Looking for the Easy Way Out: Demographic Panic and the Twists and Turns of Long-term Care Policy in Finland

Teppo Kröger

Introduction

Long-term care policy of Finland is a paradox: on the one hand, Finland has been one of the first nations to start building modern home-based care services for older people and Finnish policy is still officially adhered to the Nordic welfare model and its universalist aspirations but, on the other hand, Finnish provisions have remained below the general Nordic level and, especially since the beginning of the 1990s, policy development in Finland has been characterized by the central state's constant avoidance of responsibility.

The key features of the Nordic welfare model have included generosity in benefits and services as well as universalism, that is, the objective to cover with provisions all population groups, not just disadvantaged or impoverished families and individuals (Anttonen 2002; Kröger et al. 2003). Public services are expected not only to be available to but also actually used by middle- and high-income groups, which means that the services need to be attractive and good enough (Szebehely et al. 2017). Accordingly, high-quality and widely accessible social and health care services have been seen to be a key characteristic of the Nordic welfare model, captured in the term 'social service state', distinguished from Central European 'social insurance states' (Anttonen 1990; Sipilä 1997). Nordic countries have been pathbreakers in various areas of care policy and they have been early also to develop home care services for older people (Szebehely 2003). Finland, too, put up legislation already in 1966 to build universalist 'home help' provisions for older people (Rauhala 1996). Alternatives were needed for traditional residential care at a time when rapidly increasing female employment questioned the overwhelmingly informal model of providing care for people in old age. Like in the case of other social and health care services, the task to construct home care services was in Finland given to municipalities that, though being officially self-governing entities, were from the late 1960s to late 1980s under detailed central regulation. In addition to central control, the state used generous central grants to prompt local authorities to build up a rather uniform service system all around the country. This implementation model was a success and, by the end of the 1980s, Finland was offering home-based care to a larger part of its older population than any other country. (Kröger 1997; 2011a.)

However, this positive development was halted by the advent of the 1990s. During the 1990s home care underwent a radical transformation (Kröger & Leinonen 2012). Coverage levels dropped dramatically and many older people were excluded from publicly funded home care provisions and had to rely on their family members. The changes represented decreasing public responsibility for the needs of the older population but they took place without any

real policy debate or major modification in legislation. Since the mid-1990s Finland has also experienced widespread outsourcing of municipal care services to for-profit providers, accompanied by increasing out-of-pocket use of private care provisions that has been supported by a new tax rebate scheme (Karsio & Anttonen 2013; Anttonen & Karsio 2017; Mathew Puthenparambil & Kröger 2017). The emergence and continuous growth of the for-profit sector in long-term care has transformed the earlier model that used to be dominated by public provisions. The development has also raised concern about increasing inequalities in the access to and use of long-term care. By the late 2010s Finnish care provisions have come quite far from the centrally regulated public provision model of the 1980s.

This chapter aims to map the twists and turns in the development of long-term care policy in Finland since the start of the 1990s. Various policy changes have taken place during the last three decades. The main argument of the chapter is that these changes have to a large part been motivated by what is called here 'demographic panic', that is, fear of consequences of population ageing to the public purse. Since the late 1980s Finnish long-term care policies have been made under the shadow of the 'demographic time bomb' discourse that argues that care expenditures are to rise exponentially if determined action is not taken to curb the expenditures (see, Vincent 1995; Mullan 2000). As a result, the focus of policy has been on preventing the increase of the costs, not on developing care provisions that are needed by the growing older population. Before taking these policy turns under closer examination, key statistics concerning development of the age structure as well as the use of main care provisions in Finland are presented.

Age structure of the population and use of care services

During the last decades, the population of Finland has been ageing rather fast and the trend is projected to continue until the 2060s (table 1). In particular, the oldest age groups have been growing the most. In 1990, 5.6 per cent of the population were 75 years or older but in 2015 this share was already 8.7 per cent. This change can be characterized as modest but at the same time the share of the oldest 85+ age group has more than doubled. Ageing is expected to further accelerate in Finland. By 2040 15.8 per cent are estimated to be at the age of 75 or over. Once again, 85+ is the age group that is projected to grow fastest, covering 5.9 per cent of the total population by 2040. However, when looking at the projection for another 25 years, population ageing is estimated to slow down considerably. From 2040 to 2065, the size of the Finnish 75+ group is expected to rise only by two percentage points from 15.8 to 17.7. Not even the share of the oldest old is estimated to grow rapidly during this period: in 2060 7.1 per cent of the population in Finland is expected to be 85 years or older.

Long-term projections of the population structure are always difficult to make and they are based on a number of presumptions. The development of the birth rate affects the age structure and at the moment it is on a negative course in Finland, which might mean that younger age groups remain smaller and, thus, older age groups relatively larger than expected. On the other hand, at the moment the number of people born outside Finland is very small within the population, which is however very likely to change during coming decades. As an increase in immigration usually increases the share of younger age groups, ageing of the Finnish population might consequently be slower than currently anticipated.

*Table 1. The size of 75+ age groups in Finland, 1990-2065 (% of total population)**

Year	Age			Total
	75-79	80-84	85-	
1990	2.8	1.8	1.0	5.6
1995	2.7	1.9	1.3	5.9
2000	3.2	1.9	1.5	6.6
2005	3.4	2.4	1.7	7.5
2010	3.3	2.6	2.1	8.0
2015	3.6	2.6	2.5	8.7
2020	4.2	2.9	2.8	9.9
2025	5.7	3.5	3.1	12.3
2030	5.3	4.8	3.8	13.9
2035	5.2	4.6	5.2	15.0
2040	5.3	4.6	5.9	15.8
2045	5.1	4.7	6.2	16.0
2050	4.7	4.5	6.6	15.8
2055	5.2	4.3	6.7	16.2
2060	5.5	4.8	6.7	17.0
2065	5.5	5.1	7.1	17.7

Source: Statistics Finland 2018 (StatFin data bank, stat.fi)
* Figures for 2020-2065 are projections.

Without doubt, the Finnish population has been ageing recently and especially the size of the oldest 85+ age group has increased and will continue to increase – and it is this age group in particular who have care needs. How have long-term care provisions been able to respond to population ageing in Finland?

Looking at long-term care statistics, institutional care can be seen to have experienced a major scaling down and transformation during the period from 1990 to 2015 (table 2). In 1990 7.8 per cent of the 75+ population were living in traditional social care homes and another 3.4 per cent in nursing homes provided by local health care authorities. In 25 years these two services that used to be the foundation of long-term care in Finland have almost vanished. In 2015 only 1.7 per cent were using care homes and 0.4 per cent nursing homes. Together they covered only 2.1 per cent of the age group, while 25 years earlier 11.2 per cent of the age group had used their residential provisions.

Care homes and nursing homes have become almost fully replaced by ‘service housing’, which was introduced in Finland in the 1980s. In this new service form, each user usually has a room of her/his own, called ‘apartment’, in the housing unit and pays rent for it. There are care services available in the unit, either during daytime (in ‘ordinary service housing’) or 24 hours (in ‘service housing with 24-h assistance’), which are paid for separately. Statistics started to distinguish these two forms of service housing from each other only in 2000. In 1990 4 per cent of people over 75 used service housing, while in 2015 8 per cent used it. ‘Ordinary service housing’ was rather popular at first but more recently it has become rare as ‘service housing with 24-h assistance’ has become the mainstream. Service housing has clearly become a sort of residential care, filling the gap left by shrinking provisions of traditional institutional care. However, this gap is filled only partly: while in 1990 all together 15 per cent of the 75+ population were using either traditional care institutions or service

housing, in 2015 the figure was 10 per cent. A third of the coverage rate of residential care has thus disappeared.

