Organizational trends impacting on everyday realities
The case of Swedish eldercare
Anneli Stranz and Marta Szebehely

Introduction
In Sweden, as in all the Nordic countries, publicly funded care services for older persons constitute a part of the welfare state that many citizens experience personally – as care recipients, as family members of older people in need of care or as paid care workers. These encounters with eldercare as a welfare service and as employment have a major impact on the everyday life and welfare of large groups in the society – mostly women.

In this chapter, we describe the organizational and social policy changes of the eldercare sector in Sweden, and analyse how the changes have affected older people in need of care, their families and the paid care workers – with a focus particularly on the last group. The chapter is organized in five sections. The first section describes the data sources and methods used in the chapter; the second section gives the context for eldercare services in the Swedish welfare state; the third section summarizes three decades of organizational trends in Swedish eldercare; and the fourth section analyses how these changes have affected the everyday lives of care workers, and to some extent the users and their families. Finally, we conclude by discussing the women-friendly potential of the Swedish welfare state for care workers in light of the recent changes in eldercare services.

Methods and data sources
Sweden has a long tradition of social science research in care work inspired by feminist care theorists, in particular the Norwegian sociologist Kari Wæreness (e.g. Wæreness, 1984). The authors of this chapter both belong to this stream of research, which in Sweden was initiated by Rosmari Eliasson-Lappalainen, now a professor emerita in social work at Lund University. Already in the mid-1980s, she developed a framework programme on research into care for older people in which she stressed the need to combine an everyday life perspective with an analysis of the structural and organizational conditions under which care work takes place (Eliasson, 1986). Since 1992, research with this perspective has been generously funded by the Swedish research fund Forte through four six-year programme grants, the first two led by Eliasson-Lappalainen and the second two by Szebehely. Over the years, these programmes
have been linking feminist-oriented research on care with social policy-oriented welfare state research and studies of organizational trends in care services, and how they affect the everyday lives of care workers, care users and families of frail older people.

This chapter is mainly based on research conducted within these programmes, utilizing a variety of methods: ethnographic studies with participant observations and in-depth interviews with care workers and care users; surveys with care workers; and historical and institutional document analysis, as well as analysis of public statistics.

A significant part of the section on how care workers are affected by cutbacks and recent organizational changes is based on the NORDCARE study, a survey of care workers carried out in 2005 and 2015 by Szebehely, Stranz and Nordic colleagues. In 2005, a mail questionnaire was distributed to 5,000 unionized care workers in home and residential care for older and disabled people in the Nordic countries (overall response rate 72 per cent). In 2015, a similar questionnaire was sent to 8,000 eldercare workers in the Nordic countries (response rate 55 per cent). Since approximately 8 out of 10 Swedish care workers are unionized, the sample is fairly representative of the care workforce, although those with the most precarious employment conditions are under-represented (Szebehely et al., 2017). The survey has been replicated in several other countries and the data have been used for cross-country comparisons of employment and working conditions (e.g. Meagher et al., 2016; Stranz, 2013; Banerjee et al., 2012; Daly and Szebehely, 2012; Trydegård, 2012; Elstad and Vabø, 2008).

**Eldercare services in the Swedish welfare state**

We take our starting point in the widespread image of the Nordic universal care regime: high coverage of generously funded, publicly provided services of high quality that are offered to and used by all social groups according to need rather than to purchasing power (Anttonen et al., 2012; Vabø and Szebehely, 2012).

It has been discussed whether this image of Nordic universalism is or ever has been accurate (see e.g. Anttonen, 2002). In a wider international comparison, however, Sweden is still one of the world’s most generous countries when it comes to public spending on eldercare. In 2013, the public expenditure on long-term care (services for older or disabled people, health and social components taken together) corresponds to 3.2 per cent of GDP, considerably higher than in other OECD countries except for the Netherlands (OECD, 2015, p. 209).

