

# Prioritising care services: Do the oldest users lose out?

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Population ageing is a major concern in most European countries. Demands for health- and care services will increase, as older people typically have a higher need for such services. What is often overlooked, however, is that older users increasingly compete with younger users for the same limited care resources. We ask: How do employees in the Norwegian care sector make decisions regarding the allocation of services to younger and older users? To answer this question, we interviewed decision-makers in Norwegian municipalities. Despite providing for equal rights to services, laws allow for an interpretation of needs and this can result in the unequal distribution of services. Our study indicates that needs are defined differently for younger and older users, which affects the amount, type and content of the services allocated to younger and older people. When resources are scarce and priorities must be established, the services to the oldest suffer.

*Key Practitioner Message:* • *The article lays the groundwork for an open debate about the allocation of resources to users in different life phases;* • *The analysis conceptualises and makes explicit important normative decisions made by practitioners.*

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Population ageing is a major concern in most European countries. An ageing population implies that each person of employable age will have to provide for more old-age pensioners. It is also expected to increase the demand for health- and care services, as older people typically have a greater need for such services. These concerns are high on the political agenda in most countries (Eurostat, 2013). What is typically overlooked, however, is that older users increasingly compete with younger users for the same limited care resources. Younger users include people with developmental disabilities, people with severe physical injuries and illnesses, and people with mental illness or substance dependency. Relatively little is known about how this competition for scarce resources plays out in different contexts. In this article, we present some evidence from Norway on how employees in the municipal care sector make decisions regarding the allocation of services to younger and older users.

Norway is a country where municipalities play a very important role in the care sector. The primary responsibility for providing care services for all groups of users is currently located in the municipalities. It has been an explicit aim for some time to provide as little care as possible in state-owned specialist institutions, including somatic and psychiatric hospitals, and as

much as possible in the local environment. Equal treatment of different groups is another long-term goal. It is an ongoing debate in Norway that municipalities have been given a series of new responsibilities in recent years, but the state funding has not increased at the same rate (Gautun, Grødem, & Hermansen, 2012). This is not only a matter of money, but also of human resources. Municipalities in Norway, especially in remote regions, find it hard to attract skilled health-care personnel and are therefore liable to make tough decisions about resource allocation, juggling their limited financial and human resources as best as possible.

The situation in Norway is similar to the situation in neighbouring Sweden and Denmark. In Sweden and Denmark, too, municipalities have been given increasing responsibilities. Szebehely (2005, 2011) has argued that this emphasis on local and, preferably, home-based care is a specific Nordic trait. The same dilemmas that arise in Norway are therefore likely to be recognisable also in the other Nordic countries (Gautun et al., 2012).

We first present the development in Norway, looking at both changes in the allocation of responsibility and at the composition of users of municipal health- and care services. Next, we introduce a conceptual framework for discussing the allocation of scarce resources between younger and older users, centring on needs as

a basis for claims. We then turn to the results from a case study in five selected Norwegian municipalities, to see how decision-makers discuss the needs and claims of younger versus older users. The research question underlying the article is: What are the principles for the allocation of resources to older and younger users of municipal care services in Norway, and do these principles lead to equal or unequal treatment?

### The Norwegian context

The systematic transfer of responsibilities for primary health-care and care services from the Norwegian state to the municipalities started in the 1980s. Two reforms were particularly important: the Municipal Health Care reform in 1984 and the Nursing Home reform in 1988. The main aim of the municipal health-care reform was to transfer responsibility for primary health-care services to the municipalities, and to improve coordination between primary health care and social services. The Nursing Home reform transferred the responsibility for nursing homes – which provided more specialised health care than the traditional municipal care homes – from counties to municipalities.