Table 2. Use of local authority funded care services among the 75+ population in Finland, 1990-2015 (% of age group)

Year	Care homes	Nursing homes	Service housing[1]	Service housing with 24-h assistance	Regular home care	Informal care allowance[2]	Total[3]
1990	7.8	3.4		4.0[4]	19.2[5]	3.3	37.7
1995	6.5	3.4		4.6[6]	13.4	2.7	30.6
2000	5.3	3.0	2.3	1.7	11.8[7]	3.0	27.1
2005	4.3	2.5	2.2	3.4	11.2	3.7	27.3
2010	3.2	1.5	1.3	5.6	11.8	4.2	27.6
2015	1.7	0.4	0.9	7.1	11.8	4.7	26.6

Sources: STAKES 1995; STAKES 2000; National Institute for Health and Welfare 2018 (SOTKAnet data base)

The remaining gap was not covered by home care, either. The development has rather been the opposite. Though official policy in Finland has highlighted strongly the role of home care since the 1980s, the beginning of the 1990s saw a major drop in the coverage of home care for older people (Kröger & Leinonen 2012). Home care became targeted more strictly to those with highest needs, in order to balance the decrease in the coverage of institutional care. A new concept of 'regular home care' was launched accordingly, introduced in the

[1] Service housing means a specific housing model for older persons where each person has a small apartment of her/his own and where care services are available. Starting from year 2000, the social care statistics distinguish between 'intensive service housing' where care services are available 24 hours and 'ordinary service housing' where assistance is not available around the clock.

[2] Informal care allowance includes a welfare benefit that is paid to some family carers, accompanied sometimes but not always by different kinds of support services (like respite care, home care, meals on wheels etc.). For most services, the figures are based on the situation in one single day of the year. However, concerning informal care allowance, the reported figures represent the total number of users during the whole year.

[3] As the figures for informal care allowance as well as the service housing figures for 1990 and 1995 are registered in a different way from other figures, the total figures are only approximate.

[4] For most services, the figures are based on the situation in one single day of the year. However, concerning service housing for years 1990 and 1995, the reported figures represent the total number of users during the whole year.

[5] The term of 'regular home care' was adopted in social care statistics only in 1995. It means home care use that is provided either weekly or according to a specific care plan, which means that the user is not an occasional one. As the term was not yet used in 1990, the figure of regular home care use for that year has been estimated based on the total number of home care users (including 'irregular users') in 1990 and 1995 and the share of regular users (61%) out of the total number of users in 1995.

[6] For most services, the figures are based on the situation in one single day of the year. However, concerning service housing for years 1990 and 1995, the reported figures represent the total number of users during the whole year.

[7] Until 2007, data on regular home care use was collected only on odd years. Therefore, the figure presented above for 2000 is actually from 2001.

long-term care statistics in 1995. As a result of this development, many older people became excluded from publicly funded home care. In 1995, 61 per cent of all home care users received 'regular home care' and if this information is used to estimate the use of 'regular home care' in 1990, it can be estimated to have covered 19 per cent of the 75+ age group. By 2000, this had dropped to 12 per cent and ever since, home care coverage has remained on the same level.

If we count the provision of residential and 'regular home care' together, the coverage of long-term care has dropped from 34 per cent of the 75+ population in 1990 to 22 per cent in 2015. Even if we count in the growth of support to family carers of older persons from 3.3 per cent in 1990 to 4.7 per cent in 2015, the total coverage in 2015 proves to be 11 percentage points lower than 25 years earlier. The drop took place during the recession of the 1990s but the coverage rate never recovered from that period. In long-term care the whole period since 1990 could thus be described as a long era of austerity and cuts.

