CHAPTER 6

POPULATION AGEING AND LONG-TERM CARE: THE SCANDINAVIAN CASE

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Introduction

Similar problems should invite similar interventions, but policies have legacies and tend to follow the roads already taken. Countries are therefore attracted to different approaches even when circumstances are similar. Some tend to look for solutions in the (welfare) state, others in the family, and yet others in the market or in civil society. This chapter explores these affinities as they are played out in the long-term care area in a European context, with a special focus on Scandinavia. Scandinavian countries tends to come out as a distinct model in the major welfare state typologies, be they based in political ideology (Esping-Andersen 1990) or in cultural characteristics (Castles 1993). However, the established typologies have been criticized for being adequate for economic protection mainly, and less so for "the new social problems" (Alber 1995), which are not primarily rooted in the labour market and the class structure, but are tied to life situations, demographic change and gender. Central among these problems is long-term care—by no means new as a problem for individuals and families, but quite new as a welfare state responsibility, and representing an expanding component of modern welfare states in ageing societies.

More recently, social care services have therefore been incorporated into comparative welfare state studies, and "social care models" (Anttonen and Sipilä 1996) are added as a supplement, or possibly an alternative, to the more general "welfare state models". This chapter adds to these efforts, but for long-term care specifically. Distinct models and their roots may be more realistically and univocally identified for limited areas of welfare policies than for the welfare state in general. Some countries do not fit easily into the grand welfare state types, and may be guided by different ideals for different domains (Pfau-Effinger 2005).

The first section of the chapter discusses whether or not there is a distinct Scandinavian model for long-term care, and if so, what the characteristics of this model are, and how well it accommodates to the more grand welfare state typologies. We shall suggest that there is indeed such a model, and a small number of contrasting models, and possibly all originating from the same ground. The second section describes the Scandinavian model more concretely in terms of volumes and profiles of services, user rates and standards, with a particular emphasis on the Norwegian case. The third section spells out recent trends and adjustments and the extent to which they

represent some convergence between models, and finally the question of sustainability is addressed: How adequate are the different long-term care models for an ageing society? What are their main dilemmas and challenges?

Welfare State Models

There is a long tradition in comparative welfare state research for trying to extract a few basic welfare state regimes from the great variety of national social policies. The separation between the Bismarck and Beveridge types of welfare states was possibly the first attempt. Whereas Bismarck aimed to protect workers (and their families) against loss of income due to sickness or old age, financed via obligatory social insurance, Beveridge sought to fight poverty via a basic income security for all citizens, financed via taxes (Blome, Keck, and Alber 2009). These differences came to prevail as distinct characteristics of German and British welfare policies, and can be identified even today.

More ambitious typologies were developed later, first by Richard Titmuss (1974), who distinguished between citizens-based, insurance-based, and needs-based welfare states, and accordingly labelled them the institutional, the insurance (or achievement) based, and the residual (means-tested) welfare models. Esping-Andersen (1990) extended this model in a manner which came to give welfare state studies new energy, when he identified the ideologies and political constellations that these policies were expressions of, thereby allowing analyses of the actors, dynamics and conflicts within the welfare state. According to Esping-Andersen, one could distinguish between a social democratic, a conservative, and a liberal(ist) welfare state regime. Among the distinguishing characteristics of the social democratic model, represented by the Scandinavian countries, is the ambitious role of the state, including active and direct regulation of the labour market, and thus protecting citizens against dependency on the market (de-commodification).

In response to feminist critique for being preoccupied with economic protection, and for being less observant of social protection and care, and thereby also blind to the gendered nature of the welfare state, Esping-Andersen (1999) later included social services in his model, and the degree to which the access to (public) social services provided protection against dependency on the family (de-familization). This expansion could, according to Esping-Andersen, be nicely accommodated within the already established model, and did not have him add or re-arrange his original typology. However, a southern welfare state regime has later been added by other scholars as a more rudimentary variant of the conservative model, or as a distinct Mediterranean (Latin) welfare regime (Leibfried 1992; Ferrera 1996).

