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article

Consequences of prioritisation within long-term care in Denmark, England and Norway: towards increasing inequalities and poorer quality of care?

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Prioritisation concerns choosing something before something else, and in a welfare state context, this is about decisions on distribution, redistribution and rationing. This article investigates consequences of prioritisation within long-term care in Denmark, England and Norway. Analysing interviews with policy actors and policy documents, we find that prioritising home care, combined with increasing targeting of help and restricting institutionalised care towards those with the most severe needs, may reduce both service quality and equality for those not being prioritised. Moreover, monitoring and central control of service provision restrict individual discretion of care workers, with implications for service quality.

Key words inequality • long-term care • prioritising dilemmas • social care

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Introduction[1]

Prioritisation concerns choosing something before something else, and in an overall welfare state context, this is about decisions on distribution, redistribution and rationing (Sabik and Lie, 2008; Førland, 2018: 95). Issues of prioritisation range from the assessment of needs at the individual level to the overall allocation of resources to the long-term care (LTC) sector, compared to other societal sectors. At the intermediate level, prioritisation in the Norwegian case concerns how municipalities and local councils must balance budget limits, tensions resulting from the needs of different user groups, and basic welfare state values such as universalism, equality and justice. How resources are allocated to home care and institutionalised care, and between older and

younger care recipients, constitutes an important example of prioritisation. In each case, there are implications for (in)equality of access and quality of care.

Population ageing challenges the sustainability of developed welfare states (Österle and Rothgang, 2010). With population ageing comes an increase in needs, while municipal resources remain limited yet subject to political choices, making prioritisation crucial for policymakers, as well as for welfare state research. Our investigation includes an example of the liberal welfare state model and two countries belonging to the Nordic welfare model (Esping-Andersen, 1990). An analysis of consequences of prioritisation in Denmark, Norway and England is thus relevant beyond the three countries as it relates to different care models. Including two Nordic countries also allows us to investigate more closely how prioritisation takes place in countries that, according to established theory, are the most generous welfare states.

We discuss how policy trends and priorities affect inequalities of care provision for older people in the three countries. Specifically, we interview key stakeholders to discuss our research questions: what characterises problem descriptions and LTC policy development in Denmark, England and Norway? Which prioritising dilemmas arise in tandem with these changes? How do these trends and prioritising dilemmas impact on inequalities in terms of access and quality of care?

The article presents new empirical findings by investigating consequences of prioritisation within LTC. A widespread concern expressed by interviewees in our study is that giving priority to home care, combined with increased targeting of help and restricting institutionalised care to those with the most severe needs, may reduce both service quality and equality for those not prioritised. Interviewees' emphasis on how monitoring and central control of service provision is in opposition to the individual discretion of care workers, again with implications for service quality, constitutes a further important finding. This is important knowledge for the public officials deciding on and implementing prioritisation. Moreover, analysis of national policies and provisions is important for professionals, care and caring because prioritisation decides the scope for practising care.

Theory, method and data

Care regimes and policy ideas

We rely on the Organisation for Economic Co-operation and Development's (OECD, 2017a) understanding of LTC: 'As people get older, it becomes more likely that they will need day-to-day help with activities such as washing and dressing or help with household activities such as cleaning and cooking. This type of support (along with some types of medical care) is what is called long-term care.' We depart from the care regime literature by emphasising how responsibility for care has shifted historically and developed into distinct types of care provision (Timonen, 2005; Österle and Rothgang, 2010). Important for our focus is that these care regimes reflect prioritisation at a general level and have distributive outcomes for both users and providers of care, reducing or enhancing pre-existing inequalities of both care resources and care strains. For instance, the extent of public provision in terms of access and quality of services has large consequences for pressure on family care, the labour market participation and gendered aspects of this, and hence inequality. Thus, welfare mixes within LTC, in terms of financing of provision, are dimensions of care models that affect inequality.

The countries chosen for analysis are from two contrasting types of regime (Esping-Andersen, 1990). Public responsibility for financing and provision is distinctly lower in England than in Norway and Denmark (Timonen, 2005; Vabø and Szebehely, 2012). However, although Denmark and Norway are both Nordic welfare states, they differ in some respects. Norway provides substantially more institutionalised care than Denmark. Denmark has developed more extensive home care services. Furthermore, private service provision is more common in Denmark. Selecting these three countries allows us to investigate how prioritising dilemmas impact on (in)equality when the level of public responsibility differs, as it does between Scandinavian and liberal welfare states, and – equally interesting – what such prioritisation may lead to in welfare states usually considered to be very similar, as with Denmark and Norway.

Table 1 summarises characteristics of our country sample. It should be noted that providing comparable data and measuring social protection for LTC are inherently complex (Gori et al, 2016a).