Decentralization

The era of cuts was initiated by a reform that was planned already during the late 1980s' period of economic growth. Since 1984 municipal long-term care for older people had finally received similar central grants that health care, childcare and schools had been drawing since the 1970s (Kröger 2011a). A significant part of the expenditures of rapidly growing municipal services was covered by central grants, which started to raise concern in the late 1980s. Central authorities and policy-makers questioned the grant system, claiming that it leads to 'automatic expenditure growth'. As municipalities could count on central funding, they were not concerned about the raising costs of their service provisions, was the argument. Decentralization of economic responsibility, through a reform of the central grant system, was chosen as the policy to turn the development. In the new system, local authorities would not receive central funding based on their expenditures but based on their geographic, demographic and social characteristics. The reform did not just change the principle how central grants were determined but it also terminated almost all central regulation concerning municipal service provisions. Local authorities were given free discretion how to use the grants that they received. The idea was to discourage municipalities from extending their provisions and instead encourage them to cut their services and thus to save both local and central resources. (Niiranen 1992; Kröger 1997.)

This new policy seemed to bring immediate results as the growth of municipal services came to a sudden halt and the development soon turned into an opposite direction. However, this outcome is largely explained by a surprising coincidence. The reform was drafted during a period of economic growth but in the early 1990s, Finland experienced a sudden and deep recession. This quickly led to major cuts in all public expenditures, including central grants to municipalities (STAKES 2000; Kröger 2011a). The grant reform was implemented in 1993 at a time when the recession was at its deepest in Finland. Local authorities were suddenly under huge financial pressures and they used their new freedoms to cut down many welfare provisions, long-term care being hit especially hard (Heikkilä & Rintala 2006). The fear of policy-makers of increasing costs of growth of service provisions, in particular due to ageing, had led to a decentralization reform that together with the recession halted the development and led to a long-standing stagnation in long-term care (Kröger 1997).

Recentralization

The central grant system launched in 1993 is still in use in Finland but since the early 2000s it has drawn increasing criticism. The reform of 1993 gave local authorities the permission to freely formulate their own provisions and, not surprisingly, this led to growing variations in service provisions between different municipalities (STAKES 2000). Around the turn of the century, these local variations attracted the attention of the media, which presented these variations as a source of regional inequality (Kröger 2011a). As the whole Nordic welfare model is based on the principles of equality and universalisms, such claims caused growing concern among the population and policy-makers (Heikkilä & Rintala 2006).

The 2000s and 2010s have seen several Finnish governments trying to make a major reform of the structures of social and health care. Tackling regional inequality has been one of the key starting points of these reform pursuits. At first, the government tried to reform the structure of local authorities, to create 'stronger' municipalities but this failed due to political disagreements between coalition parties of the government and also due to incompatibility of the reform plans with the Constitution of Finland. (Kröger 2011a.) The current (2018) government has even raised the stakes and pushing for the reform using a novel approach: the government wants to create a new administrative level of regions and move the responsibility for social and health care from local authorities to these new regional authorities. Even this plan has attracted a huge amount of criticism, especially as it comes together with a plan to marketise a main part of social and health care provisions through the introduction of a wide-ranging customer choice model. A key motivation of the current government for the reform is, once again, concern for the anticipated growth of social and health care expenditures, due to population ageing. The government hopes to decrease the expected growth of care expenditures by 3 billion euro through the reform. (Kröger 2017.) Critiques have claimed, though, that the reform will probably increase, not decrease expenditures. Also the need for savings has been questioned. Among others, the National Audit Office of Finland (2017) has stated that these saving plans are unrealistic and that actually there is no need for them as, in an European perspective, Finnish social and health care provisions are already efficient and ageing of the population is no more dramatic in Finland than it is in other countries.

Whether the social and health care reform will be legislated by the Parliament of Finland is not clear at the moment. The bills are currently debated in parliamentary deliberations. The government holds a majority in the Parliament but only narrowly and the reform plans have been subject to massive criticisms. One thing is clear, however. The decentralization reform of 1993 was largely motivated by 'demographic panic' and the same goes to the reform plans of the 2010s. However, this time the planned policy instrument is the opposite: the government plans to recentralize social and health care, to take them away from local authorities and to put them in the hands of new regions that are to be centrally regulated to a much higher degree than the municipalities have been ever since 1993. The regions are expected to do what the municipalities are now claimed to have failed to do: to prevent the anticipated growth of care expenditures, due to population ageing, by cutting further the provisions of social and health care to older people.

