidance on the funding of long-term care emphasises the obligation of the NHS to provide free long-term care for some older people but implies criteria for eligibility which, if rigorously applied, might well produce an empty set. The aim clearly is to transfer as much long-term care as possible to the means-tested social services budget. Thus funding will be by what is in effect a discriminatory inheritance tax; those old people unfortunate enough to become disabled will suffer the added grief of seeing the resources they had hoped to be their final gift to their children melt into the pockets of nursing home proprietors and shareholders. In the longer term, no doubt the rich at least would find ways of avoiding payment, and the problem will reappear.

COMMENT

In the immediate future the principal issue is the funding of long-term institutional care, although Nuttall *et al* imply that at some stage payment for long-term domiciliary health care might also be put into question. Although at any one time only around five per cent of our elderly population are in institutions, this gives a misleading picture. American data show that for people aged 65 years, one man in seven and one woman in three will spend a year or more in institutional care before they die. Whatever the decision about the future, the present generation of older people may feel that society is reneging on a contract; if they had known that their life savings would be consumed in nursing-home fees they might have been less prudent. The technical problems in this area are complex indeed; the ethical issues probe the very roots of British society.

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Social Policy — Lorna Warren

The following article takes a comparative stance in two major respects: firstly, the papers chosen for discussion are linked by the common goal to analyse welfare provision in Sweden, and secondly, their approach explicitly or implicitly invites comparison with provision in other countries.

Walter Korpi. 1995. The position of the elderly in the welfare state: comparative perspectives on old-age care in Sweden, *Social Service Review*, **69**, 2, 242–273.

Walter Korpi takes a broad overview of the post-war development of welfare for older people in Sweden in the clearly demarcated areas of pensions, poverty, social relationships, health and social conditions, and in particular, formal care. Within these spheres, Korpi highlights outstanding features in or affecting the provision of care. He begins with the example of pensions which, at 76 per cent of the net average wage, are considerably higher than in most other advanced industrial countries, and have helped to make Sweden the only country to have effectively eliminated poverty amongst older people. In terms of family relations, what stands out are the high proportions of older people living alone – 41% in 1990 – and that they prefer this to living with their children. The two groups maintain substantial contact, but the increasing participation of women in the labour force has inevitable implications for their availability as informal carers.

General health trends indicate a positive 'compression of morbidity'. However, the fact that life expectancy continues to increase means that the number of years during which older people are bedridden and in poor health remains stable. In 1988, those aged 75 years and over used about 60 per cent of all short-term hospital care. As for other forms of care, along with Denmark, Sweden has the highest extent of home-help use in Europe, with 17 per cent of older people receiving such support, though the proportion of older people in institutional care, as well as having help available from children and spouses, is average for Western Europe.

The rest of Korpi's paper explains the context of these patterns. The care of older people has traditionally been seen as a main area for public policy in Sweden. While there exists the familiar split between health and social care, the county councils and the municipalities have direct elections and the power to levy taxes, giving them a degree of independence from central government. There are similarities with the United Kingdom regarding the general development of care: from poor-houses, minimum pensions and residential care through to post-war support for community care on social and economic grounds. Likewise, the key steps in the official Swedish strategy for care echo British community care policy; the two main goals being security and adequacy of care for older people, and self-determination and freedom of choice even where care needs become great.

A significant feature in the evolution of social care has been the

tension between attempts to make home-help more flexible and the reaction of municipalities to cost pressures. Current trends are for the greater specification and contracting out of services, seemingly a reversal of the move from charring to caring (Walker 1985). Indeed, British initiatives to break down the artificial barriers between care services have in many cases run to ground because of the financial investment (initially) required (Walker and Warren forthcoming). Similarly, schemes recognising the important contribution of informal carers have familiar drawbacks: the employment of relatives to provide home care pays a poor salary while the majority of carers are women (*cf* Challis and Davies 1986). It will be interesting to observe the long-term impact of the use of sickness insurance benefits to care for older people.

Within institutional care, attention has been switched towards service houses or apartments, which offer 'assisted living', and towards 'group living' (with residential staff) for individuals suffering confusion or senility. Thus there is a greater range of institutional care. But serviced homes are relatively cheap and typically meet only less severe needs, while group living, nursing homes and long-term hospitals which meet severe needs have much higher average costs. Indeed, total costs for the care of older and handicapped people in Sweden were 44 per cent higher in 1990 than in 1980.

This being so, calls by the recent Conservative-Centre government have been for greater private entrepreneurial activity even though a clear majority of the public prefer to keep the care of older people in the public sector. Efforts to improve efficiency have included the transfer of ultimate responsibility for medical as well as social care of older people to municipalities, which appears to be encouraging the establishment of both team planning and follow-up studies of referrals to determine their necessity, adequacy and suitability. Some municipalities have encouraged young older people to assist in home-help services but, along with other schemes such as the promotion of networks, Korpi deems it a limited initiative.

Bo Carlsson. 1995. Developments in the Swedish early retirement scheme: the drive against high welfare expenditure and ill-health, *Journal of Social Policy*, **24**, 2, 193–217.