A third important reform that was passed in the 1980s but only fully implemented between 1991 and 1995 was the reform in services to people with developmental disabilities. As late as the 1980s, the main form of care for this group was state institutions (Tøssebro, 2009). The reform transferred responsibilities for this group to the municipalities, and made it clear that the ideal was to be normalisation and housing outside institutions. This created challenges of a new magnitude for the municipal home-based services as well as the necessity to find housing for a new group of users, many of whom had extensive care needs (Hansen & Grødem, 2012). In the early 1990s, a high-profile government-appointed committee presented their proposals for future elder care in Norway. The committee strongly emphasised normalisation and home-based care, also for the older people.

While there were no major reforms in the 1990s, that decade and the next saw a series of action plans to improve municipal services, particularly for people with mental illness and substance dependence (Gautun et al., 2012).

It is important to emphasise that despite the many reforms and action plans, no group of users of municipal services are privileged over others in the legal documents. All laws, regulations and guidelines refer to 'users' or 'claimants' irrespective of age, gender or diagnosis (cf. Gautun et al., 2012, Chapter 4). The overarching principle is that all claimants shall receive services according to their needs.

There are currently 428 municipalities in Norway, varying in size from about 300 inhabitants to more than

600,000. While 75 per cent of the municipalities have fewer than 10,000 inhabitants, the proportion of the population who live in such small municipalities is only 28 per cent. Correspondingly, 3 per cent of municipalities have more than 50,000 inhabitants, but these account for 29 per cent of the population. As municipalities may tax both local businesses and inhabitants, access to financial resources depends to some extent on the characteristics of the local industries. Municipalities also have considerable freedom to organise their services as they see fit, as long as all statutory services are provided. Despite the variation, it is a common complaint that state authorities require municipalities to provide a long list of services, while increases in state funding do not correspond to the increased demands.

### Developments in municipal care services

Register data from Statistics Norway show that the number of work years in municipal home care services almost doubled in the period 1992–2006 (Brevik, 2010; Gautun et al., 2012). This increase was, however, almost entirely an increase in the services provided to younger users. The increase in resources available to users under 67 more than doubled in 2006 compared with 1992. The services to the 'young old', that is, 67–79-year-olds, decreased. During the same period, there was a reduction in the home-based services delivered to the oldest population when we adjust for demographic change (Gautun et al., 2012). This decrease in home-based services has not been compensated by places in institutions. In 1991, half of the population aged 90 years or more lived in institutions providing long-term care. By 2011, this figure had been reduced to less than one third (Ram, 2013).

About 60 per cent of the resources allocated to municipal home care services in Norway by the end of the first decade of the 2000s went to users under 67 years of age. This fact is little recognised in the policy debate centred on care for older people.

The slight decrease in resources to the 'young old' may be partly related to better health and more adequate housing for this group. The decrease in resources allocated to the 'oldest old' is -however-unlikely to be fully explained by such factors. The remainder of this article discusses how decisions about services and resources to older and younger claimants, respectively, are justified. As mentioned, nothing in the reforms, action plans or legal documents justifies preferential treatment based on age, diagnosis or any other group criteria; need alone should be the determinant. It is therefore worth looking into the debate about need as a basis for claims in social policy before moving on to the case study in the municipalities.

## Need as a basis for claims

In much writing on welfare state policies and typologies, a distinction is drawn between ‘rights’ and ‘needs’ as the basis for claims. The Marshallian tradition of social citizenship famously emphasises the progressive development of civic, political and social rights (Marshall, 1956) as a hallmark of modern societies and, ultimately, of welfare states. ‘Need’ as a basis for claims, on the other hand, is associated with earlier poor relief and charity. The distinction rests, however, on the assumption that access to rights can be determined on the basis of easily defined criteria, such as age (for old-age pensions) or family status (for child-related benefits). In the social care sector, obviously, the interaction between rights and needs is different. Health- and care services are allocated ‘as a right to those who have the need’ (as demonstrated in Gautun et al., 2012, Chapter 4). Thus, claimants not only have to claim their right, based on some objective criteria such as age, diagnosis or place of residence, they are also required to demonstrate their need. In doing this, they can draw on various discourses linked to the alleviation of suffering, human dignity, independence, (re)habilitation and so on. Decision-makers, on the other hand, are influenced by current dominant opinions regarding what one can reasonably expect from life in different life phases.