Deinstitutionalization

Long-term care statistics presented above show that since the early 1990s, institutional provisions have experienced a dramatic and continuous decrease in Finland. Still in the early 1980s, care homes organized by local social welfare agencies and long-term wards in local hospitals were the two mainstream solutions for intensive long-term care needs. In international comparison, these services covered a rather high share of older people. Also in this respect, things started to change in the late 1980s. Criticism of all kinds of institutions had been going on since the 1960s and in the 1980s this criticism reached long-term care institutions, which were claimed to provide inhuman and non-individual care that did not respect human dignity of older people. Ageing in place was soon adopted in Finland, like in many other countries, as a new frame of reference in long-term care. (Kröger et al. 2003.)

'Service housing' was introduced as a new kind of care service, being claimed to provide more individual care than what was offered by traditional institutions. Most service housing units offered one-person rooms, which brought more privacy compared to traditional institutions that often had several beds in each room. The original idea of service housing was that people could move there rather early and gradually use more services when their needs increase. (Kröger et al. 2003.) This objective was lost, however, as soon service housing units started to remind traditional residential units. Their users had more and more needs and as services had to be provided in a more intensive way than originally planned, a new term of 'intensive service housing' (aka 'service housing with 24-h assistance') was taken into use and distinguished from 'ordinary service housing'. Since then, 'ordinary' units have disappeared and 'intensive' units have become units of rather traditional residential care.

Cutting down institutional care has not been motivated in Finland only by a strive to get rid of inhuman practices and to enhance the quality of care. From early on, policy documents have highlighted that institutional care is expensive and should therefore be avoided. Central authorities have given local authorities guidelines that have stipulated maximum levels of institutional provision that municipalities should not exceed. Soon 'intensive service housing' started to be counted in as residential care in these recommendations. Coverage levels are expected to decrease over time: the clear and outspoken policy objective has been to reduce the coverage of residential provisions. The motivation for these recommendations has been primarily to cut the costs of long-term care services, not to enhance the quality of services. (Kröger et al. 2003; Kröger 2011a.)

The staff:user ratio in Finnish residential care is lacking much behind the other Nordic countries and the conditions of home care have also considerably weakened since 2005 (Kröger et al. 2018). This would not be the situation if serious attention would have been addressed to quality issues. The adoption of the ageing-in-place framework has been used as a ground for continuous efforts to decrease institutional care provisions but in Finland the deinstitutionalization policy did not bring any further investment in home care. As a result, home care has failed to take over the responsibility for older people with high service needs. (Kröger & Leinonen 2012.) As many older persons do not receive adequate care from home, the result has been growing waiting lists to institutional care. This negative development is explained by that deinstitutionalization has been used in Finland primarily as a cost-cutting instrument within the context of growing numbers of people in old age, not as a method of responding to growing care needs with home-based services that promote increased quality of life for older people.

Refamilisation

A key function of formal care provisions is their contribution to defamilisation, that is, taking over a part of care responsibilities of families and thereby reducing family dependencies. Defamilisation strengthens the autonomy and rights of individuals and also makes the access to care more equal between people with dissimilar levels of family resources (Saraceno 2010; Kröger 2011b). From the perspective of defamilisation, Nordic welfare states have regularly been described as the leading welfare regime. The emergence and growth of publicly funded formal care services has given people other options besides family care. However, since the early 1990s the development of long-term care in Finland has been characterized by refamilisation, not defamilisation, as the responsibilities of families for the care of their older members have been increasing, not decreasing.