The Esping-Andersen typology is grounded in a combination of structural and political factors, implying that a certain welfare regime has developed in response to some commonality in structure (problems) in combination with some commonality in ideology and practical solutions (outcomes). The active role of the state in Scandinavian welfare policies is, for example, attributed to the strong social democratic parties in these countries during the constituting years of the modern welfare state, motivating them to find solutions in "their" state, so to speak. Universal arrangements financed by general taxes were probably also popular because Scandinavian populations were very homogeneous at the time. Taxes, services, and clients had high legitimacy because they referred to people like oneself.

Other welfare state typologies have a cultural more than a political basis. As welfare policies seem to cluster geographically and have similar characteristics in neighbouring countries, Castles (1993) suggested that these clusters refer to a "family of nations", with a common background in history, language, religion or family culture. The geographical location of these clusters is indicated by the labels assigned to them, such as the Scandinavian model (or cluster), the Continental model, the Mediterranean model, and the Anglo-Saxon model. An Eastern (post-communist, transitional) model has later been added.

The overlap between the Esping-Andersen and the Castles typologies is evident from Table 1. The fact that the structural (Esping-Andersen) and the cultural (Castles)

Table 1: Welfare State Typologies

Welfare State Regimes (Esping-Andersen)	Families of Nations (Castles)
Social democratic	Scandanavian
Liberal	English-speaking
Conservative	Continental
(Mediterranean)	Southern
(Post-communist)	(Eastern)

typologies overlap, suggests that they are rooted in a common ground. When we speak about welfare models or regimes, we refer to a limited number of countries with characteristic similarities between themselves, and characteristic differences vis-à-vis other countries. The background for these differences may be structural, cultural or both. The geographical location of the clusters suggests that the cultural legacy has a

strong impact even on today's policy, and probably particularly so in problem areas that are by tradition a family responsibility.

The southern family is tighter and more collectivistic than the northern according to Reher (1998). The same goes for the eastern relative to the western family, according to Hajnal (1965, 1982). They both argue that European family cultures have developed over centuries and are quite stable, yet also changing in response to more recent circumstances. Their particular forms are, however, remarkably resilient, and are basic features upon which social policies and welfare states are formed rather than vice versa.

However, the strength and character of family norms are hardly produced by geography, although climate and living conditions may have been influential in the formation of living arrangements. Differences in family norms and practices are more likely rooted in history and religion, and may follow the historical lines of Christianity and Islam, Catholicism and Protestantism (Höllinger and Haller 1990; Reher 1998). Influences from the Roman Empire may also be observed, for example in family and inheritance laws (Hantrais 2004). Later on, more or less dramatic political events may have had repercussions within the family, such as the two world wars, and the Iron Curtain thereafter. The suppressive communist era in Eastern Europe may have forced people to seek protection in the family, and then most likely in more traditional family forms (Szydlik 1996). In contrast, the north-west of Europe has a long tradition for more independent relationships between family generations according to historians such as Laslett (1983). When Britain and Scandinavia were early in the development of social services on traditional family ground, this was therefore not by chance or by opportunity only, but also by choice. Scandinavian countries eventually allowed the state an even more active role and responsibility than in Britain, a policy that reduced dependency on the family further in Scandinavia. These trends have had favourable repercussions for gender roles and opportunities in Scandinavia, although the direction of causality is not totally clear.

In real life, both the longer lines of tradition, and more recent and local influences from need pressures and political ideals are involved. The cultural legacy may represent some persistent characteristic, while structural and political factors are more responsive to current conditions. Thus, even if collective family norms are deeply rooted within a country, and this country is therefore attracted to a family care model, it may come to change policies if circumstances are compelling. This being said, the cultural, political and institutional traditions of a country represent a path dependency on the past, and a resistance to change, and may come to be played out also in the revisions that have been deemed necessary. The German long-term care insurance is a

case a point. The late inclusion of state responsibility for long-term care may be explained by the familist orientation in German welfare policies, whereas the reform itself was dressed in old and familiar clothes, as a universal and obligatory insurance arrangement.