The public effort as regards LTC is highest in the two Scandinavian countries. We also see that coverage is higher in Denmark and Norway than in England. However, looking at the intensity of care, as measured by number of hours per week of home care for those aged 65+, we see that England has the highest intensity. This reflects a situation of much more extreme targeting of help in England. Given the labour-intensive character of LTC services, employment in health and social work as a share of total employment provides a rough indicator of their quality. This reveals distinct differences between Norway at one end and the UK at the other. Finally, the indicator on development in coverage between residential care and home care shows that coverage is decreasing in all three countries. Table 1 provides some indicators for public provision but not total effort within LTC. Needs not met by the public sector must either be met by family care, the voluntary sector or private purchase, or else remain uncovered. However, to our knowledge, there are no comparable data on this.

In responding to the pressures of ageing, policy actors need to find solutions that are both sound (cognitively) and fair (normatively) in order to build a coherent public discourse on LTC that can forge consensus among policy elites and convince the public of its merits. Hence, a policy ideas perspective, emphasising the importance of ideas and discourse in defending and challenging institutional solutions, informs our analysis (Schmidt, 2002, 2011; Béland, 2005; Taylor-Gooby, 2005). Policy ideas provide problem descriptions and policy solutions with adhering normative evaluations that are indispensable tools for policy actors engaged in political struggles and consensus building within LTC. To detect such policy ideas, we approached key policy actors. In the following, we focus on what these actors identify as the most important trends and prioritising dilemmas with implications for inequality and quality of care.

Interviews and supplementary document analysis

Our research relies mainly on qualitative interviews, supplemented by documentary analysis. We selected interviews as a suitable method to scrutinise different actors' problem descriptions, and how these interweave with the presentation of policy solutions, accentuating some particular aspects of the 'problem' that go with emphasising specific policy solutions. Hence, this serves to illustrate the active use of discursive framing of problems and solutions, where actors use ideas to challenge, change or preserve institutions (see Béland, 2005; Rostgaard, 2014). A limitation

Table 1: Care regimes in Denmark (DK), Norway (N) and England (E) (UK when not available for E alone), 2015

Dimensions/countries	DK Statist paradigm		N Statist paradigm		E (UK) Familialist/individualist paradigm	
Public spending on LTC (% of GDP), 2015[a]	2.5%		2.5%		1.5%	
Coverage LTC recipients 65+[b]	15.2%		14.6%		4.9%	
Coverage home care: LTC recipients 65+[b]	11.3%		7.3%		3.0%	
Coverage residential care: LTC recipients 65+[b]	3.9%		7.3%		1.9%	
Average weekly number of hours per recipient 65+ of home care: (DK, N) or household (E)[c]	4 (2010)		5.02 (2017)		12.4 (E, 2008)	
Employment in health and social work as a share of total employment (2015 or nearest year)[a]	17.4%		20.4%		12.4% (UK)	
Practising nurses per 1,000 population (2015 or nearest year)[a]	16.7		17.3		7.9 (UK)	
LTC workers per 100 people aged 65+ (2015 or nearest year)[a]	8		13		–	
Funding[d]	Public funding: general taxation, modest user charges (4% in 2013)		Public funding: general taxation, modest user charges (15% in 2013)		Taxation and substantial user charges – means testing	
Percentage of age group 65+ living in institutions or in service housing (residential care) and people receiving home help for the time period c. 2000–15						
Year	2007	2014/15	2000	2014/15	Early 2000	Early 2010
Residential care	c.5.2	c.4.1	c.12.0	c. 7.4	2.6	1.9
Home care	c.16.7	c. 11.9	c. 15.6	c. 8.2	3.9	3.0

Notes: GDP = gross domestic product. [a] Data from Tables 8.1, 8.12, 11.19 in OECD (2017b: 215, 213, 149, 159, 211). [b] Data for Denmark and Norway for 2016 from Tables 6.2.13 and 6.2.14 in NOSOSCO (2017: 169–70). Data for England for 2008 and 2013 (residential) from Table 5.2 in Gori et al (2016a: 81). For England, it should be noted that the cash allowances of Disability Living Allowance and Attendance Allowance have higher coverage, at 23.5 per cent in early 2010. [c] Data for Denmark from Burau and Dahl (2013: 90). Figure includes home help only. Danish authors' calculations based on information adopted from Danmarks Statistik. Data for Norway from own calculations based on Statistics Norway (2018). Age group is 67+. Includes time for direct provision of home care, including practical assistance (home help) and home nursing care. [d] Data from NOSOSCO (2015: 164). [e] Data for Norway and Denmark from Figure 6.2.7 in NOSOSCO (2017: 166). Data for England from Table 5.2 in Gori et al (2016a: 81).

of our approach is that extension of the empirical material is restricted, reflecting limited available resources. This meant that the number of interviews and coverage of documents had to be constrained and focused. Moreover, recruitment of interviewees was particularly time-consuming for certain groups and countries. Thus, although we include representatives of four different stakeholder groups, our selection cannot be considered fully representative. For instance, a wider group of political parties could be covered, as well as representatives from other workers and professions within LTC (such as nurses' organisations). Our document analysis supplements, but cannot fully remedy, the aforementioned limitations.