Michel Foucault pointed out that ‘Need is also a political instrument, meticulously prepared, calculated and used’ (Foucault, 1977, p. 26). It follows from this observation that the interpretation and acknowledgement of need is a political process. There is a large, and growing, literature on ‘the politics of needs interpretation’ (Dean, 2010; Fraser, 1989; Langan, 1998). This literature starts from the insight that needs are not objective or self-evident; rather, there is a process of ‘needs interpretation’ that is lodged in social and political discourse, and that takes place in given institutional settings. Needs must be understood in terms of how they are labelled and constructed by different actors or groups, in different contexts, and also in terms of the reactions to such constructs. Drawing attention to the intrinsically political nature of needs interpretation allows for a discussion of various discourses and opposition to discourses as well as power and resistance and the shaping of institutional contexts.

An important distinction in this context is the expression of needs as ‘claims for redistribution’ or as ‘claims for recognition’ (Fraser, 1997). It can be argued that while the struggle for redistribution was the main focus for social movements in the Fordian era, social movements in the 1990s and 2000s increasingly emphasised recognition. While the former would use the language of ‘interest’, ‘exploitation’ and ‘redistribution’, the latter argued in terms of ‘identity’

‘difference’ and ‘cultural dominance’ (Fraser, 1997). Fraser (2000) and Fraser and Honneth (2003) convincingly argued that both forms of claims are relevant for social justice, as long as the claim for recognition is expressed as a normative standard for ‘participatory parity’. This refers to the right to be listened to on equal terms in processes where redistribution takes place. Seen in this light, the struggle for recognition can help support the struggle for redistribution in circumstances where potential axes for injustices are simultaneously cultural and socioeconomic. Struggles for recognition that take the form of creating in-group solidarity and an exclusionary identity, on the other hand, are less relevant to discussions of social justice (Fraser, 2000).

Since Nancy Fraser’s influential writings on this topic in the late 1990s, new approaches have entered social policy debates. One major turn has been the emphasis on ‘social investment’ (Morel, Palier, & Palme, 2012). Briefly put, the key idea of this paradigm is to turn welfare spending from ‘passive’ to ‘active’ measures, or from consumption to investment. Preventing social problems is better than curing them once they occur, and investments are likely to be more profitable the earlier they are promoted (Esping-Andersen, 2003; Giddens, 1998). It is likely that this new way of thinking about welfare spending also gives rise to a new basis for needs interpretation, that is, ‘claims for investment’. Claimants can present their needs not as a demand for (‘passive’) redistribution or recognition but rather as a demand ‘to be invested in’. Claimants can argue: ‘If you invest in meeting my needs now – help me build skills, cure my illness – I will become a gainful and taxpaying citizen in the future’. For some groups of claimants, becoming a taxpaying worker may be out of reach, but they can still play on the investment argument: ‘Help me now, and I will need less tomorrow’. For yet other groups of claimants, even this is too ambitious – some claimants have no hope of improvement ‘tomorrow’. This is the case for the very old, and for younger users with chronic, lasting and potentially fatal illnesses or disabilities. These groups of claimants will have to find another language with which to articulate their needs.

We argue that the various bases for needs claims are highly relevant to a study of the allocation of health- and care resources in Norwegian municipalities. Claimants of health- and care resources differ in how they make their claims. Many younger user groups, most obviously those with physical disabilities, are well organised and have increasingly used the language of recognition as a basis for claims. This is true, for instance, of the Independent Living Movement. Also, younger users can make claims based on investment. If they can be fully rehabilitated, or fully enabled to manage any disabilities and participate in paid employment, society has made a good investment. The

investment argument is also available to groups of younger users who cannot rely on the recognition argument, such as users dependent on substances. Older users are likely to be left with the redistribution argument, and possibly with arguments drawing on how they have invested years of labour in society and deserve something back. This was an initial hypothesis for our fieldwork in municipalities. In the fieldwork, our aim was to understand the increase in the resources spent on younger users, and the simultaneous decrease in resources spent on older users. How does claimants' 'needs talk' play out in a situation with scarce municipal resources?

