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EDITORIAL

Social inequalities in ageing in the Nordic countries

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Introduction

Like most other countries in the world, the Nordic countries are in a phase of demographic change in which the number and proportion of older people are increasing markedly. This long-term trend includes a rapid growth of the population aged 85 or older, often called the oldest-old. This unique development in the history of humankind, "the longevity revolution", is in the Nordic countries as in many others, accelerated by the great post-war cohorts' entrance into higher ages. The simple fact is that old age is now longer than ever before. In all Nordic countries the number and proportion of the oldest old have increased dramatically (Jørgensen et al. 2019).

The ageing of our societies puts new focus on the inequality mechanisms inherent in our societal structures. Despite major changes in societies and living conditions, including disease panorama and medical-technological innovation, substantial inequalities continue to be profound also in the rich countries of the world today. The Nordic countries are by no means an exception, despite being so well reputed for their high equality ambitions and comprehensive universal welfare states. In fact, these countries have surprised the research community by having health inequalities of such magnitude that it has been phrased a puzzle (Bambra 2011) or a paradox (Mackenbach 2012). Inequalities continue to exist also beyond retirement ages, but our knowledge of inequalities at older ages is sparse. The few existing studies show that social inequalities in health and the risk of dying, profound forms of inequalities, exist also among older persons in the Nordic countries (e.g. Enroth et al. 2019; Rehnberg et al. 2019).

Within a larger Nordic research programme, we have over the course of seven years set out to expand our knowledge on social inequalities in ageing (the SIA project, www.sia-project.se). We have done so by conducting comparative studies both at the micro-level of individuals, and at the macro-level of welfare state institutions, in particular health care and long-term care systems. The SIA-based articles included in this special section are not a comprehensive collection of the project outputs, but rather a selection of studies on how social inequalities in ageing are spelled out in the Nordic countries. Hence, some of the articles focus on trends and risk factors in old age for different health and social outcomes, such as life expectancy and social exclusion. Others scrutinize institutional changes of social policy programmes regarding health care and long-term care, and how that in turn has bearing on health and social inequality developments. All papers have a comparative perspective and include at least two Nordic countries.

The Nordic countries—one welfare regime with different nuances and important changes over time

The Nordic countries have for decades been of key interest to welfare state research, spurred by Esping-Andersen's seminal book "The three worlds of welfare capitalism" (Esping-Andersen 1990). In the book he argued that the Nordic countries had pursued a special route in the relative importance of the triangle family-markets-state for the provision of welfare, with Sweden being the archetype of that specific welfare regime. Since then, many articles and books on the Nordic welfare states have noted important changes but concluded that the Nordic countries still share many characteristics and are relatively distinct from most

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other rich Western countries (Kvist et al. 2012; Kangas and Kvist 2019; Kautto and Kuitto 2021).

So how can the Nordic model of welfare be characterized? Kildal and Kuhnle (2005) identify three fundamental features: comprehensive, institutionalised and universalistic. Of these, the idea of universalism is perhaps the most fundamental – that the social policy programmes of the welfare state should be for all, and not only targeted to the poor. To achieve this, a fundamental objective is that programmes should be of high quality to also attract the more well-off. There are of course many more chief characteristics of the Nordic approach to welfare and the ambitions therein. To mention a few: high level of gender equality, low levels of income inequality and poverty, high public expenditure and a broad range and scope of social services, relatively generous benefit systems and the important role of taxation for funding. Compared with other European countries, the Nordic countries indeed have much higher coverage and public expenditure for long-term care towards older persons (European Commission 2021a). Notable is also the importance of individual rights and duties. For example, there is no legal obligation for adult children to support their parents in old age, and individual, as opposed to joint, taxation is another feature of the Nordic model.

From a late-life perspective one can note that historically the Nordic countries have been successful in combatting old-age social exclusion and poverty (Kangas and Palme 2000; Fritzell et al. 2012). This is of relevance for the social phenomenon and individual experience of loneliness. The issue of multidimensional social exclusion as a predictor of loneliness among older persons is scrutinized in this special section by Dahlberg et al. (in press). While findings indicate that the Nordic countries have relatively low levels of loneliness, their study indicates a clear association between social exclusion and loneliness.

In general, when viewing the Nordic countries from the outside, they may look the same. While many similarities exist between the countries, Nordic researchers have also highlighted important differences between them and with consequences for the dynamics of social inequality, for example differences in terms of out-of-pocket payments within health care and long-term care system are discussed by Tynkkynen et al. in this special section (Tynkkynen et al. in press), and the authors note the much higher out-of-pocket payment in Finland.