First, we analyse interviews conducted in 2018 with key policy actors within the LTC sector of the three countries. Second, we scrutinise selected policy documents, including Green and White Papers, and policy papers. We thus aim to cover the policy positions of key stakeholders to describe the political LTC discourse. Our main emphasis is on the views expressed by our interviewees.

We conducted 15 telephone interviews aiming to bring out some of the institutional voices in the eldercare discourse, and their policy ideas, encompassing problem descriptions, trends, issues of prioritisation, consequences for inequality and implications for the overall edifice of the welfare state. We approached four policy groups: *party-political actors*, covering one representative for a party within government, as well as one party representing the opposition; *users of LTC* (interest organisations for older people or other organisations with a mandate relevant to users of care services); *representatives of LTC workers* (trade unions covering a large group of LTC workers); and *representatives at the local level*, that is, organisations for the municipalities in Denmark and Norway, and the local councils in England. We have benefitted from consultations with national experts in the UK, Denmark and Norway in the identification of our choice of key actors and the design and translation of questions.

Interviews lasted on average about 30 minutes. They were conducted in a two-stage process: interview questions were sent to the respondent, including two questions formulated as multiple-choice regarding potential trends in LTC and possible dilemmas of prioritisation, though with possibilities for adding comments. Development of the lists of trends and prioritisation dilemmas were the result of discussion within the project group and national experts, as well as recurrent topics identified in the research literature. We asked respondents to send responses to these two questions before the interview took place. During the interview, the respondent had the opportunity to clarify, or elaborate on, issues regarding the multiple-choice part.

The main section of the interview guide contained open-ended questions about key challenges, policy measures to address these and how to mobilise needed resources. Moreover, we asked interviewees to consider the extent to which LTC policy was seen as a consensual or conflicting policy field, and to name areas of specific contention and consensus. Finally, they were asked to reflect on possible consequences of prioritising dilemmas in terms of inequality and care quality. Combining open-ended and closed questions, and sending these beforehand, was a way of engaging and preparing the interviewees with the research topics to be elaborated upon in the subsequent interview.

Both researchers took notes during the interviews, and all interviews were audio-taped, allowing us to focus on our questions (Kvale and Brinkmann, 2009). One researcher wrote a draft summary based on the notes and consulting the audiotape when needed. The other researcher then read and quality assured the summary.

Table 2: Overview of interviews

Interview no.	Organisation and country (E, N, DK)	Policy group representative
1	Pasient- og brukerombudet (POBO) (Health and Social Services Ombudsman) ombudsman organisation for users of health and care services, N	User organisation
2	Fagforbundet (Norwegian Union of Municipal and General Employees), N	Trade union
3	Enhedslisten (The Red–Green Alliance), DK	Political party, opposition
4	Unison, E	Trade union
5	Høyre (Conservatives), N	Political party, government coalition
6	Fag og Arbejde (FOA), DK	Trade union
7	Ældresagen (DaneAge Association), DK	User organisation
8	Arbeiderpartiet (Labour), N	Political party, opposition
9	Labour, E	Political party, opposition
10	Dansk Folkeparti (DPP) (Danish People's Party), DK	Political party (non-governing, support party in Parliament)
11	Kommunernes Landsforening (Association of Danish Municipalities), DK	Local government level
12	Local Government Association (LGA), E	Local government level
13	Age UK, E	User organisation
14	Kommunesektorens organisasjon (KS) (Organisation for the Municipal Sector), N	Local government level
15	LGA Conservatives Group, E	Political party

Analysis of the interview summaries was structured by the dimensions provided in the interview guide, with particular emphasis on interviewee experiences and views on policy trends and prioritising dilemmas within LTC. In a second round, both researchers discussed and agreed on important findings from the interviews and identified relevant quotes reflecting these experiences. Table 2 provides an overview of the interviews.

Results

Trends in LTC

An overall prioritising dilemma is how comprehensive public responsibility should be within LTC. This topic is important in all three countries, with funding of social care especially important in England. When we asked interviewees to consider the main challenges within LTC services for older people, there was relative agreement on these. Interviewees saw demographic changes, in terms of increasing old age dependency ratios, as a key factor, involving several aspects. These include questions of: financing; wage and working conditions; recruitment; and adjusting the number of hands to accommodate increasing need (I1, I15).[2] These are factors identified and well known from the literature (Colombo et al, 2011; León, 2014; Gori et al, 2016b,