This generosity is reflected in Swedish policy documents and social legislation that ensures the individual a right to assistance. However, eldercare is not carried out at the national level, but by 290 highly independent municipalities that are responsible for financing the services through municipal income tax and for organizing the service provision. Within the limits prescribed by legislation, the local authorities decide on tax rates, establish local guidelines, set budgets and organize services for older people, as well as for other groups in society. As a reaction to population ageing, financial crises and competition with programmes for other groups with stronger legal protection such as preschool children and disabled persons below retirement age, many municipalities have tightened the eligibility criteria for entering eldercare services (Szebehely and Trydegård, 2012). Measured as expenditure for eldercare services in relation to the population 80 years and older, the public spending has not kept pace with the ageing population since 1990, while the spending on disability services has increased considerably (SALAR, 2014, p. 19).

As a result, without changes in national eldercare policies or legislation, for decades the service coverage has declined: between 1980 and 2015, the proportion of the population 80+ receiving either home-based or residential care has dropped from 62 to 37 per cent (NBHW, 2016, Tables 6 and 8; Ulmanen, 2015, p. 21).
In the 1980s and 1990s, the decrease was sharpest in home care, but more recently it is residential care that has declined most drastically: between 2000 and 2015, more than one-quarter of residential care beds have disappeared and the proportion of the population 80+ in residential care has decreased from 20 to 13 per cent (SOU, 2017, p. 220). In the same period, the number of home care users has increased, but the increase has not compensated for deinstitutionalization as hardly any home care user receives the same amount of care as in residential care (Ulmanen and Szebehely, 2015, p. 84). Ageing-in-place policies are certainly not unique to Sweden, but the decline in residential care has been more dramatic than elsewhere, and while the coverage of both home care and residential care is still comparatively high, Sweden is no longer among the top five countries in Europe (Rodrigues et al., 2012, pp. 89–91).

Also important in this context is that the number of hospital beds in Sweden has declined rapidly since the early 1990s (Szebehely and Trydegård, 2012). Today, Sweden has significantly fewer hospital beds and shorter lengths of stays in hospital than almost all other OECD countries (OECD, 2015, pp. 105, 109). As a result, older people often leave hospital with remaining care needs, and the eldercare services are increasingly targeted to those with greatest needs. Those living in residential care have become older and frailer, their length of stay shorter (Schön et al., 2016), and a higher proportion of home care clients are very ill. In both arenas of care, the proportion with dementia is growing (NBHW, 2014).

As several scholars have argued, home care services have serious problems in meeting the large care needs; instead, the family or privately purchased help have to fill the gaps caused by ageing-in-place policies (Ranci and Pavolini, 2015). This offloading of services from the state to the family and the market is clearly visible in the case of Sweden: both family care and privately purchased care services, financed out of the pocket of the user, have increased (Ulmanen and Szebehely, 2015). This changing mix in the political economy of care is unevenly distributed from a social class perspective. In the 1980s and 1990s, family care, in particular help by middle-aged daughters, increased mainly for older people with fewer resources, while privately purchased care increased among those with more resources. However, more recently as a consequence of the drastic decline of residential care, family care provided by both women and men has increased in all social groups. This has had negative consequences for both women and men’s well-being and working life, but the problems are more common among women (Ulmanen, 2015).

The care workforce in the Swedish welfare state

The Nordic model is often seen as being successful in recognizing caregiving work through a process of state responsibility and professionalization. The publicly financed social care system constitutes an important labour market primarily for low-educated women, and the eldercare sector employs a high proportion of care workers.

The gender-segregated labour market, and thereby women and men’s different working conditions, is a prominent feature in Scandinavian countries (Borchorst, 2012). A typical care worker in the Swedish context has long been seen as a middle-aged white woman. Women still form the majority of eldercare workers (9 out of 10), but an increasing proportion of the care workforce are immigrants. One in three men care workers and one in five women workers are born outside the Nordic countries, the majority in countries outside Europe (Statistics Sweden, 2016a; see also Behtoui et al., 2016).

