GIGAPP Estudios/Working Papers

Programa de Doctorado en Gobierno y Administración y Pública
Instituto Universitario de Investigación Ortega y Gasset
ISSN: 2174-9515

Grupo de Investigación en Gobierno, Administración y Políticas Públicas

estudios/Working Papers

Edición Especial (WP-2015-02)

Document Title

Norwegian long-term care: Legacies, trends, and controversies

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Reception: 20/10/2014
Accepted: 29/01/2015
Published: 23/02/2015

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Abstract:
The NorSpaR project aims to analyse the main public policy initiatives by which Norway and Spain cope with the new social and economic challenges derived from the so-called New Social Risks (NSR). Although both countries present significant differences in their institutional settings (such as Spanish EU membership), or its belonging to diverse welfare regimes types (Norway is generally included in the Nordic regime, while Spain is part of the Mediterranean one), both countries share a common interest in addressing the aforementioned challenges while maintaining social cohesion. In the last decade, governments in both countries have tried to respond to those challenges by reforming their labour markets, adapting their unemployment schemes, as well as their gender, family and long-term care policies. The analysis covered in this project includes three areas of public policy addressing NSR. First, dependency is one of the most daunting challenges for post-industrial societies experiencing population ageing and with an increasing number of frail people in need of care. This situation is forcing governments to rethink their long-term care policies. Second, family and gender public programs need to respond to the growing difficulties of families in reconciling professional and family life. Third, in the transition to a post-industrial order, and in a context of mass unemployment, social protection systems have a renewed prominence. Along with the so-called passive policies offering financial support to the unemployed, active labour market policies are geared to put people back into work. In our analysis we try to find answers to the following questions: What are the challenges that each of these policies have been trying to address in recent years? How have these policies evolved? What kinds of reforms have been implemented, and which ones have been neglected? Have the policy goals and targets of welfare programs been modified in any significant way? Have the policy tools (services, transfers, funding or models of provision) changed? To what extent have these policies been successful in coping with social and economic problems? To what extent a social demand in favour of these changes exist? What are the main political and social actors intervening as stakeholders in these policies? Finally, what are the major similarities and differences existing between the two countries? To what extent are there policy proposals that might easily travel between them? Could they foster mutually enriching exchanges of information?

Keywords:
Welfare State; Public Sector Reform; Public Policies; Labour market; Long Term Care; Family Policies; Europe

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Project financed by the EEA Grants through the Norwegian Embassy in Spain

Norwegian long-term care: Legacies, trends, and controversies

Daatland, Svein Olav

This paper is part of a Special GIGAPP Working Paper series aimed at disseminating the results of the NorSpaR Project (Coping with New Social Risk in Norway and Spain: Long-term policies, gender and family policies, and labour market and unemployment protection). This project has been financed by the EEA Grants through the Norwegian Embassy in Spain, and conducted by a group of Norwegian and Spanish researchers, including: Erling Barth, Inés Calzada, Svein Olav Daatland, