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Economising Care for older Adults

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Introduction

Economising of care for older adults can be seen as processes of marketization, which is demonstrated for example in introducing efficiency-oriented measures, fostering competition between different social service providers, and increasing choices of older adults in need of care (for example Auth 2012). However, there are more subtle ways of economizing care than marketisation of the arrangements of care at a societal level through policies.

Economising can take place so that the governing rationality rests on formulations of economic values, practices and metrics (Brown 2015, 29). It means that until then spheres and practices of life that have been noneconomic undergo a process of remaking the knowledge, form, content, and conduct appropriate to the spheres and practices of markets (Çalışkan & Callon 2009). Such economization does not always involve monetization (Brown 2015, 30). Callon (1998) has identified economisation that consists of processes whereby objects and issues in society which are often controversially qualified, by different actors economic.

This kind of economizing is discursive and often lead to actions, such as marketization. The marketization of care for older adults in Finland has been documented in not too numerous studies (for example Karsio & Anttonen 2013; Burau et al. 2017). In this paper, I am interested in discources of economizing that is traceable on the quality recommendations for good ageing and securing the services in Finland. I study the four documents published by the Ministry of Social Affairs and Health in 2001, 2008, 2013 and 2017 (STM). The research question is: how is the economizing of care for older adults framed in these four quality documents?

Data and methods

As said, the data consist of four documents published by the Finnish Ministry of Social Affairs and Health at four different instances. Below is a short description of each of them. The quality recommendations are meant especially for municipalities that are responsible for arranging publicly financed social and health care services. They are policy documents that each emphasizes ageing in place and home care instead of institutional care. Guidelines are national, but they allow municipalities the freedom to adjust to the local circumstances and make adjustment according to resources in use as long as the national legislation is being followed. The documents are openly available in the internet:

- 2001 (STM) Quality Recommendations for care and Services for Aged Persons (Ikäihmisten hoitoa ja palveluja koskeva laatusuositus) was prepared in cooperation with Stakes that at present is National Institute for Health and Welfare (THL), the Association of Finnish Local and Regional Authorities (Kuntaliitto), non-governmental organizations in the field, scientific community and older adults. It has 26 pages

- 2008 (STM) Quality Recommendations for Services for Aged Persons (Ikäihmisten palvelujen laatusuositus) was prepaed by Stakes and the Association of Finnish Local and Regional Authorities and it has 55 pages.
- 2013 (STM) Quality Recommendations for Ensuring Good Ageing and Improving Services (Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi) was prepared in a broadly-based working group set by the Ministry of Social Affairs and Health. During the process there has been several hearings of the parties and the possibility to comment on the draft via internet. It has 78 pages.
- 2017 (STM) Quality Recommendations for Ensuring Good Ageing and Improving Services 2017-2019 (Laatusuositus hyvän ikääntymisen turvaamiseksi ja palvelujen parantamiseksi) was prepared in a working group set by the Ministry of Social Affairs and Health. During the process experts have been consulted and the possibility to comment on the draft via internet. It has 40 pages.

Data has been analyzed by critical reading against the research and conceptualization of economizing. The analysis is influenced by discourse analysis by leaning on the notion that societal structures such as these policy documents provide openings and constraints on local actions and discourse (see van Dijk 2001). I have also done some word counts (quantitative content analysis) fcusing on words that relate to economy, money and market activities. More text about methods later on. After this, there will be a subchapter on economising but I was not yet able to write it.

Some first impressions on results

Here I have only been able to make a list of some observations from the data. I have so far managed to read the data through carefully against theories on economising. There is need to keep in mind that all four documents state, in different ways, that it is a public responsibility to ensure that older adults have sufficient social and health care services. They also state that ageing in place is a primary policy goal and that older adults themselves and their close ones have the primary responsibility to ensure care and good life. Public responsibility of municipalities is to support this with good quality services that are mainly consumed at home. My reading focuses on one aspect of these documents, the process of economising –how it is discursively done and are there differences across time.

- The first quality document (STM 2001) portrays the care for older adults as a social right, the three latter ones are mentioning the right for social and health care services, but the notion of social rights is not there any more. This represents a step that is taken away from citizens right and towards something else, juridicalisation at least but not necessarily consumerisation. Only in the 2013 (STM) document mentions the word consumer and in connection with third age, who are still active amongst other things as consumers. Health and social care service users are thus not defined as consumers.

- The closer to the present time the documents come, the more there are discussions, estimates and calculations on how to increase the disability-free years of the ageing population. To support this goal, there are programs, guidelines, statistics and recommendations for municipalities how they can support and trim their inhabitants to eat more healthy, exercise more and help the older adults to invest in their health and wellbeing. Older adults are portrayed as human capital so that the subject is in charge of itself responsible for itself and needs to invest in itself in order not to burden the public service system (see Brown 2015, 38). Investing in oneself and getting good health,

functionality and being well are returns of these investments, which then burden the public purse as little as possible.

- Already in 2001 (STM) quality indicators are mentioned, but in 2008 (STM) they are first listed and the closed to the present time it gets the more indicators there are and the more specific they become. For example how large percentage of population 75 and over feel that they have weak memory (STM 2017, 38). In the process of economising, numbers are labelled as a form of truth with the authority to influence and to guide individuals, care providers and policy makers. Economising implies a concern with the idea of efficiency, which then is steered with the help of numbers. Economising in financial terms compares activities and processes that bear no resemblance and allows notions of competition and benchmarking to gain attention (Kurunmäki et al. 2016). These national indicators are set in place so that municipalities may compete against one another and attempt to increase their rating in using least resources in care. The aim is to make municipalities compete, aim to increase rating and show ranking (see Brown 2015, 36.) The National Institute for Health and Welfare collects data and publishes comparative reports and many of the indicators are freely available in internet (Sotkanet) so that anybody can make their own comparisons. This is part of the top-down management techniques by the state with centralized authority, policing, rules, quotas, intensivization, guidelines and benchmarks (Brown 2015, 34).

- I also tried to pay attention to issues that are not discussed. All four documents pay attention to the staff in social and health care services, the scarcity, recruitment difficulties, education levels, number of staffing in services. Attention is given to the fact that skilled, motivated and committed personnel that is feeling well at work is a base for good quality services. However, not one of the documents mention the salary levels of the employees as something that may influence the quality of the service. The 2013 document even states that there are numerous trained social and health care professionals, who are not working in the field (STM 2013, 40). This can be seen as part of the human capital accumulation where employers are concerned over the skills of the employees since it influences the quality of care they produce. Less attention is given to the possibilities of employees to manage with the salary they get.

- Another avoided theme, entirely in the 2013 (STM) and 2017 (STM) documents is the user fees for the clients. In 2001 (STM, 21) it is mentioned that clients have the right to know what the fees are. In 2008 (STM, 30) it is stated that there is need to ensure that user fees are not creating an unbearable burden for the clients. At the same time when the individual responsibility on care (Anttonen et al. 2012) has been increasing, less concern is given to the costs of care that the individuals bear. At the same time, especially the 2017 document emphasizes the costs that care incur to municipalities are widely discussed.

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