### Material and methods: the case study

Five municipalities were selected for the case study. The selection was based on an analysis of register data on the characteristics of the municipalities, and we chose cases to ensure variation along the lines of size (number of inhabitants), geographic location, proportion of the total budget the municipalities used on care services, and the expenditure on care services per inhabitant. We conducted interviews in two large municipalities (more than 50,000 inhabitants), two medium-sized (20,000 to 30,000 inhabitants) and one small municipality (fewer than 10,000 inhabitants). All the major regions of Norway were represented.

We approached the municipalities by sending letters with information about the survey to the top administrative leaders, followed by phone calls. All the municipalities we contacted agreed to participate. All the informants were employees in services or municipal administration. Six informants were top administrative leaders, either of the municipality at large or of the health- and care service sector, depending on local organisation. Four were heads of the offices responsible for resource allocation and organisation (*bestillerkontor*). The remaining 11 informants were leaders of service teams, responsible for the day-to-day organisation and implementation of services. All informants were sent letters outlining the purpose of the study and the terms of participation. Informants, as well as municipalities, have been anonymised.

Fieldwork took place in the summer and autumn of 2012. The interviews were recorded and transcribed. The interview guide covered five topics: (i) which services the informants' unit provided, and how service provision was organised; (ii) which groups of users increased, and how resources were allocated; (iii) explanations for the increase in the number of younger users; (iv) whether the increasing demand for services among the younger has drawn resources from elder-care; and (v) key future challenges for health- and care services (for further details, see Gautun et al., 2012).

### Driving forces for increased number of younger users

The informants in the case study generally confirmed the findings from the register data, presented above. There has been a major increase in the resources spent on users under the age of 67. The number of users in this age group has increased, and many of them have complex needs and thus require much support. Numerically, the older users still dominate, but many of the younger users receive very extensive services. Measured in terms of the allocation of resources, therefore, younger users dominate.

### New user groups and new methods

The group of younger users that has increased the most, according to our informants, is those with psychiatric diagnoses. Also, some mentioned people with a combination of substance dependency and psychiatric diagnoses, so-called 'double diagnoses'. This was described as a very demanding group to work with. Children and young people with diagnoses were also mentioned as a growing group, including those with diagnoses such as attention deficit hyperactivity disorder (ADHD), Asperger's syndrome and autism. Many of the younger users in Norway are children: prematurely born children, children with severe behavioural problems and those with cognitive or physical disabilities. Municipalities cooperate with the families in aiding these children.

The younger users who were described as the most demanding, however, were users who would until recently have been cared for in the state specialist institutions, including somatic hospitals. This is a very diverse group, and includes patients with cancer, survivors of traffic accidents, patients with chronic diseases such as multiple sclerosis (MS) or chronic obstructive pulmonary disease (COPD), and users in need of a ventilator. The informants were acutely aware of how the boundaries between state hospitals and municipalities have been redrawn for these patients:

*If we go five, or perhaps only two years back in time, having patients in ventilators in the municipalities was not an issue. They were in hospitals! But now we increasingly face such patients. Then it's COPD . . . they used to be in hospital for days, now it's day surgery. This makes new demands on us. (Top-level leader, medium-sized municipality)*

The municipalities thus reported that while the largest numerical increase was in psychiatric diagnoses, the most demanding patients, both in terms of money and human capital, were somatic patients in need of intensive care.

Perhaps paradoxically, better technology in the medical field has made life in municipal health- and care services more complicated. Technological changes and changes in specialised health care were presented by our informants as key driving forces for the increased care provided for younger users in municipalities. New technologies make it possible for municipalities to give services they never offered before. Patients in need of ventilators, for instance, are not a new group; what is new is that this service can now be offered outside the specialist institutions.