Table 3: Trends in LTC

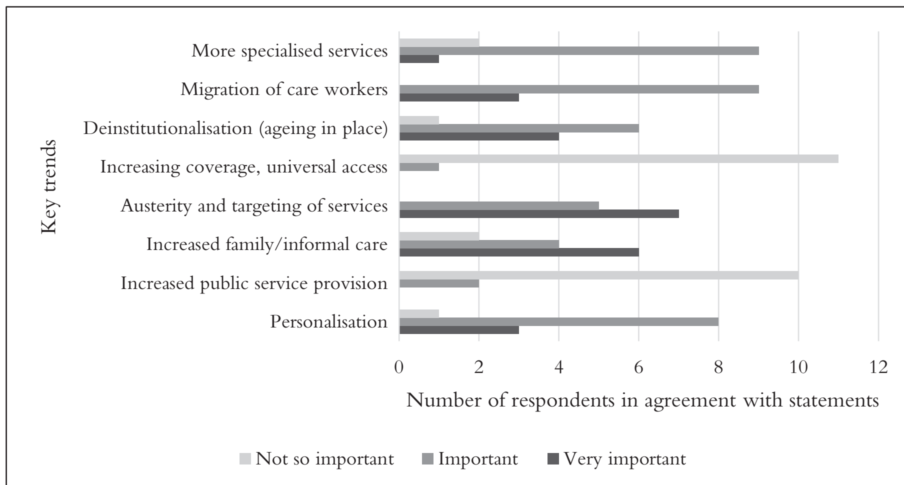
Trends	Very important	Important	Not so important
Integrated care/coordination of care (collaboration within and between the cure and care sectors to enhance quality of care and quality of life)	6	5	2
Personalisation (user involvement and control, flexibility, freedom of choice, cash for care)	3	9	1
Marketisation (increase of privately purchased services – for-profit or non-profit – and use of contracting-out mechanisms)	3	7	3
Increased public service provision	0	2	11
Increased for-profit service provision	3	6	4
Increased non-profit (voluntary sector) service provision	1	5	7
Increased participation of family/informal care economy	6	4	3
Investing in welfare technology and preventive care	5	6	2
Austerity and targeting of services	7	5	0
Increasing coverage, universal access to LTC	0	2	11
Deinstitutionalisation (ageing in place)	4	6	1
Migration of care workers	3	9	0
More specialised services (work teams) directed towards special user groups/diagnoses (for example, dementia, palliative care)	1	9	2

Greve, 2017). However, although actors begin from the general problem of population ageing and increasing dependency ratios, there are important nuances between actors emphasising lack of welfare sustainability and the need to prolong working life (I5, I8), and actors on the other side seeing austerity as the problem and growth in the public sector as the solution (I3).

In a next step, we asked interviewees to designate the importance of key trends in eldercare. Interviewees were asked to consider 13 possible trends and given the opportunity to suggest alternative trends.[3] Table 3 provides the distribution of answers, based on 13 of 15 interviews, for each of the given trends. Two interviewees misunderstood or declined to answer the multi-choice part of the interview guide. This also applies to Table 4. The remaining 13 informants completed the scheme wholly or partly, so the number of answers varies for different items. Due to this, comparing answers across countries is less meaningful for some instances of trends and dilemmas.

Figure 1 sums up the main findings from our questions on trends, displaying several interesting patterns. We comment upon some major topics. We see, for instance, that personalisation (9 important; 3 very important) and developments of more specialised services (9 important; 1 very important) are important trends, as well as migration of care workers (9 important; 3 very important). On the other hand, there is a clear trend towards less public service production, and no increase in coverage and universal access. We also notice that respondents see austerity and targeting of services as an important

Figure 1: Key trends in elderly care



(5) or very important (7) trend. Moreover (not shown Figure 1), ten interviewees saw marketisation as important (3) or very important (7). Six interviewees considered deinstitutionalisation important but only four considered this a very important trend.

Do we see differences between the three countries in terms of trends? In the multiple-choice part, most English interviewees singled out integration and personalisation, along with austerity and targeting, as very important (3) or important (1) trends. The unimportance of increasing coverage and universal access was unanimous (4). Danish interviewees also displayed shared outlooks on the low importance of increasing coverage and universal access, as well as increasing public services. In contrast to England, they indicated less importance of non-profit voluntary sector provision; all five English interviewees ticked 'not so important' for this trend. Different from both England and Norway, investment in welfare technology and preventive care was seen as a very important (3) or important (2) trend. For Norway, we identified agreement on personalisation as important (4) and more specialised services as important (3) or very important (1) trends. Finally, there was agreement on seeing increased public provision as not so important (3) and austerity and targeting as very important (2) or important (1).

The foregoing indicates the importance of austerity and constrained public provision as a crosscutting trend, though we should stress that the severity and consequences varied between countries. The emphasis on austerity and lack of public funding was most outspoken in England, and less so for Denmark and Norway, as conveyed in both the interviews and supplementary documents (Hjemmehjælpskommissionen, 2013; HCCLGC, 2017; Meld. St. 15, 2017/18).