Part-time work is more common in eldercare than in other parts of the Swedish labour market, also compared to other women-dominated sectors. More than half of the eldercare workers work part-time, often involuntarily as they are not offered full-time work, or as a response to arduous working conditions (Meagher et al., 2016).
Even if the training levels have increased over time as a result of various state initiatives, still one in five residential care workers and one in four home care workers lack relevant training (NBHW, 2013, p. 148). Reflecting the increased health problems among older people in both residential and home-based care, present national guidelines stress that all care workers should have training as assistant nurses, but there is an obvious gap between policy ambitions and the actual situation when it comes to formal training.

Compared to all women in the labour market, the eldercare sector is characterized by high physical demands due to heavy lifting and work in uncomfortable positions, which is related to a high proportion of occupational injuries among care workers. Physical load injuries are three times more common in eldercare than the average in the labour market (Work Environment Authority, 2007). Both back pain and exhaustion are reported considerably more often by care workers than by the rest of the workforce, and these problems have increased significantly among care workers in recent years (Statistics Sweden, 2016b).

Also, the psychosocial working conditions are more problematic in care work than in the labour market in general: eldercare workers report four times more often than the rest of the workforce that they have been exposed to violence or the threat of violence at work, and almost twice as often that they find their jobs psychologically demanding. Eldercare workers also report more limited decision latitude and more stress at work – an unhealthy combination of high demands and low control (high-strain jobs) that has increased in the last two decades, and was reported twice as often by eldercare workers in 2015 as by the rest of the workforce (Statistics Sweden, 2016b).

Notifications of occupational disease due to social and organizational causes have increased by over 70 per cent between 2010 and 2014. These notifications are often related to psychosocial working conditions, in particular to relationships at the workplace such as demanding contacts with clients, threats and violence, and lack of support from managers and colleagues (Work Environment Authority, 2015). Thus, it is not surprising that sickness absence is high among eldercare workers – in particular among women workers: female eldercare workers have 50 per cent more sick days than women in the rest of the workforce (NBHW, 2015, p. 133).

A comparison of two public sectors (the women-dominated home care sector and the men-dominated technical sector) reflects the pattern of gender differences in working conditions. In the home care sector, the managers are responsible for much larger groups of employees, and thus have less time to support the workers; the workload is higher for both managers and workers, and the possibilities of influencing their own work situation are fewer (Work Environment Authority, 2014).

De-caring organizational trends in eldercare services

Home care

As in many other countries, care for older people was almost entirely confined to institutions until the early 1950s when home care services started to develop on a small scale, inspired by the British experience during the war. In all social groups, these services soon became very popular: between 1960 and 1980, the number of users increased from 60,000 to 250,000 (Szebehely, 2005). In the first decades, the home care services were characterized by personal and stable relationships between care workers and users. Each worker helped only a couple of clients per day, and each visit lasted for an hour or more. The way the services were organized left the worker with enough discretion, time and knowledge about the individual user. Therefore, the workers had the possibility to adapt their help to the varying situations of different care recipients. However,
the work itself was not regarded as a proper job. In the beginning, housewives were employed by the hour, no formal educational requirements were demanded, and the pay was lower than in, for instance, cleaning jobs. Informal qualifications, such as the care worker’s experience of homemaking and informal care, necessary for coping with the work, were not recognized (Vabø and Szebehely, 2012; Eliasson-Lappalainen and Motevasel, 1997).

Since the early days of home care, the employment conditions and the salaries have improved, but the hourly pay for a care worker is 79 per cent of the national average, and part-time work and employment by the hour are still more common than in most other occupations (Meagher et al., 2016). Further, the way care work is organized has not improved – rather the opposite. From the 1980s onwards, rationalization strategies aiming at cost-efficiency were introduced. A Taylorization of care work took place: the daily organization of home care became increasingly predetermined; the tasks to be carried out at each occasion were set in advance; a horizontal and vertical division of labour and a standardization and fragmentation of care into manageable ‘care products’ were introduced (Vabø and Szebehely, 2012; Eliasson-Lappalainen and Motevasel, 1997).

During the last decades, these ‘de-caring’ organizational trends have increased with the international wave of market-inspired reforms often labelled New Public Management (NPM). A central aspect of NPM is the introduction of a purchaser-provider split: a division between the purchaser/needs assessor and provider units that implied a significant change in the daily organization of home care services. It brought about an increased distance between the ‘office’ and the ‘workshop’, between the decisions and the actual provision of help. This resulted in new demands on exactness and clarity in the ‘order’; increasingly often, the work task is connected to a standardized time frame such as 5 minutes to make a bed, 10 minutes to change incontinence pads or 15 minutes for a shower, and the number of visits carried out per day has increased (Meagher et al., 2016).

Another aspect of NPM is the increased reliance on private actors as providers of publicly funded services through the introduction of market-inspired measures such as competitive tendering and user choice models. Over the last two decades, the share of private provision of the publicly funded home care services has increased from less than 3 per cent in the beginning of the 1990s to 23 per cent in 2016. The entire increase has taken place in the for-profit sector: only 3 per cent is provided by non-profit organizations and 20 per cent by for-profit companies – a mix of large, international corporations and many small and often short-lived companies (NBHW, 2017, Table 9; Erlandsson et al., 2013).

Responsibility for controlling the quality of care services rests with the municipalities, even when care is provided by a private company. Partly as a reaction to the increasing number of private providers, there has been an increased focus on how to regulate and measure quality in eldercare, and how to monitor the quality of care. As a result, there are increased demands on staff to document the care they carry out. This trend is strengthened by the focus on individualized and person-centred care stressed in legislation and national policy documents. For each client, a care plan is to be set up where the individual’s particular needs, habits and preferences are to be noted, and the care workers are supposed to regularly update these plans and to document all activities with and for a particular client in relation to the plan. Both care workers and their managers thus spend increasingly more time on documentation of various kinds.

**Residential care**

With the exception of the increased presence of care plans, documentation and for-profit providers (an increase between 1990 and 2016 from 0 to around 17 per cent of residential care;
NBHW, 2017, Table 10; Erlandsson et al., 2013), the organizational trends in residential care and home care are quite different. An important turning point was the introduction of the Ädel-reform in 1992, when the responsibility for nursing homes was shifted from the healthcare sector to the municipal social service sector. Since then, there is no legal distinction between nursing homes and other forms of residential care homes, and all forms of residential care are guided by a ‘social care model’, with a norm of small care units and a relatively high degree of privacy for residents.

Today, a typical residential care home consists of several units (floors) where 8–12 residents live, each in a private room or small apartment with their own furniture, and the resident is formally regarded as a tenant. More than 95 per cent of residents have a private bathroom, and more than 80 per cent have private cooking facilities, usually a kitchenette (NBHW, 2017, Table 2).

The staffing level is high in international comparisons. There is usually no specialized cleaning, laundry or housekeeping staff; instead, each care worker is responsible for most aspects of care (personal care, domestic work and social support) for a handful of residents. Compared with many other countries, there is less differentiation of care workers with different levels of training: care workers with no or shorter training (care aides) do more or less the same tasks as those with longer training (assistant nurses) (Daly and Szebehely, 2012).

It has been estimated that 70 per cent of all residents have dementia, with half of them living in specialized dementia units (NBHW, 2014, p. 25). These units, initially called ‘group homes’, started with the ambition to create a family-like setting in a small-scale stand-alone building in which staff would cook and do other household activities together with the residents (Wilson et al., 1993). Nowadays, these units tend to be part of larger facilities, and because of the residents’ increasing frailty, joint domestic activities are much less prominent (Verbeek et al., 2009). More recently, insufficient staffing levels in dementia care, in particular at night, have led to intense political debate and media coverage, caused by the results from unannounced inspections in 2010 which found that 55 out of 94 dementia care units inspected had inadequate staffing at night (Choiniere et al., 2015). As a result, in 2016 new binding guidelines were implemented stating that in all residential care (including dementia units), personnel have to be available around the clock. Whether this will lead to increased staffing levels or a reallocation of staff from day to night shift is still to be seen.

Consequences of cutbacks and organizational changes for care workers

In line with international care research, Swedish scholars have highlighted the complexity of care work: the coexistence of negative and positive aspects related to care as relational and emotional work. These aspects are often stressed as making the work meaningful (e.g. Trydegård, 2012; Elwér et al., 2010), while organizational conditions or lack of resources that prevent the staff from giving the care the elderly person needs lead to feelings of inadequacy. Such feelings have been shown to be a risk for care workers’ health and well-being, and are also strongly related to considerations to quit the job (Stranz, 2013; Trydegård, 2012). Thus, the encounters between caregivers and care recipients are a central source of motivation and job satisfaction as well as of stress and fatigue. Care research often underlines that the organization of care and the conditions under which it is performed have obvious impact on both the quality of work and the quality of care (Stranz and Sörensdotter, 2016; Stranz, 2013; Daly and Szebehely, 2012).

Early research on home care has illuminated an occupation and a work practice that had been quite invisible and unacknowledged in social science research and as a part of the welfare state. In the 1980s and 1990s, this research provided knowledge about the everyday care practices
under different organizational conditions in Swedish home care (e.g. Eliasson-Lappalainen and Motevasel, 1997; Szebehely, 1995), giving a base for comparisons over time. In the 1980s, a home care worker usually helped four older persons during a full-time workday, and the workday was dominated by domestic tasks combined with social and emotional support. Twenty years later, a care worker would help twice as many users per day, the time for household tasks being significantly reduced. The focus of the work had shifted from care of the home to care of the body, with less time for the social aspects of work. This shift was a result partly of increased care needs among those deemed eligible for home care, and partly of the attempt to reduce public expenditure by shifting the responsibility for household chores from the state to the family or the market (Vabo and Szebehely, 2012).

There are fewer detailed descriptions of residential care work in earlier days, but it seems reasonable to state that nursing home care in the 1980s had more characteristics of assembly line care than 30 years later. After the Ädel-reform in 1992, the units became smaller, and each care worker became responsible for providing holistic care for a smaller number of residents rather than conducting a specific task for 20–30 residents. The care workers in the more medical model of nursing homes before 1992 had considerably less discretion in their workday than the care workers in the small-size social model residential care home. However, more recently, cutbacks and the process of marketization have had an impact on everyday care work in both residential and home-based care.

The NORDCARE survey 2005 and 2015: deteriorating working conditions

In this section, we analyse some of the structured and unstructured (open-ended) survey questions from the 2005 and 2015 NORDCARE surveys, based on responses from 378 home care workers and 819 residential care workers in Swedish eldercare.

The sharp decline of residential care beds has affected both residential and home-based services: in both arenas, the care needs of clients have increased radically. However, the care needs differ significantly between home care and residential care: according to the 2015 NORDCARE survey, 43 per cent of the residential care workers reported that all or most of their clients require help to move from the bed, compared to 7 per cent of the home care workers.

Another aspect of a heavier workload is the increase in the number of clients a care worker assists during a working day. Between 2005 and 2015, there has been an increase in both arenas of care, but particularly in home care: from 8.6 clients on average per day to 11.8, and in residential care from 8.6 to 10.1. In home care, the number of visits is even larger as often a care worker visits the same client several times a day: in 2015, a home care worker made 15 visits per day on average and more than half of these visits lasted 15 minutes or less (these questions were not asked in 2005).

In line with the more restrictive needs assessment in home care, and thus a raised threshold for entering the services, domestic tasks such as cleaning have declined and tasks focusing on bodily care have increased. Another, partly expected, change is that documentation of both medical and social activities is a rising task in everyday care practice due to policies on quality control. The proportion of respondents answering that they do administrative tasks such as documentation several times every day has more than doubled between 2005 and 2015 – up from 11 to 28 per cent in home care and from 16 to 37 per cent in residential care.