### New ideals for care

Underlying the informants' stories of the increase in demands from younger users was a story of changing ideals for care. Services have moved from institutions as an ideal – where users had similar needs and were cared for by experts – towards decentralisation and normalisation as ideals. This implies that care, as much as possible, shall be provided in municipalities. Also, care should be given in the individual's home, so that the patient can remain in familiar surroundings. This has led to practices that some informants clearly thought were somewhat extreme, such as patients depending on ventilators being cared for in their own home with a nurse present in the family home 24 hours a day. Some of the informants clearly expressed a wish that the most demanding patients could be transferred to specialised care.

### Rights consciousness and high expectations

Another driving force for increased municipal services to younger users is actions taken by family members and advocacy groups to pursue users' rights. The informants described a dynamic where access to social services was increasingly formulated as a right, and where users had the opportunity to contest the municipality's decisions. Media and advocacy groups also highlighted individual rights. At the same time, material standards have increased and the population increasingly expects services of the highest level. This was the climate in which the large reforms and action plans, which resulted in expectations being directed at local municipalities, were introduced. Moreover, demand appeared to be unlimited. Several informants described how their investment in particular services appeared to generate demand. Developing, for instance, high-quality services for children with mental disabilities led to more children being diagnosed, more parents requesting services for their children, and even families with children with special needs moving to the municipality in order to benefit from the good services.

The informants described how they constantly negotiated with users and their advocates. The starting point

in the municipalities was that users should have services that were 'good enough' and 'responsible', but users frequently wanted a higher standard. In the informants' stories about this, family members and advocacy groups appeared as one unified front. Parents of children with disabilities, for instance, were described as an active group with strong advocacy organisations. Administrators of services in municipalities had experienced how these advocates used the media, local politicians and, in some cases, the District Governor, to push for more extensive services for their users. The informants, however, also described how this pressure was managed, and that in most cases they were able to maintain a principled approach where the extent of services was not determined by how active and demanding the users were. Resisting pressure was not easy, however, and informants in one of the larger municipalities described how they increasingly spent money on lawyers to ensure that the decision-making process was fully in accordance with the law.

Despite the professional pride the informants had about not giving in to pressure, their accounts of how pressure was managed were somewhat ambivalent. Some admitted that they probably gave in sometimes and increased services to very active users – not by a lot, but by a little. *'I wish we were even stronger'*, one informant sighed in this context. Pressure is also about articulating needs, and users who downplayed what they needed were likely to also receive 'downplayed' services. An important point to make in this context is that employees of municipal services could also be advocates for 'their' users. If they saw that the user had needs that were not being addressed, or that the users needed more time, they could argue for more with the decisions makers in their own organisation.

### Older versus younger?

When we asked whether the expansion of services for younger users affected services for older users, the informants generally expressed the view that 'setting users against each other' was not legitimate. They were unwilling to say that the vast increase in services for younger users took resources from the older ones. However, some informants who rejected the suggestion that services for older users suffered appeared to contradict themselves later in the interview when they talked about how difficult it was to provide high-quality services for older users. It appears to be a trend in our data that informants who were close to the service provision were more aware of the issue than were informants who worked in planning and resource allocation. Informants who worked close to service provision lamented that it was difficult to get money for activation and social activities for older people. *'Had they had developmental disabilities, they would get*

[this service] *right away*', one informant said. Some informants in administrative positions also reflected on how it always seemed easier to make cuts in practical help given to older users. Interestingly, informants who had experience from actual service provision could talk about how the decisions service providers made 'on the spot' tended to privilege younger users:

*We don't get the resources to give all the services we are required to provide. We need to set priorities on the spot, for instance about who to help first and who can wait. What we cut is washing and cleaning for the old. And, that day and that day we have to drop helping them with showering. We use our resources increasingly on health care.* (Service leader, medium-sized municipality)

*Our priority is to get the younger users out of bed in the morning and get them to work. There is a lot of pressure on our services in the mornings and evenings. It's not ideal, but then we give priority to the younger users.* (Service leader, medium-sized municipality)

Overall, our informants were careful not to set groups of users against each other, and they were unwilling to suggest that younger users 'take from' older users. But they still reported that when resources are scarce, and priorities must be set, services to the old are easier to target.