Concerning the character of familisation, Chiara Saraceno (2010; 2016) has made a distinction between *familialism by default*, where the welfare state does not provide support or alternatives to family care but expects it to take the responsibility for care, and *supported familialism*, where families are supported to keep up their financial and caring responsibilities through financial transfers and other welfare policies. According to Saraceno (2016, 316) familialism by default clearly upholds gender and social class inequality, as it leaves the responsibility to provide and finance care to the family, while the effects of supported familialism are more ambivalent.

Finnish policies have sometimes been highlighted as a textbook example of supported familialism as since the 1980s there has been a payment-for-care that many local authorities have paid to family carers and as this is paid directly to the carer (and not to the older person) and as also respite care has been developed in Finland since the 1990s (e.g. Saraceno 2010, 37). The care statistics presented above show that, besides service housing that has been replacing traditional institutional care, the only long-term care provision that has grown since the early 1990s in Finland is support for family carers. While institutional and home care provisions have become targeted considerably more strictly than earlier, the coverage of informal care support has grown continuously. The motivation behind this policy has not been only to recognize the value of the work of family carers but also to encourage them to stay in their caring role and, thus, to reduce the demand for publicly funded care services (Kröger & Leinonen 2012). Supported familialism has been used by the Finnish authorities as a strategy to prevent pressure towards an increase of care provisions and towards growing care expenditures. (See, Sipilä & Simon 1993.)

However, supported familialism is only a part of the whole development that has taken place in Finland. As we could see from table 2, the growth of support for informal care has not compensated the cuts in the coverage rates of formal care services . The gap that emerged in the 1990s has never become filled, which means that a considerably larger part of older people need currently to depend on themselves and their families than what was the situation 30 years ago. Only one out of four persons aged 75 or over received some kind of publicly funded long-term care in 2015, though many more are in need of support in their everyday lives. This means that familialism by default has also landed in Finland. Care responsibilities are being pushed back to many families, though attitude surveys show that older people and their family members expect the state to provide the necessary care to people in old age. Unwilling provision of family care seems to have increased. This development was strengthened by a change in municipal home care practices: earlier services covered personal care as well as household tasks but since the 1990s, household

tasks have become almost fully excluded from municipal provisions. Families have had to step in and take more responsibility for cleaning, meals and other tasks that were not part of more and more medically oriented home care. At the same time, many older people do not receive formal personal care, either, so families are expected to increase their responsibilities not only for household tasks but also for personal care. And finally, service fees for formal care have become raised and their structure has become altered – so that, for example, in service housing the basic monthly fee does not yet include care services – which has increased the financial burden of older people and their families (Karsio & Anttonen 2013).

All in all, after a period of defamilisation during the building up of public care services in the 1960s, 1970s and 1980s, Finland has experienced an era of refamilisation since the early 1990s, displayed in decreasing coverage levels of formal care provisions. The main motive for this change of direction was the need to cut public expenditures due to the major recession of the early 1990s. That recession passed by in a few years, but the policy of refamilisation has remained. It has been practiced in Finland since the 1990s as a precaution for the feared demographic time bomb, as an instrument to curb the anticipated growth of public care expenditures.

Marketisation

The decentralization reform of 1993 did not only change the way how central grants are allocated but it also freed local authorities from almost all central regulation, also concerning outsourcing. Until then, municipalities had been allowed to outsource their service provisions to non-public providers only to a very limited extent but now this limitation was abolished. By 1993, practically no for-profit long-term care provision existed in Finland. Non-profit organisations had played a minor part in provision of care services for older people – and in the innovation and experimentation of new models (like home care in the 1950s) they had been major players, collaborating closely with public social and health care authorities (Kröger 2002). Local authorities had delegated certain parts of care provisions, like the new sector of service housing, to non-profit providers. Since the mid-1990s, based on EU regulations, close connections between non-profits and local authorities started however to be seen as inappropriate, distorting the competition in the market, and new for-profit providers started to emerge rapidly.