Furthermore, the emphasis in England on integration as an important trend points to the challenges of linking National Health Service (NHS) and social care services in a coherent way. The strong trend towards investment in welfare technology and preventive care in Denmark fits well with the country's position as a leader in welfare technology development among Nordic countries and as a forerunner, with Sweden, in preventive care innovations (Nordens Välfärdscenter, 2010; Rostgaard, 2011: 197). In the next section, we connect some of these trends to potential prioritising dilemmas within LTC, as set out by our interviewees.

Table 4: Prioritising dilemmas

Prioritising dilemmas	Very important	Important	Not so important
Home care versus institutionalised care	7	3	1
Personal (human) care versus welfare technology	2	4	6
Younger (under 67 years) versus older users	0	4	8
Prioritisation between different user groups, for example, dementia versus groups with functional impairments	0	4	7
Active and preventive (reablement, rehabilitation) versus passive (compensatory, non-rehabilitation) care	4	3	5
National standardisation versus local autonomy	4	5	4
Equality of access versus freedom of choice	2	5	2
Monitoring and central control with service provision versus individual discretion of care workers	4	5	2

Prioritising dilemmas

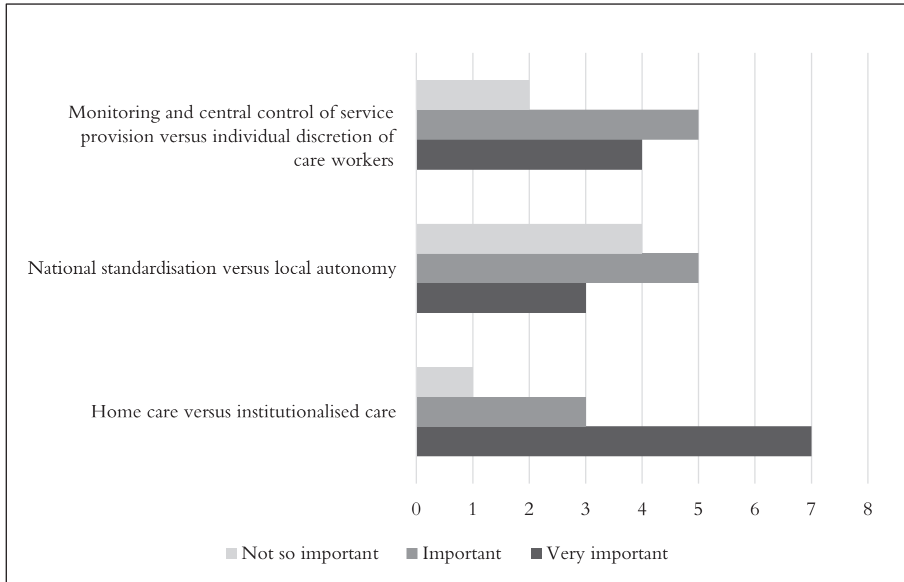
Confronted with eight possible prioritising dilemmas, interviewees answered as displayed in Table 4. As before, interviewees had the opportunity to suggest alternative prioritising dilemmas but no one chose to do so.

While Table 4 summarises and presents overall responses, we here also comment upon differences between countries. Concerning prioritising dilemmas, the dilemma on homecare versus institutionalised care is most pressing in England and Norway, where it is considered to be very important (3) or important (1, in England). This may be because the transformation towards home care has been implemented in Denmark to a larger extent than in the other two countries (see Table 1). For the dilemma of monitoring and central control of service provision versus individual discretion of care workers, differences between countries were minor, though with the strongest emphasis on this in Denmark (2 very important; 2 important) and less so in England (1 very important; 1 important). Moreover, national standardisation versus local autonomy was emphasised somewhat more strongly in Denmark (2 very important; 2 important) and Norway (3 important; 1 very important) than in England (2 not so important; 1 important; 1 very important).

Three prioritising dilemmas identified by the LTC actors interviewed deserve attention as they are considered to have particular importance (see Figure 2). Although the feedback on possible prioritisation dilemmas does not give a uniform picture across countries and actors, these three dilemmas have particular relevance for the question of increasing inequalities. Of the three, we consider the first two as especially important across the countries.