### **Why are driving forces for services to younger users not driving forces for services to older users?**

Our interviews with informants identified three main driving forces for the increase in services to younger users of municipal health- and care services: changes in ideals of 'good care', technological changes, and an increased awareness of rights combined with increased expectations. In principle, each of these factors should also be a driving force for increased services to older users. Rights are the same for everyone, as are the ideals of more localised and home-based care, and many of the relevant technologies are targeted especially at the old. However, far from expanding, services for the old have actually declined. So why do the forces that drive expansion in services to younger users not constitute a similar driving force for services to older users? This issue was not addressed directly in the interviews, but there was much information to be gained from how the informants talked about older versus younger users.

#### Knowing and using one's rights

As noted above, the many reforms and action plans have not given rise to particular rights to distinct groups

of users. Rights, however, must be articulated and promoted in order to have much practical value. This may be particularly important when we consider rights in the sense of 'the right to have one's needs assessed'. Needs must be presented in a way that makes them seem relevant for decision-makers – and claimants must be willing to acknowledge that they have needs that they can reasonably expect public services to meet. Older and younger users appear to approach this in different ways, and this was a key point in the interviews. Informants systematically described the older users as more modest and humble than the younger users. Older users were described as '*modest and happy with what little they get*'; '*not wishing to be demanding*'; '*very humble*', '*not having the same consciousness of rights as the younger generation*'. All the informants seemed to assume that this was a matter of cultural differences between generations – that present-day older people come from backgrounds where modesty and self-reliance were important virtues.

Younger users, on the other hand, were typically described as conscious of their rights and unafraid of exercising them. Equally importantly, younger users had families that could exert quite extensive pressure on the municipalities. Families were described as demanding, with high expectations.

*I as a mother would work much harder to help my disabled child than I might have done for my sickly mother. One thinks, oh well, mum is old; this is just how it is . . . We fight more for our children.* (Service leader, large municipality)

Even when family members of older claimants pushed for more extensive services for 'their' users, the attitudes of the users themselves could undermine the efforts of the family. If family members constantly argued for more and better services, while the older user expressed gratitude for what he or she got and refused to ask for more, it was relatively easy for decision-makers in the municipality to dismiss the claims of family members as excessive. After all, the wishes of the claimant him- or herself were to be taken into account, and decision-makers could question how realistic the family members were about the situation of the service recipient. This dynamic was much less likely to play out when parents made demands on behalf of their developmentally disabled child, or a spouse made claims on behalf of a partner with advanced cancer.

#### Assumptions of needs

The guiding principle for decision-makers in the municipal sector was that users of services should be able to live a normal life. Conceptions of what is normal at various stages of life therefore tended to

guide resource allocation. This meant in practice that services for the older users had a different aim than services for the younger users. Younger people were seen as active, at a life stage where they normally should be in education or employment and able to go out with friends in their spare time. Older people were retired, and it was frequently assumed that their social needs were limited. While it could relatively easily be determined what a user needed in terms of nutrition and medical treatment, it was harder to decide what was needed in terms of personal hygiene, cleanliness, routines around meals and social life. Is it necessary to have a daily shower? How much social life should a 20-year old, or an 80-year old, expect?

Some informants claimed that younger users received more help than older users because the younger users received more individually tailored services with the intention to enable them to live as normal and active a life as possible. That means to be more socially active outside their homes, to undertake education and also participate in the labour market. Younger users had the opportunity to receive home help, home nursing and personal assistants. Older users received only home help and home nursing, which gave them standardised help. Older users seemed to have less opportunity to choose between caregivers, or to determine the content of the help given to them. One example was that service providers in many cases prepared meals together with younger users with developmental disabilities. This took a lot more time compared with what was usual when it came to older users. The older users received dinner in plastic bags that the caregivers heated for them. Another example was that older users might not receive help to take a shower, as documented above; caregivers gave higher priority to the personal hygiene of younger users who needed to get to work.