The Scandinavian Model

Both typologies, that of the welfare state regimes and that of the family of nations, identify the Scandinavian welfare state as a distinct model, although under different labels. Whether or not there are distinct clusters of nations as far as social services are concerned is still a controversial issue (Rauch 2007). We shall conclude that there are indeed such clusters, although some of their characteristics are quite fluid, and the borders between them are blurred. Table 2 summarizes some of the distinctive characteristics, how they go together within the cluster, and how they tend to

Table 2: Policy Antecedents and Outcomes by Welfare State Cluster ca. 2005

	SC[a]	E	C	SO	P
Fertility rate	1.7	1.6	1.5	1.3	1.3
Female employment	71.4	59.1	57.7	41.3	54.4
Direct taxes	43.1	29.2	26.2	26.8	20.9
Social security contribution	14.7	25.9	32.8	29.0	30.7
Total tax revenues	50.6	36.1	43.3	37.6	31.5
Outlays of government	55.9	42.1	49.5	45.1	38.2
Social transfers	17.0	12.0	16.8	14.5	11.3
Education expenditure	7.9	4.9	5.7	4.3	5.3

[a]SC = Scandanavian; E = English; C = Continental; SO = Southern;
PC = Post-Communist.
Source: Adapted from Castles and Obinger (2008), Table 2.

distinguish between clusters. The selected variables are quite general, and refer to structural and cultural conditions on the one hand, and to policies and policy outcomes on the other, and then mainly referring to the role of government (the state). Countries are in this table organized according to the Castles typology, with data adapted from Castles and Obinger (2008).

The Scandinavian countries stand out with comparatively high fertility rates and high levels of female employment, both illustrating the active role of government (politics) for equal opportunities and the reconciliation of family and work. Birth rates are particularly low in southern and post-communist (transitional) countries, where also female employment is low and indicates that welfare policies are family-based and traditional gender roles are still strong.

Table 2 also illustrates the large state sector in Scandinavian countries. Total outlays of government are higher than under any of the other clusters. Note also that tax rates are high. Other countries have lower taxes, but higher revenue from insurance. Scandinavian welfare policies are mainly financed by general taxes in combination with moderate user fees. Other welfare states are based on more or less universal insurances or on more selective arrangements, often in combination with comparatively higher user fees (Rodrigues and Schmidt 2010). And finally, the two indicators for social policy outcomes in Table 2, social transfers and education, both indicate that the level of state investments in welfare policies are higher under the Scandinavian regime than under any of the other models. The general features of each welfare state type are also played out in their long-term care systems, which we shall now turn to.

Long-Term Care Models

The distinctive characteristics of the different clusters of countries are even more evident when we limit the perspective to social services and more specifically to long-term care. Anttonen and Sipilä (1996) explored the European "social care models" empirically by comparing country levels of services for children (daycare, pre-schools) and elders (home help, institutional care). On this basis they identified two distinct, and two or three more tentative, models. One of the two distinct types was the Scandinavian model of public services, where services for both elders and children are universal and widely available, and mainly provided by local governments. The contrasting case was represented by the family care model, which is typical for Southern (Mediterranean) countries. These countries have a limited supply of social services for both elders and children, leaving these responsibilities mainly to the family. Other models were not equally distinct, but Anttonen and Sipilä also identified a British means-tested model, in which the state assumes the responsibility for services, but on a lower level than in Scandinavia, and therefore subject the services to more strict means-testing. They finally added a continental subsidiary model, represented most typically by Germany. The primary responsibility for elders is also here located in the family, but service levels are considerably higher than in southern countries, whereas the state assumes a more indirect role than in Scandinavia by

having service provision carried out primarily in the private sector on commission (and control) by the state.

Some countries do not fit squarely into these types, because they score high on child care and low on elder care or vice versa. Leitner (2003) suggests there are different varieties of familialism. Welfare policies may de-obligate families by providing services as an alternative to family care (de-familization). Policies may also, or alternatively, support and compensate families in their caring efforts (familialization). Both types of policies are present in any welfare state, but differently balanced between regimes and between sub-areas within each regime. Familialization is more often found in child care, de-familialization in elder care. Modelling therefore becomes more distinct if we consider long-term care separately. We shall then suggest that the most distinctive features of different long-term care models (or regimes) are to be found along the following dimensions: the state role, the mode of financing, the major instruments, and the eligibility criteria. On this basis we suggest four types or regimes with (1) the public service model (Scandinavia) and (2) the family care model (Mediterranean) as the two contrasting cases—the former based in state primacy, the latter based in family primacy. In-between are (3) the (state) means-tested and (4) the (family) insurance-based models, the first represented by England (and other English-speaking countries), the latter by Germany and neighbouring continental countries. The Scandinavian and English models are both tax-financed, with the state primarily responsible, but less generously (or radically) so under the English model. The Continental and Southern models are both based in family primacy, but less so (policy moderated) under the continental model. The family dominated model is so to speak the traditional order that the other models have originated from.

Table 3 illustrates the characteristic features of the different long-term care models. Norway is here representing the Scandinavian model, England the means-tested model, Germany the insurance-based model, and Spain the family care model. Post-communist countries will empirically belong to the family care model, and if so illustrating that traditional family roles have survived the state communist era. Statistics have, however, not been available for these countries.

It must be pointed out that long-term care in Scandinavia includes both younger and older clients. Older clients dominate institutional care (nursing homes), while the younger are more likely to live in assisted housing and to be served be domiciliary services. Families are, moreover, more dominant in the care for children and younger adults than in elder care. The long-term care regime is for these reasons quite differently balanced for young and old clients in Scandinavian countries. This chapter concentrates on elder care. Other countries may have other practices, and valid

comparative statistics are therefore hard to find. Readers should take these uncertainties into consideration.

This being said, table 3 summarizes the distinctive features of each model. The state assumes a primary responsibility for long-term care under the (Scandinavian) public service model, a more limited role under the other models. This is seen both in terms

Table 3: Policies and Outcomes of LTC Under Different Models, ca. 2005

LTC models	Public service	Means tested	Insurance based	Family care
Illustrative country	Norway	England	Germany	Spain
State role	Primary	Residual	Subsidiary	Subsidiary
Major instrument	Services	Mixed	Transfers	Mixed
Eligibility	Universal	Selective (means-tested)	Universal	Selective (family-tested)
LTC expenditure (% of GDP)[1]	2.3%	1.4%	1.4%	0.6%
Public LTC exp.[1]	86.0%	65.0%	70.0%	26.0%
User rates: %65+[2]				
… in institutions	5.3%	3.5%	3.8%	4.1%
… in home care	19.3%	12.6%	6.7%	4.2%
Total	24.6%	16.1%	10.5%	8.3%

[1] OECD (2005); [2] Huber et al. (2009); [3] May include younger clients/residents.

of legislation and in practices. Family legislation varies across Europe (Millar and Warman 1996; Hantrais 2004). Formal obligations are in southern countries assigned to the extended family, with the state in a subsidiary or residual role. Continental countries tend to confine responsibilities to parents and children, not to the wider family network. Northern countries have no legal obligations between adult family generations, hence the primary responsibility for long-term care rests with the state, at least in theory. In real life, families take on a large, if not a dominant, role also in

Scandinavia. England and other liberal(ist) regimes tend not to impose legal obligations for care on the family, and family relationships are in general not strictly regulated. But as the state is not very generous, the means-testing leaves more responsibility to the family and other private sector than in Scandinavia.

The family is dominant in elder care in (nearly) all countries, possibly with the exception of Scandinavia. The comparative OASIS survey found a fairly equal family-state balance for Norway, whereas the family was clearly dominant in Spain, with Germany and England in intermediate positions (Daatland and Lowenstein 2005). The SHARE study found family help to be less intense, but more frequent, in Scandinavia in comparison with continental and southern Europe (Albertini, Kohli, and Vogel 2007). Other estimates have suggested a 50-50 split in the Scandinavian case, while a 25-75 split is indicated for other developed welfare states, with even more family dominance under the family care model (Huber et al. 2009). The estimated 50-50 division between the family and the welfare state in Scandinavia refers to hands-on-care. If also other activities were included in the equation, such as emotional support, companionship, transports, and care management, the family (and other informal helpers) would probably dwarf the role of any formal care system.

While the state is criticized for being on the retreat in Scandinavia (Szebehely 2005), state responsibilities are expanding in countries like Germany and Spain (OECD 2005) - in Germany via the obligatory long-term care insurance from 1995 onwards, and more recently in Spain via a new legislation on protection under dependency. Service levels may for these reasons come to increase on the continent, and possibly decrease in Scandinavia, and if so to produce some convergence between models.

Services are the main instrument in Scandinavian long-term care policies, and provided mainly by local governments (municipalities), but monitored and financed by the state. Countries operating under the insurance and family care models are inclined to give higher priority to cash transfers (cash-for-care) in support of family care. The German long-term care insurance illustrates this, as rights may be drawn in cash or in kind. The insurance has, however, also allowed a financing of more nursing homes, but is primarily used as (cash) support for family care, which was also the original motivation. Other long-term care insurances may be provided in cash only (Austria) or in kind (as services) only (Japan). Cash transfers are also available in Scandinavia, but are provided to few, and then mainly to families of dependent children or younger disabled.

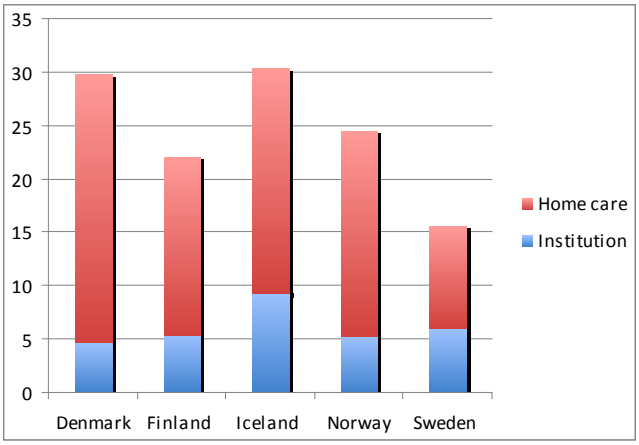
Outlays on long-term care are for these reasons high in Scandinavia, as illustrated in Table 3 by the higher expenditures in Norway (2.3 percent of GDP) than in England and Germany (1.4 percent), and lower still in Spain (0.6 percent). Outlays are even

higher in Sweden and Denmark than in Norway, but somewhat lower in Finland and Iceland. Most of these expenditures are in Scandinavia channelled through the public sector, 86 percent in the Norwegian case, compared to 65-70 percent in England and Germany, and only 26 percent in Spain.

Service levels are therefore quite high in Scandinavia; in particular as far as community (home) care is concerned, possibly because a professionalization of domiciliary care is in more obvious contrast to traditional family values than the more professionalized institutional care. The high(er) institutional care rate in Scandinavia is to some extent also a response to the household structure, with high rates of single households among elders, and few in shared households with adult children.

There is considerable variation in service levels and standards also within Scandinavia, as illustrated in Figure 1. Services are more accessible in Denmark and Iceland than in Sweden. Iceland has the largest institutional care volume, while

Figure 1. Access to Home Care and Institutional Care in Scandinavian Countries



Source: Huber et al. (2009)

Denmark gives comparatively stronger priority to community care. A few other countries are equally ambitious in terms of levels and outlays on long-term care, most notably the Netherlands, which uses an even higher share of its GDP to long-term care than the Scandinavian countries according to Huber et al. (2009). Netherlands also has a record high rate of institutional care, perhaps for historic (and idiosyncratic) reasons.