First, respondents in all three countries identify a dilemma between home care and institutionalised care. Increasing home care and reducing institutional care (deinstitutionalisation) is the most common LTC reform in Europe (Ranci and Pavolini, 2015: 281). It is thus not surprising that interviewees are preoccupied with challenges arising from this trend. We consider this a major dilemma identified in our study. Some Norwegian interviewees stressed the particular situation of some

Figure 2: Key prioritising dilemmas



municipalities that are sparsely populated and have long travelling distances for care workers, where institutional care could be a better option than the current trend towards deinstitutionalisation (I1, I14). However, informants were worried not only about older people receiving less comprehensive care at home when their needs are more in line with the continuous presence of staff available in institutional care, but also that the services offered as home care have been reduced. The Danish Home Help Commission (Hjemmehjælpskommissionen, 2013: 39) reports statistics that partly support this claim (see also Rostgaard, 2014). This commission was appointed by Denmark's Parliament, with a mandate to describe challenges in home care and recommend how to make better use of resources. According to its report, the number of recipients of practical help and the time allocated to these recipients have decreased, while the number of recipients of care has increased somewhat. The commission identifies the emphasis on reablement as one possible explanation.

In Norway, a White Paper (Meld. St. 29, 2012/13: 33) identifies similar trends of deinstitutionalisation and increases in healthcare rather than practical help. This report also states that some will have the opportunity to buy extra services and adjust their housing situation to their needs, and calls for a good balance between individual and public responsibility (Meld. St. 29, 2012/13: 80).

In England, we find similar discussions in a report on adult social care (HCCLGC, 2017). The committee provides evidence of how funding constraints have directed care and support to fewer people, concentrating it on those with higher needs. The number of people receiving local authority-funded social care fell by nearly 300,000 between 2009/10 and 2013/14 (HCCLGC, 2017: 13). This focusing on and prioritisation of those with a higher level of needs is also associated with a deterioration in the quality of care, catering for only minimum requirements and a lack of attention to preventive services (HCCLGC, 2017: 4, 12–23). The written evidence of the Association of Directors of Adult Social Services (ADASS) submitted

to the Communities and local Government Committee (CLGC) speaks directly to the issue of investing in preventive care:

> Directors see increased prevention and the integration of health and social care as the two most important ways in which savings could be made over the next three years. But, as budgets reduce further in real terms, it is becoming harder and harder for councils to manage the tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs. As a result of this tension, this year councils will be spending 4% less on prevention than last year. (ADASS, 2016: 5)

Taken together, our study suggests that the level of institutionalised care is insufficient in Denmark, Norway and England. Moreover, while priority has been given to home care over institutionalised care in all three countries, our study also suggests that the level of home care services is insufficient.

Second, many interviewees are concerned with the dilemma of the monitoring and central control of service provision versus individual discretion of care workers. As might be expected, representatives of LTC workers consider this important; however, they are not the only actors stressing this. Interestingly, the Danish Home Help Commission's 14th recommendation reads: 'The commission recommends that municipalities reduce the detailed control of time and individual services, with the aim of ensuring more flexibility and room for professionalism in the interplay between citizen and worker' (Hjemmehjælpskommissionen, 2013: 20, authors' translation).

One aspect of this is the declining morale of workers, who have to make decisions based not on professional goals, but on limits (for instance, time limits) set by local authorities, which change the care relationship from relation-building to rapid, task-based support, resulting in a poor experience of care for older users (I13). The English informant with this concern also noted underfunding as a major problem, leading to a growth in the number of people with 'unmet care needs'. This refers to instances where people who need help with essential activities of daily living (ADLs) received no help at all, or where they received help, it did not meet their needs. In 2016, the number of people aged 65+ with unmet care needs in England was nearly 1.2 million (Age UK, 2017). This was an increase from 800,000 in 2010. A more recent figure cited for 2017 showed an increase to 1.4 million (I13).

Related to this, and to the dilemma between home care and institutionalised care, DaneAge Denmark (I7) explained the austerity situation by referring to changes in quality standards. For instance, in home help, where cleaning was previously allocated at one hour per week, this was reduced to 45 minutes, and then to 45 minutes three times a month, and later to 30 minutes twice a month. The interviewee added that those receiving help are not becoming healthier and more able to do cleaning tasks themselves as time passes – their need for help has not reduced. Thus, quality standards have become less generous and austerity measures have been implemented. Another aspect of reducing public quality standards is that family and relatives are increasingly expected to be included and to do practical tasks such as shopping and cleaning (I6).

In sum, this dilemma accentuates the quality dimension of care, where informants voice worries over declining quality levels of care when the individual discretion of care workers is constrained. Austerity measures reinforce declining service quality

and may serve as an impetus for wealthier users to buy extra services, with negative impacts on equality. This dilemma of monitoring and central control is stressed rather more in Norway and Denmark than in England. One possible reason is that services in the Nordic countries have been more comprehensive, and that cost-saving measures and control of service delivery are considered more challenging than when the service level is more limited.