Table 3.1 shows the trends in some aspects of psychosocial working conditions related to demands and discretion at work. In home care, the most dramatic changes concern the reduced possibility for the care workers to plan the daily work and the reduced scope for discussing work-related difficulties with colleagues. In 2005, 39 per cent reported that they most often had
Anneli Stranz and Marta Szebehely

the possibility to plan their daily work, compared to 16 per cent in 2015. In these respects, the residential care workers are much better off: they report more freedom of action in their daily work and more time to talk to their colleagues compared to staff in home care, and these aspects of working conditions have not deteriorated to the same extent. In contrast, in residential care, the work intensity has increased considerably: in 2005, 40 per cent of residential care workers reported that they most often had too much to do compared to half of the workers in 2015. In 2015, this is a central difference between the work arenas. The experience of having too much to do can contribute to the higher proportion of residential care workers reporting that they feel inadequate in relation to the care recipient, compared to home care workers (Table 3.1).

Research has shown that the eldercare sector is highly exposed to change – both reorganization and implementation of new work methods – and that frequent changes often influence the work situation in a negative way (Fläckman et al., 2009). The results from NORDCARE confirm this research in that an increased proportion of the residential care staff is worried that their work situation will change (Table 3.1).

When the staff’s experiences of physical and mental exhaustion and back pain are compared between the years, we can see an increase in all three aspects, in particular in residential care settings (Table 3.2).

### Table 3.1 Psychosocial working conditions in home care and residential care, 2005 and 2015, per cent

<table>
<thead>
<tr>
<th></th>
<th>Home care</th>
<th>Residential care</th>
<th>2015: comparison of residential care/home care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2015</td>
<td>2005</td>
</tr>
<tr>
<td>Most often too much to do</td>
<td>36</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Most often possible to affect the daily planning of the work</td>
<td>39</td>
<td>16 ***</td>
<td>47</td>
</tr>
<tr>
<td>Most often enough time to discuss difficulties in work with colleagues</td>
<td>57</td>
<td>35 ***</td>
<td>59</td>
</tr>
<tr>
<td>Most often feel inadequate</td>
<td>22</td>
<td>24 ns</td>
<td>32</td>
</tr>
<tr>
<td>Most often worried that the work situation will change</td>
<td>22</td>
<td>25 ns</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: *** p < 0.001; ** p < 0.01; * p < 0.05; T p < 0.10; ns not significant.

### Table 3.2 Reactions to working conditions in home care and residential care, 2005 and 2015, per cent

<table>
<thead>
<tr>
<th></th>
<th>Home care</th>
<th>Residential care</th>
<th>2015: comparison of residential care/home care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2015</td>
<td>2005</td>
</tr>
<tr>
<td>Almost always feel physically tired after a working day</td>
<td>28</td>
<td>32 ns</td>
<td>29</td>
</tr>
<tr>
<td>Almost always experience back pain after a working day</td>
<td>11</td>
<td>20 *</td>
<td>15</td>
</tr>
<tr>
<td>Almost always feel mentally exhausted after a working day</td>
<td>14</td>
<td>24 *</td>
<td>16</td>
</tr>
<tr>
<td>Have during the last year seriously considered quitting the job</td>
<td>40</td>
<td>46 ns</td>
<td>40</td>
</tr>
</tbody>
</table>

Note: *** p < 0.001; ** p < 0.01; * p < 0.05; T p < 0.10; ns not significant.
There is also an increase between 2005 and 2015 in the proportion of care workers who seriously have considered leaving their job, particularly in residential care (50 per cent versus 46 per cent home care). In both arenas, the proportions are very high (Table 3.2). This measure does not reveal if workers will actually quit but it is an indicator of how the working situation is perceived. Obviously a large and increasing proportion of care workers find their situation at work problematic.

An analysis of comments to an open-ended question in the 2005 NORDCARE survey about reasons for considering quitting in the eldercare sector showed that these were strongly connected to physical and mental strain and worries about one’s own health (Stranz, 2013). In a preliminary analysis of the comments to the same question in 2015, similar themes regarding a high workload, both mentally and physically, and how that affects one’s health, are predominant.