Many changes of the last two or three decades have cast doubts on the extent to which the uniqueness of the Nordic model remains. With some variations between the countries, we find growing income inequalities, less generous benefit systems, and higher importance of private for-profit actors within health and social care. The latter is highlighted in the paper by Rostgaard et al. in this issue (Rostgaard et al. in press). Importantly, convergence between the Nordic countries and other European countries also appear because of changes in which other European countries take an interest and sometimes adopt policies resembling the Nordic countries (Kangas and Kvist 2019).

Health care and long-term care in the Nordic countries

The Nordic countries are to a large degree social services states, relying not only on social protection in terms of redistributing income, but even more so on care services for children and older persons (Anttonen and Sipilä 1996). As the number and proportion of older persons increase, the question of long-term care is now increasingly part of the agenda of social protection, in this region and elsewhere. At the EU level, this is perhaps most evident in the proclamation of the European Pillar of Social Rights which included long-term care among its 20 principles: "Everyone has the right to affordable long-term care services of good quality" (European Commission 2021b). Generally, long-term care can take many forms and may be provided by the state, market, volunteers, or family members. With the reference to a long-term care *system*, we refer to the organised policy and practice effort to provide care for older people at home, in the community and in residential care.

From a European perspective, it may seem that the Nordics are forerunners and have achieved the goals set out by the EU Pillars of Social Right (European Commission 2021b). In a comparative perspective, the Nordics stand out in having comprehensive health care and long-term care systems in place, with characteristic features that distinguishes them from other countries. This includes public dominance in the organisation, funding, and to a lesser degree today, provision of care. Characterising this region is also the emphasis on having generous, affordable, and attractive care services (Vabø and Szebehely 2018). As is the case for other countries, also in the Nordic countries informal carers are the main providers of care for frail older people living at home. However, when more substantial care is needed, it is common to receive formal and publicly provided care. Help and support by family often remain important in such situations, if a family member is available. Services are mainly tax-financed and, in comparison to many other countries, more often provided by trained staff (OECD 2020). A common driver behind the development of these characteristics is the quest for equality across social class and gender, both in assessment procedures as well as in equity outcomes. As an example, in the article by Liljas et al. in this special section, the authors find that health care professionals place great emphasis on equal treatment in the hospital discharge process and aim to let the health situation steer the

post-hospital care to the highest degree possible (Liljas et al. in press).

The Nordic approach to health care and long-term care is also known for the broad public support for an encompassing welfare state. As the American welfare theorist Robert Cox has said, and here speaking more narrowly about the Scandinavian countries, "the core values of the Scandinavian model are not only important to the scholars who observe the model, but they are widely shared by the citizens of Scandinavian countries and constitute an important component of national identity in those countries" (Cox 2004: 207). Indicated by the relatively high share of gross domestic product devoted to the long-term care sector, the general public thus both identifies with and believes in the continuation of this encompassing welfare state, even in times of financial crisis. As an example, long-term care has traditionally been the top priority among voters in local elections in Denmark, when compared to other public services. The Nordic countries have thus been able to develop and implement wide-reaching and encompassing care policies for frail older people in need of care and their families. Traditionally, the Nordic countries have accordingly been labelled 'caring states' (Leira 1992) and their particular model of welfare has been named 'the public service model' (Anttonen and Sipilä 1996).

Often, the chief characteristics of the Nordic welfare states are understood as fixed and permanent components. However, with the need for adapting to ageing societies, also the Nordics have seen comprehensive reforms, and with various consequences for inequality among older people. Both the health care and long-term care systems have been subjected to New Public Management (NPM) reforms (Szebehely and Meagher 2018), which has introduced new steering and incentive structures and has changed the role of professionals, patients, and service users. It has also meant the entry of private for-public providers. As is highlighted in the article by Rostgaard et al. in this special section (Rostgaard et al. in press), the former public dominance in provision of long-term care has changed, as private for-profit providers and to some degree non-profit voluntary providers have taken over within the last decades. Combined with increasing retrenchment and prioritization of long-term care provision for the frailest, this has amplified inequalities across gender and social class.

The NPM reforms have also led to free choice of provider in both health care and long-term care. This has introduced the notion of the active consumer as co-producer of welfare, with the power to exit and therefore participate in the development of better quality of care. However, as argued in the article by Erlandsson et al. in this special section (Erlandsson et al. in press), the implementation of choice models in the Nordic long-term care systems has raised concerns about increased inequalities among older persons, since skills and resources required for making informed choices are not equally distributed. They find that older adults have different resources and abilities to overcome difficulties raised by design flaws in choice models which raises new barriers for groups, who were already disadvantaged.

The contributions in this special section point to increasing differences in the reform paths taken by the Nordic countries. In a case study of Finnish and Swedish health care systems, Tynkkynen et al. (in press) find that recent health care reforms sought to strengthen primary care, care integration and coordination as well as health care system resourcing and capacity. The two countries share the same overall policy goals but the implementation of (at times different) measures has undermined the actual policy aims. Especially in Finland, there is a problem of affordability for older people with multiple care needs.