Space does not allow us to discuss further dilemmas in detail. However, a third dilemma – national standardisation versus local autonomy – was described by one English informant as a situation where local councils fund care and this results in strong geographical differences in terms of what each area can afford to spend on care services (described as a "postcode lottery") (I4). Here, austerity measures may reinforce the inequality-enhancing effects of the postcode lottery. However, whereas the interviewee called for strengthening national standardisation, the representative of the Local Government Association (LGA) defended local autonomy by rephrasing the 'postcode lottery' as "postcode choice" (I12). The argument made was that this secures services adapted to local users' needs, though the interviewee added that the LGA supported the introduction of a national minimum eligibility threshold as part of the Care Act 2014. Similar arguments for local autonomy were voiced by the Norwegian Association of Local and Regional Authorities (I14), also emphasising the importance of having a framework of financing (mainly decided at the state level) that was wide and flexible enough to allow local trials to improve quality of services.

Concluding discussion: towards increasing inequalities and poorer quality of services?

Our analysis shows that for Norway and Denmark, quality and content of care were at the forefront of topics, whereas funding was less discussed compared to England. In England, the funding issue was dominant, as well as the need for integrated care and cooperation between health (NHS) and social care. However, there is a close connection between the issues of funding and the quality and integration issues, reflecting the basic priority question on how responsibility and care supply are to be divided between the collective, the individual and the family.

While actors in all countries stressed the issue of LTC funding, English actors called for a more fundamental system change as access to care is very limited. Funding of social care and the integration of health and care services have been long-standing issues in the UK, where the devolution in 2000 of health and social care policy responsibility to the separate governments in England, Scotland, Wales and Northern Ireland has also been important (Glendinning, 2017: 109). Several commissions have reported on the issue and provided recommendations. In England, the Care Act 2014, planned to come into effect in 2016, introduced a 'capped' costs model, that is, a lifetime maximum that an individual would pay for their care. However, as noted, the government postponed the introduction of this (Jarret, 2018). Underfunding is a core issue through the whole report of the CLGC, as reflected in the overall conclusion:

> it is clear from our inquiry that unless significant extra funds are provided in the short and medium terms, the social care system will be unable to cope with the demands placed upon it. Extra funding alone will not solve the

> problems that face us, but without it the other steps we have suggested will quite simply fail. (HCCLGC, 2017: 67)

We have argued that two prioritising dilemmas are particularly important. How do these dilemmas and trends affect inequalities in terms of access to and quality of care? We address these dilemmas before returning briefly to the role of ideas in LTC policy.

Home care and institutionalised care

LTC actors in Denmark, Norway and England identify a dilemma between home care and institutionalised care. A widespread concern expressed in our study is that giving priority to home care, combined with the increased targeting of help and restricting institutionalised care to those with the most severe needs, may reduce both service quality and equality of groups not given priority. Although deinstitutionalisation was an area of broad consensus, interviewees identified several potential problems and dilemmas regarding social divisions. As nursing homes become more like local hospitals, taking care of the most vulnerable users, one interviewee raised concerns about "the space between", where home-dwelling older people with few means, though in need of a more adapted home that they cannot afford, could lose out to those with a better financial situation. Here, more commercialisation and individualisation could create social differences.

In this approach, the concept of '*omsorgstrapp*' ('steps of care') becomes relevant. This concept is mentioned explicitly by one interviewee and its meaning is addressed by many. The concept means that, reflecting different care needs, care services are given to a different extent (steps) according to the principle of the lowest effective level of care (Helsedirektoratet, 2016: 39–48). Basic home care services, for instance, are at a lower level than day-and-night care in residential homes. The point here is simply that as priority is given to those most in need, resources for important help to those at the lower steps are not available to the extent they should (and used to) be. Giving priority to higher rather than lower levels of need results in an escalation of such needs (I12, I15). Besides an escalation of demand, this priority setting also results in higher expenses associated with the development of more critical needs (I15). In addition, declining service quality de-universalises eldercare (Szebehely and Meagher, 2017).

It was also noted that a very strong prioritisation towards home care could lead to a situation where people with an identified need of a nursing home bed did not get this. Marketisation was identified as an important trend (see Table 3) and could be linked to the equality of access versus freedom of choice dilemma (see Table 4), also viewed as important. Actors in all three countries considered the topping up of services, that is, paying for additional services, as a politically divisive area, reflecting different ideological views on collective and individual responsibility, according to one union representative. Interviewees described how the system does not meet lower-level needs. Topping up of services may be a result of insufficient public services in terms of quality or content. As Moberg (2017) and Hjelmar and Rostgaard (2020) argue, topping up publicly provided services challenges the universal character of Nordic eldercare. Interviewees in Norway frequently addressed this issue, expressing worries about a development where not all have the financial means to pay for additional services not provided by the public. Vabø and Szebehely (2012) describe how such developments may result in a two-tier care system, where publicly provided care

services are basic and residual, rather than used by, and attractive to, all population segments. Such a system strengthens rather than equalises class differences as those with financial resources buy extra services others cannot afford.