As indicated in Table 3.1, the working situation in home care is characterized by decreased discretion and increased stress, while in residential care the higher workload is the most salient feature. Some quotes from the two groups of workers illustrate these different trends:

Home care:

If things go on like this, that we have 13 or 14 clients per day, I don’t think I can keep working until I retire.

Physically and mentally demanding; afraid of forgetting things with users; feeling that you can’t manage at an increasingly rapid speed.

It is because I can’t give the care that my care recipients or users deserve and because we are so controlled by the minute; stress, stress.

Residential care:

Because we get new bosses and directives several times per year and because we document too much so the clients suffer (less time for walks, for instance) and that is hard.

There are many more demands on care staff. Demands from residents and family. Sometimes it feels you’d have to be superhuman to live up to everybody’s wishes and demands. We don’t have enough staff for that. Also, all the documentation is exhausting.

Because it gets worse and worse, both for the residents and for us staff.

When it comes to worries about health and fears that their own bodies will not manage the increased stress and workload, the care workers’ statements are more similar across the two arenas of care work:

My body is ageing; you get older and can’t take it because of the workload and not enough staff (residential care).

Because I won’t make it until the end because the organization of home care tears us into pieces (home care).

Bad pay, increased workload, stress, worn out body (residential care).

A common feature for the majority who responded to the survey in both years is that a high proportion (just over 70 per cent) found their tasks interesting and meaningful, and around half of the respondents agreed that they often get a lot back in meeting with the care recipient. The relational aspects, both with clients and colleagues and the feelings of doing meaningful work, were the main reasons for staying at work in 2005 (Stranz, 2013) and are also frequently mentioned in the 2015 survey.
The results from the NORDCARE surveys from 2005 and 2015 highlight the fact that it is the shortcomings in the organization of work that make staff consider quitting, and that it is the relational aspects that make them want to stay. However, even when the organizational and material resources are insufficient, care is still provided but at the expense of something – or someone – else. The care workers risk their health, both physically and mentally, and this is the most important reason why respondents consider leaving their work in the eldercare sector.

Concluding remarks

Both home-based and residential care have gone through major organizational changes over the last decades, and in both forms of care the organizational reforms have been implemented with hardly any consideration of the consequences for staff. Obviously, new organizational models have been introduced in stark opposition to the actual results of care research showing that time, continuity and discretion for care workers to meet the varying needs of different care recipients is crucial for good care.

Both national statistics on work-related injuries and the NORDCARE survey present a picture of worsening working conditions for the staff in eldercare, a trend that can be related to declining resources and organizational changes. Further, policy ambitions concerning the quality of care and the users’ scope to influence their care have increased substantially in recent years with policies emphasizing an individualized approach to care. Thus, at the policy level, the welfare state’s ambitions have increased while at the same time financial resources have decreased and organizational conditions have deteriorated, making it more difficult for care workers to actually carry out high-quality care.

Care workers become worn out and want to quit. As the care workers’ bodies are their main working tool, it is their bodies that are bearing the cost of increasingly demanding working conditions. Care workers’ needs for better working conditions are not recognized, which contributes to declining physical and mental health.

Care services are an essential part of the Nordic model. These services are often regarded as the embodiment of the women-friendliness of the Nordic welfare states (Hernes, 1987). Whereas care services certainly are empowering for groups of women as care users and family members of older persons in need of care – or at least were so before the cutbacks and ‘de-caring’ organizational trends – some researchers have problematized the notion of women-friendliness from the perspective of paid care workers. Those working in the care sector have a different class – and often also ethnicity position from the group of women usually in focus in the discussion of the women-friendly welfare state – the white middle class (Dahl, 2004; Borchorst and Siim, 2002).

From a social justice perspective, it is crucial that care workers are included in the equality ambitions of the welfare state. It would only be relevant to speak of a women-friendly welfare state if the workers’ right to provide care that they find adequate is recognized and they have good pay and working conditions.

References


Organizational trends in Swedish eldercare