Recent Trends

Scandinavian trends over the last couple of decades identify Denmark and Sweden as contrasting cases (Daatland 1999). Denmark has maintained a stable and high access to services. Sweden has become more selective in distribution, with declining user rates, but with more resources (intensity) provided to the selected few. The lower access to services implies a push towards more family responsibility, representing a re-familizaton of care according to Johansson et al. (2003). Common to all Scandinavian countries—perhaps with the exception of Iceland—is a de-institutionalization trend, with sheltered housing and community care in expansion, whereas traditional institutions (nursing homes) are in decline relative to the 80+ population. More home-like nursing homes, and development of assisted housing as alternatives to institutional care, have blurred the earlier distinction between intra- and extra-mural care. If assisted housing had been added to the nursing home rates in Figure 1, some 8 to 12 percent of the 65+ population, and 20 to 25 percent of the 80+ population, could have been listed as residents of "special housing" (Szebehely 2005).

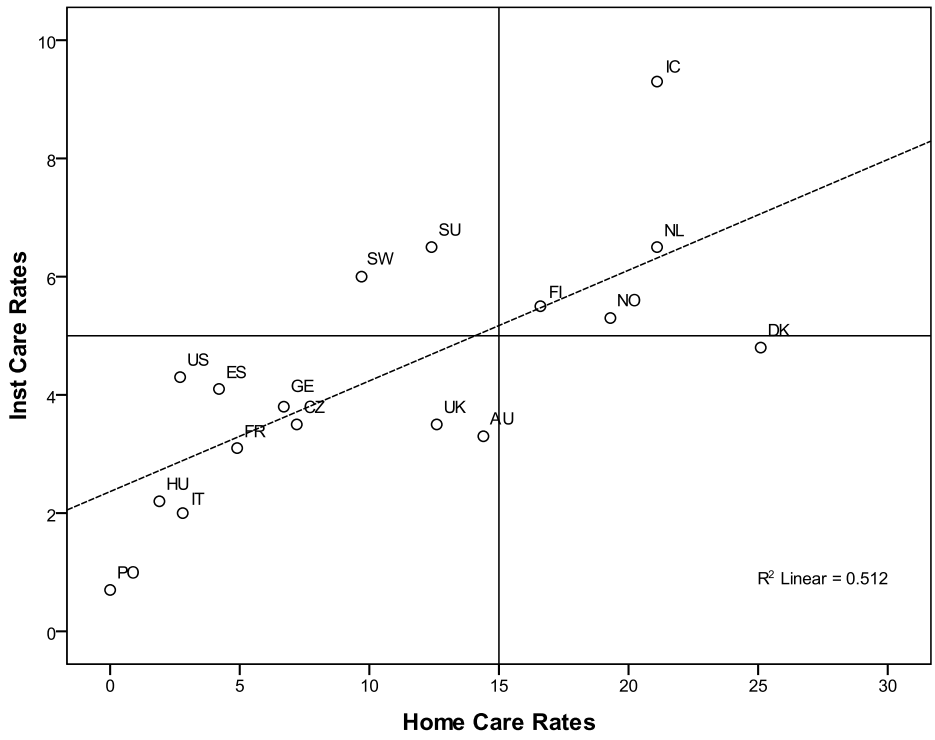
Institutions used to be the dominant form of long-term care in Scandinavia as well as in most other countries. Resources (expenditures) are today more equally split between institutions and community services, but to a varying degree within Scandinavia. Denmark has a tradition for operating a more open care regime, Norway and Iceland give higher priority to institutional care, which is now consuming around 70 percent of long-term care resources for elders in the Norwegian case. User fees (co-payment) are still moderate, and represent 2 percent of the community care costs, and around 15 percent of the costs for institutional care in Norway (in 2009), possibly even lower in other Scandinavian countries. Home help is, for example, free-on-delivery in Denmark.

Services have increasingly been contracted out to private providers, and more so under conservative than under social democratic governance. And yet, services are still mainly (80-90 percent) public. Private provision is, however, on the increase, which is another indication of a possible convergence between Scandinavian and the Continental long-term care.