Different conceptions of social needs was a key point in another recent study from Norway which also compared services given to older and younger users of municipal care services (Hamran & Moe, 2012). Hamran and Moe quoted service providers as saying: *'The old above the age of 80 have little energy, so there is the need for rest . . .'*; and claiming that when older users have day centres to attend, combined with certain cultural activities and family visits, they do not request much more (Hamran & Moe, 2012). At the same time, however, they expressed concern that many older users were lonely and stated that more social contact would be good for them.

Overall, service providers tended to assume that older users did not need a high standard of personal hygiene, calm and company around meal time, firm morning routines or social contact beyond a minimum. This must be understood in the context of general conceptions of ageing, and of old people as passive and

lacking in energy. What are seen as reasonable and legitimate needs vary with age, and younger users are assumed to have needs at a higher standard. When services are allocated on the basis of needs, variations in which needs are seen as legitimate will clearly have consequences.

### Social investment in care services?

Above, we pointed out how social investment has become a catchphrase in social policies. Younger users and their advocates can play on social investment arguments when promoting their cause. To some extent, this is what happens in examples such as those quoted in the previous paragraph; where younger people with mental disabilities are allocated time to cook with a service provider, while the older are fed ready-meals. The younger, mentally disabled users may in time be enabled to cook without assistance, while the older users' days of cooking are assumed to be over. Similarly, giving priority to helping younger people get ready in the morning so that they can get to school or work makes sense if the long-term goal is that they should become more independent. Services for older users have no such ambitions. As one informant put it, services for older users are geared towards creating 'a good life here and now'. Several informants hinted at this way of thinking: *'We probably do spend more on younger users, because of activation and education . . . the old are not to be trained for future efforts'*, said one. Another added: *'In a preventive perspective, in a public health perspective, the distribution of resources could not be otherwise'*. Younger users, particularly those who were recovering from substance abuse or learning to live with a psychiatric diagnosis, could over time be trained for employment and go on to live 'ordinary lives'. The older users, as one informant put it, 'have life behind them'.

### Conclusion

Register data indicate that the social care services for older people have been reduced in Norway in the last 20 years, at the same time as major reforms and action plans have increased municipal services for users under age 67. We have emphasised in this article that the documents transferring new responsibilities to municipalities claim that all users of municipal services are to be treated equally. A tendency towards a more preferential treatment of younger users therefore must be explained by other factors than official guidelines. We have sought explanations in municipal decision-makers' assumptions, norms and priorities. We have emphasised how the principle 'to each according to his or her needs' implies that assumptions about needs in varying life phases will guide the allocation of resources.

This article is based on a relatively small study of five municipalities. It would be interesting to expand the study to include more municipalities. It is possible that the findings might be more varied if we, for instance, made a systematic comparison of municipalities with different modes of service organisation. It should be emphasised, however, that the image painted in the various municipalities was strikingly similar. The arguments or dynamics seem to be the same regardless of size or geographic location.

A key aim of this article has been to make explicit the assumptions that implicitly guide decisions about resource allocation in care services. Most importantly, we questioned how needs are articulated and understood for users in different phases of life. Older users have a limited repertoire of needs claims. They cannot refer to investment arguments, and there is no strong tradition in Norway for demanding recognition as older citizens. This leaves the older users with redistribution arguments, which appear to carry less force.

The findings in this article ultimately lead to a number of normative questions. Is it acceptable to make strong assumptions about what people's lives should look like in different life phases and to allow such assumptions to determine resource allocation? On what criteria – if any – is it acceptable to transfer resources from the older to the younger? How should one weigh the voices of users and their advocates against the assessments of care providers? Presently, quiet and largely implicit battles are being fought over these issues, with consequences for older people's standards of hygiene, social life, food standards and routines around meals. Our contention is that the arguments should be made explicit, and that we need an open discussion about what needs people in different phases of life can expect public services to recognise. These discussions should not be left to service providers, but need to be addressed at the political level.

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