In contrast to Korpi, Carlsson focuses on just one aspect of Swedish welfare provision – the early retirement scheme – and devotes an introductory section to looking explicitly at the 'crisis in the welfare

system'. Citing earlier work by Korpi (1993), he outlines the shift from the active politics of Social Democracy to 'a growing cross-party acknowledgement that high welfare expenditure cannot be defended easily' (p. 195). Against this backcloth, Carlsson asks whether the increasing numbers of early-retirement pensioners is as dramatic as claimed and whether efforts to reduce long-term sickness through rehabilitation can succeed.

Patterns may, of course, be affected by definitions of entitlement. Early retirement is not in fact limited to older workers: introduced in 1963, the concept has developed to encompass individuals aged between sixteen and sixty-five years who are entitled to a pension if their ability to work is reduced by at least 50 per cent. Nevertheless, the majority of individuals receiving such benefits (60%) are over 55 years. Pensions may be permanent or temporary, although consideration is given to the situation in the labour market. However, since 1991 'labour market cases' aged 60+ years and no longer entitled to employment relief must, like any other worker, have a medical diagnosis to be granted a pension.

Studies into the increase of early retirement have located causes in more liberal legislation, the impact of the workplace and, alternatively, the social abuse of alcohol and drugs. Underlying such explanations is the assumption of early retirement as the product of individual agency, arising from one or more of: increasing awareness of the possibility of entitlement, weakening of the work ethic, and acknowledgement of work injury as a form of illness. On the other side are arguments which support 'system rational action': early retirement pensions are awarded on the initiative of Local Insurance Offices where they seem a 'cheaper' solution than sickness cash-benefits.

Statistical information confirms the complexity of the issue. To outline a handful of examples, a third of all early retirement pensions are temporary, while partial early-retirement pensions have come to play a large role, challenging the belief that the majority of individuals in ill health have been permanently severed from the market. However, costs have increased because early retirement pensions are becoming more common in younger age groups, who receive their benefits for an extended period. This is not to suggest that early retirement pensions have been granted too easily. Among the 20–34 years cohort, more than 60 per cent are affected by mental ill-health. At the same time, most individuals granted partial early-retirement pensions in 1988 have since had their benefits changed to full early-retirement pensions. Carlsson concludes that partial pensions are merely delaying the 'wearing-out' of the individual, and that the increase in the experience

of workplace harassment and stress, and the diminishing value of work, must be considered along with the physical demands of some occupations.

Challenges to the early-retirement scheme include an argument that early-retirement pensions have negative effects on the individual such as social isolation and inactivity, are used by the state and the capitalist system to deal with problems in the labour market and to conceal unemployment, represent 'the inflation of social rights' by the Social Democrats which has led to a substantial and unnecessary decrease in labour supply, should be replaced by more efficient measures to rehabilitate workers, *e.g.* through the transference of money from the social insurance system to the health system, and are a disadvantage to the Swedish economy since there is a positive connection between work, self-fulfilment and security.

The general solution to stem the increasing number of early retirement pensions has been the earlier use of rehabilitation with the aim of reducing the average number of sickness-benefit days. But this too is problematic. As benefit reforms in the United Kingdom have shown, reduction may be the result purely of changes in eligibility criteria. Initiatives by Local Insurance Offices, such as stationing official administrators at companies to bring forward work-related programmes, establishing contacts with various agencies to support a positive change in attitudes towards work and liaising with local employers, fail to meet the effects of tougher labour market conditions and changing moral attitudes. Carlsson also responds to critics who believe that the social insurance system is too beneficial and discourages people to return to work. He points out that individuals are motivated by other than instrumental gain – protection of their health, for example – and highlights the anxieties of a return to work, particularly when health remains uncertain, former colleagues may have left or team-work is required.

COMMENT

The two articles give a useful insight into some key areas of provision affecting the lives of older people in Sweden, and display a contrast between the macro-level and wide-ranging style of Korpi's piece and Carlsson's concentration on the finer theoretical and practical details of one specific policy. Despite their different approaches, the two analyses have common elements. Both draw out issues of gender. Carlsson highlights the predominance of women among those granted early-retirement pensions, though we are left to speculate on the cause of this

imbalance. In the area of home-help provision for older people, there has been a decline in the number of women users (as well as users with little formal education), which Korpi attributes to the failure to distribute public services solely on the basis of need.

Shortcomings include Korpi's uncritical use of the phrase 'the problems of the aged' and of the dependency ratio in his presentation of demographic changes. Information on provision in other countries is patchy, especially where comparisons are made based on data that covers different periods (*cf* the section on numbers of older people living alone), although this is not to underplay the difficulty of obtaining equivalent figures. Both authors give scant attention to the relationship between health and socio-economic status. Indeed, Carlsson simply talks of poor physical and social working environments, which are not necessarily linked to occupational status. No reference is made to the significance of minority ethnic status in early-retirement pension provision, while Korpi avoids discussion with the observation that the issues surrounding the increasing proportions of older immigrants have not yet been addressed.

At the end of the day, neither author can be certain about prospects for maintaining the quality and standards of care for older people in Sweden. In response, Korpi leaves his account simply as that – a charting of key trends. Carlsson, on the other hand, makes an appeal to a social welfare model, warning against the general drawing of rehabilitation into the market's circulation of transactions and arguing instead for individual social rights to guarantee 'a satisfactory life, beyond the workplace' (p. 216).

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