Scandinavian countries are, however, yet standing out from most other European welfare states in that both institutional care and home services are quite generously provided, as well of a high standard. Nursing homes provide single rooms to (nearly) all residents, and staffing is quite high (around 1:1, one full-time staff per bed). Public opinion is yet quite critical, and then partly due to high expectations.

Levels of services are illustrated in Figure 2, where institutional care and home care rates are plotted against each other for selected countries, including the USA. Scandinavian countries, with the exception of Sweden, are located in the upper right cell of the diagram (together with the Netherlands), with high scores (levels) on both types of services. Note also the positive correlation between the volumes (user rates) of extra-mural and intra-mural care. Some countries are low on both, some are high on both, only few have a compensatory pattern, where low rates on one are compensated by high rates on the other. Note also that as the diagram lists only services, the total volume of long-term care is underestimated for countries with comparatively higher investments in cash transfers, such as Germany.

Figure 2. Access to Long-term Care by Country (percent 65+ with home care and institutional care)



Source: Huber et al. (2009)

Present Dilemmas, Future Sustainability

Having established that welfare states differ not only in their efforts, but also in the direction these efforts take, it may be pointed out that all of them have some form of

mixed responsibility between the family and the state for long-term care, with supplementary efforts also from other actors such as neighbours, friends, civil society, and the market.

Long-term care was traditionally a family responsibility throughout, and still is in many countries, but some form of public, and collective, responsibility has expanded in response to modernization. Governments first developed pensions for economic protection against income loss under illness or old age. Such autonomy between family generations was later on also guiding the development of institutions, assisted housing, and domiciliary services to support independent living. Some countries did so only reluctantly, others—and first and foremost the Scandinavian—went a long way in defining long-term care as a government responsibility in order to protect citizens' autonomy also vis-à-vis the family. The (central and local) state therefore came to share hands-on-care with the family, even to replace family care for the most needy, but normally left families to cater for social and emotional needs.

Family care yet survived, but partly in other forms. The state has not replaced families even in Scandinavia. The two have become partners in care. Long-term care has to an increasing extent become a mixed responsibility for the family *and* the welfare state, but these mixes are quite different. Family care is still dominant in elder care in most welfare states.

How adequate the different models are for an ageing population is a controversial issue, not only because welfare policies are rooted in political and ethical norms about the normal (traditional) and right (moral) thing to do, but also because countries are differently located as far as population ageing is concerned. The observed convergence in elder care (less state in Scandinavia, more state in continental Europe)—however small—may be a response to more similar problem pressures in terms of population ageing on the one hand, and family change on the other.

The between-countries variation in population ageing is quite solidly documented, even when we allow a considerable range of uncertainty the further ahead the projections are taken. There is yet sufficient knowledge about mortality, fertility, and migration to conclude that some countries are facing a far more radical population ageing than others. Germany and Spain may serve as examples. These two countries are expected to increase their 65+ populations from around 16 percent today to around 30 percent in 2040. Even more radical is the expected change for Italy and Japan, as their 65+ populations are projected to reach around 34 percent by 2040, nearly a doubling since the year 2000. The 80+ population, with the highest risk of needing care, will increase even more, and most radically so in Japan, from close to 4 percent

of the population in 2000 to 14 percent in 2040. Italy and Switzerland can also expect to reach the 10+ percent level for the 80+ population before 2040 (Table 4).

Scandinavian countries were early in the demographic transition, but future ageing will be more moderate. The 65+ population is expected to increase from around 15 to around 24 percent between 2000 and 2040 in Scandinavia, while the 80+ population will nearly double and reach around 8 percent in 2040. Ageing will therefore be substantial in Scandinavia too, but considerably lower than in continental and southern Europe, such as in France, Italy, and Switzerland, where the 80+ population