Since the 1990s, encouraged by the EU, Finnish municipalities have increasingly used competitive tendering to outsource a major part of their care service provisions. In these tenders, non-profits need to compete with for-profits on equal terms and, though non-profit providers have kept their share of service provisions, it is for-profit provision that has been growing rapidly. In 1990, only 0.5 per cent of all social service personnel in Finland was working for for-profit organisations while in 2014 the figure was already 18.6 per cent. In care for older people, the share of for-profits is even higher than in all social care: 21.3 per cent of eldercare staff were employed by for-profit providers in 2014 (Anttonen & Karsio 2013, 107;)

Outsourcing of municipal care provisions has not been the only way that Finnish authorities have promoted the growth of for-profit care provisions. In 2001, a new tax rebate scheme was introduced. People, who use their own money to purchase for-profit home care (or home renovation) services, started to receive half of the service fees back through a new rebate

included in the income tax system. As people with low incomes (like older people receiving only the flat rate national pension) do not pay much income taxes, this scheme was drafted specifically for the middle and upper classes. Around the same time, service fees for publicly funded long-term care were raised especially for people with good incomes. These changes were implemented clearly to attract these groups to use for-profit care services instead of public provisions. Furthermore, middle and upper classes were averted away from the public care system by the tightening access to public care.

Put together, these marketization policies would fill their expected function in lessening the demand for public care but, on the other hand, they also set in motion the development of a two-tier service system in Finland. Low-income groups continued using public care services, having no choice, while other groups would move gradually and increasingly to use for-profit provisions. Pushing people to use marketised care and to pay an increasing share of the costs may have been a functioning strategy to decrease the threat of expanding costs of public long-term care. However, this policy has also eroded the basic principle of the Nordic welfare model, universalism and led to the emergence of a two-tier system where older people with low income use publicly provided long-term care services and increasingly family care, while those who can afford it, purchase for-profit services to fill the gaps left by cuts and retargeting of public care. (Mathew Puthenparambil et al. 2017.)

Conclusions

Since the early 1990s long-term care in Finland has experienced many changes. Governance of the care system has been reformed first using decentralization and now recentralization, both in order to curb the growth of expenditures of care provisions of local authorities. Traditional institutions have become replaced by service housing and overall the coverage of residential provisions has considerably decreased. The gap left by reduced institutional care has not become covered by a corresponding investment in home care. On the contrary, the coverage of home care also dropped radically in the 1990s and has never recovered since. The main goal of Finnish long-term care policy has ever since been to minimize institutional care and to keep older people at home as long as possible. Access to both institutional and home care has been made more difficult and older people are increasingly pushed to look for support from their families and from the emerging market of for-profit care services.

The overarching motivation for all these policy changes has been the wish of policy-makers to avoid responsibility. None of these reforms has been made in order to face the actual needs of the ageing population and to provide the support that is needed. Instead, these policies have been implemented specifically in order *not* to provide the necessary assistance and care. Demographic panic has been the foundation of long-term care policy-making in Finland since the late 1980s and the authorities have focused their attention and innovativeness to find ways how the public sector can escape from facing the real needs of ageing citizens and their family members.

In performing this task, the authorities have not lacked ideas and efforts. First, in 1993, they implemented decentralization in the fear of the demographic time bomb and now, 25 years later, they for the same reason wish to implement recentralization. Deinstitutionalization, refamilisation and marketization have all been used primarily in order to cut down public responsibilities for long-term care. The primary goal of all these reforms has been to curb

the anticipated growth of expenditures of care provisions. No real effort has been made to meet long-term care needs better than earlier as the attention of policy-makers has been in looking for the easy way out. However, there is no easy way out because ageing of the population and the related growth of care needs is a simple fact. The Finnish welfare state has so far refused to recognise this fact and tried to avoid responsibility for increasing long-term care needs. However, burying one's head in the sand is not a very effective public policy in the advent of a looming care crisis.

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