Ageing population and the oldest old

Quality of life of the oldest segment of the population poses a special challenge to the ageing welfare societies. In the Nordic countries, a clear majority of persons aged 85 years and older live at home, most of them alone, and many of them even without any formal services. Multimorbidity is common (Halonen et al. 2019), as the frequency of most major chronic conditions, dementia in particular, increase steeply towards very old age. Recent studies imply that functional ability of the oldest old may be improving, but a majority still need help at least with household tasks or outdoor mobility. Even in the age group of 90+, every added year of age increases the likelihood of functional problems (Raitanen et al. 2020). The good news is that longer lives seem to entail more years in reasonably good health. The more challenging news is that the longer we live, the more help and care is needed in the last years of life. This should not be understood as a failure of our health promotion activities or health care, but simply a trade-off situation between longer lives and unavoidable biological ageing. Some findings imply compression of morbidity at very old age, meaning that the months and the proportion of life expectancy lived with disability has shortened (Enroth et al. 2020). Yet, the fact that more and more people live up to very old age means that the absolute number of individuals with disability and in need for services is rapidly growing. This development challenges the policy of ageing-in-place, commonly adopted in the Nordic countries. While living at home, supported by home care when needed, is the commonly accepted priority, the declining coverage of residential services even among very old people suffering from dementia (Aaltonen et al. 2019) is increasingly identified as a problem.

Social inequalities among the oldest old are not an easy topic for research. Overall, there are not too many representative population-based studies in this age group as those

who live in residential care are hard to reach. Individuals with cognitive problems are not always able to give informed consent, and other health problems may prevent face-to-face data collection. In this respect, the Nordic countries have many advantages. Exhaustive population registers help identify individuals in all age groups, dates of birth and deaths, and mainly, also information on use of health care and social services is available. In addition, acceptance of research in the population has been high, and to a large extent, old people and their families have been willing to participate. This helps to minimise a common problem in studies of the oldest old, namely that findings are biased towards the healthiest part of the population or concentrate solely on institutionalized people. These favourable conditions have contributed to the success of several high quality and longitudinal population studies on health and functioning of the oldest-old people in the Nordic countries, such as the SWEOLD study (Lennartsson et al. 2014), the Vitality 90+ Study (Enroth et al. 2021) and the Danish Birth Cohort Studies (Rasmussen et al. 2017), among others. Research on older people is also highly enhanced in the Nordic countries by the possibilities to link data from registers with survey data.

It is easy to believe that social inequalities in health, well-known in younger population groups, would be less prominent among the oldest old. Perhaps long life and high age equalize the situation through life-long selective mortality, overall high morbidity, and disability, and at least in theory, the universal care system. This, however, seems not to be the case. Recent studies demonstrate that social inequalities in mortality, health, and functioning are maintained also among the oldest-old: higher occupational class during working life and higher education mean more additional years, less multimorbidity, better functioning, and better self-rated health even at the age of 90 years or older (Enroth et al. 2021; Enroth and Fors 2021). Also, analyses in Finland and Sweden imply that improved functioning and self-rated health of the oldest-old during past decades were largely driven by the positive development in the higher social classes only, and the relative inequalities tended to increase (Enroth and Fors 2021). In this issue, Enroth et al. (in press) show that the increase in remaining life expectancy is apparent even at the age of 90 in four Nordic countries, life expectancy is associated with the level of education, and those with higher education had also gained more added years between 2001 and 2015.

The oldest-old are the group in the population that is most dependent on care services. Therefore, they are also most vulnerable to the recent changes in the Nordic care policies and practices. As the traditional Nordic universal and publicly provided care system diversifies, it requires more choices from the care recipient, demands more involvement from family members, decreases the overall care availability and at least in some countries encourages more out-of-pocket paid services. Consequently, the impact on the oldest-old is likely to be significant.

The articles presented in this special section do not primarily concern COVID-19. Still, it is obvious that the pandemic has made many of the societal changes and challenges ahead more visible, such as the ageing of our population and the profound social inequalities. Given that the pandemic in terms of number of deaths hit particularly older people, and the fact that many actions taken by authorities lead to an accentuated risk of social exclusion for older people, discussions on the design of our health care and long-term care systems came to the forefront. Not least regarding the quality and provision of care for older people which is a key focus of attention in this special section. The issue of socioeconomic inequalities was also highlighted by the pandemic, since well-known pre-existing inequalities became intertwined with COVID-19 inequalities to a large extent (Bambra et al. 2020). Therefore, we believe that the discussions and conclusions of these articles, that in a multitude of ways explore social inequalities in ageing, have bearing also on the post-COVID era. These societal challenges are by no means exclusive to the Nordic countries. Instead ageing populations and inequalities are world-wide phenomena and hopefully the collection of articles presented here can shed light on important aspects of ageing and social inequalities relevant also to this larger scene.

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