Table 4: Indicators of Population Aging for Selected Countries

Percent of population…	Age 65+		Age 80+	
Year:	2000	2040	2000	2040
Denmark	14.8	24.1	4.0	6.9
Finland	14.9	26.2	3.4	9.0
Iceland	11.7	22.6	2.8	7.1
Norway	15.2	26.3	4.3	8.6
Sweden	17.3	25.2	5.0	7.9
England	15.9	25.4	4.0	7.3
The Netherlands	13.6	25.5	3.2	7.6
France	16.1	26.6	3.7	9.1
Germany	16.4	29.7	3.7	8.7
Switzerland	15.3	33.1	4.0	11.1
Italy	18.1	33.7	4.0	10.0
Spain	16.9	30.7	3.8	8.5
Poland	12.2	24.1	2.0	7.5
Czech Republic	13.8	28.8	2.4	8.5
Hungary	15.1	25.7	2.6	7.1
USA	12.4	20.4	3.3	6.0
Japan	17.4	35.3	3.8	14.1

Source: Huber et al. (2009)

will nearly triple between 2000 and 2040. Looking beyond Europe, Japan stands out with the most rapidly ageing population, where more than 14 percent are expected to be 80+ in 2040, the double as that of the USA—a country with as yet a quite young population thanks to high fertility and in-migration.

The radical population ageing in countries like Germany, Italy, Spain, and Japan is mainly explained by their low birth rates (Gaymu et al. 2008). An additional factor is the high life expectancy in Japan and Mediterranean countries, now exceeding that of Scandinavia, which used to be world leading in terms of longevity. Scandinavia is, however, blessed with higher birth rates than these other countries, thanks to an active family and equal opportunities (gender) policy, which have made it easier to combine work and child rearing for women. Scandinavia is thus facing a slower pace of population ageing than central and southern Europe. The ironic thing is that countries in southern and eastern Europe, with the strongest and most collectivistic family culture, are the very countries where people are now most hesitant to establish new families (Esping-Andersen 1997). The more individualistic north and west of Europe, with a tradition for weaker family ties, is currently a more favourable territory for family formation.

These countries face different dilemmas. For Scandinavia the challenge is one of solidarity between age groups: Will younger workers continue to support the expensive Scandinavian welfare state and the high taxes needed to sustain it? For Continental Europe the challenge is related to family solidarity and equal opportunities: Is family care dominance feasible and reasonable when populations are ageing and women are entitled to equal opportunities?

The Scandinavian welfare states need strong(er) solidarity between age groups when populations are growing even older. The good news is that European populations, including the Scandinavian, are still very supportive to the welfare state, and to provisions for older people in particular (Taylor-Gooby 2004). Older people score high on deservingness; they so to speak embody the most honourable of clients, and attract more support in popular opinion than any other needy group, although more so for long-term care than for old age pensions (van Oorschot 2006).

Long-term care is therefore still protected in public opinion and as such in democracy, but further population ageing may add to these demands and put intergenerational solidarity at risk on both the societal and family levels. Will younger cohorts and younger family generations be able and willing to respond?

The problems are located both in demography and in the welfare state. Population ageing is general, but challenges are in fact quite different because the rate of change

varies, and so also do the already established policies. Some countries are privileged by a well-developed care system and moderate population ageing ahead. Others are in a double jam, and are squeezed between poorly developed services *and* a rapidly ageing population. Scandinavian countries are among the more fortunate, but with distinct challenges and dilemmas in the searching for sustainable solutions.

The familialist welfare states need larger and stronger families when they in fact grow smaller and weaker. Family dominance in care is therefore hardly feasible when the older generations are increasing in numbers, whereas the younger are decreasing. Italy is currently trying to fill the gap with close to one million migrant carers from post-communist countries, but the Italian solution can hardly be made into a general norm.

Interestingly, each model seems to have resonance in their populations. While family care seems to be the preferred choice in familialist welfare states, services are the preferred choice in countries where services are available and of a decent standard (Huber et al. 2009). Elders in the more northern regions of Europe try to live by the ideal of intimacy at a distance. They prefer independence for themselves, and fear becoming a burden on their families. Other ideals prevail in more familialist countries, where family care is expected, if not wanted, from both sides of the relationship (Daatland 2009). Common demographic, financial, and political realities may speak for a convergence of trends. It seems to me that the Scandinavian model is not the worse position from which to confront this eventuality.

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