Norwegian interviewees mentioned that in sparsely populated municipalities, local authorities might give priority to nursing homes rather than home care. While this is contrary to the overall trend of more home care and less institutionalised care, it might prove to be very rational in some rural contexts, where this is a more effective, and less costly, approach to the demographic challenge and, most importantly, secures quality of care (for similar arguments, Munkejord et al, 2018). Here, the two Nordic countries in this study differ; however, it is too early for us to make a conclusive assessment of this possible development.

Monitoring and central control versus individual discretion of care workers

A second dilemma emphasised in our analysis is the one of the monitoring and central control of service provision versus the individual discretion of care workers. One interviewee referred to "15-minute visits" as inadequate for care workers to really do their job, making it very difficult to secure human dignity and encourage user independence (I12). Union and user representatives noted increasing surveillance, control, reporting schemes and counting, as well as very tight work schedules, with specific tasks to be accomplished within a given time (I2, I6, I13).[4] An unintended outcome was that less time was spent with users to observe the effects of care efforts (I2). They argued that a reform of trust was needed which acknowledged that care workers have an education of several years and are able to perform professional assessments and make decisions about how to provide good care.

This interviewee's views align with 'the decentralisation of the welfare state dilemma' (Vike et al, 2016). This describes a situation where individual care workers, in their concrete work situation, experience a gap between needs and what can be delivered, and have to perform the rationing of care themselves.

Some municipalities in Norway and Denmark have addressed the call for alternatives to the standard-time governance model. Rostgaard (2014: 199) describes an ongoing counter-reaction in Denmark. On the basis of a critical assessment of the standard-time governance model in Bergen (Norway) for home care services (Førland et al, 2017), a reform of trust was initiated and implemented in 2018. This reform emphasises building competent teams of carers, trusting their professionalism and providing supportive and motivational leadership (Bergen kommune, 2017). The idea of a trust reform was taken from previous reforms introduced in Copenhagen (Bentzen, 2016; Eide et al, 2017).[5] In Norway, the implementation of trust reforms has been associated with political changes in local government, from right to left. This includes the idea of 'bringing back services', that is, 'in-house' rather than private provision, indicating an important dimension of the local politics of care. English trade unions also argue in favour of once again having care services delivered directly by the public sector.

Ideas and LTC policy

The aforementioned reform efforts are interesting in an ideational perspective as they could be interpreted as a form of challenge to the purchaser–provider model, part of the overarching New Public Management principles for reforming public

services according to market logics (Eide et al, 2017: 8). In this struggle, ideational constructs such as 'stopwatch care' have been important tools in delegitimising existing institutional care organisation and pointing out alternative organisational forms, as encapsulated in the idea of 'trust reforms'.

The role of ideas is also central in understanding the overall context of austerity, and how this affects LTC policies. First, views on austerity and constraints on public sector growth reflect different ideas about how the economy works, and thus the role of the state. Second, in addition to these cognitive ideas, basic normative ideas concerning the degree of resource pooling needed to build just institutions of care provision are central. At present, ideas on permanent austerity, implying a need to reduce or limit public resources and increase other elements in the care mix (market, family and voluntary sector), seem to dominate, challenging normative ideas of egalitarian and universal service provision.

Finally, does everything therefore boil down to money? We departed from an understanding of prioritisation dilemmas as relying on economic resources, different user groups' interests and basic welfare state values. Our analysis has shown that funding is crucial, and interviewees in England particularly emphasise funding. However, prioritisation dilemmas also come from the introduction of private providers and the aim to provide more choice, or from the balance between national standardisation and local autonomy.

As argued by Ilinca, Rodrigues and Schmidt (2017), there are few comparative studies of inequality and inequity in the use of LTC. This article is thus an important contribution, shedding light on consequences of prioritisation within LTC in three countries. Further research should include more European countries from the same and other welfare regimes. By extending both the number of cases and actors, this research will help us better understand how prioritisation influences basic welfare state values, such as service quality and equality, and whether some kinds of prioritisation can result in sustainable services that also have high quality and are available to all citizens.

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Notes

[1] This article reports findings from a project on prioritisation within Norwegian care services. The study has a smaller international component designed to set Norwegian experiences in a comparative perspective.

[2] The letter 'I' denotes 'interview', numbers refer to number as listed in Table 2. I2 thus refers to Interview no. 2 (trade union representative, Norway).

[3] None of them did, apart from one Danish interviewee (I3), who noted that rehabilitation measures were used solely as austerity measures in situations where rehabilitation efforts are pointless.

[4] As an illustration of this, the ethical care charter of the Unison trade union has a stopwatch on the document cover page and calls for ending 15-minute visits (Unison, 2013).

[5] Eide et al (2017) note that similar initiatives in the Netherlands in 2007, the so-called Buurtzorg model, developed by a non-profit organisation, have spread to other countries, among them the US and Japan, and also mention it as inspiration for the trust model of the municipality of Oslo in 2016 (Eide et al, 2017: 9–10).

Conflict of interest

The authors declare that there is no conflict of interest.

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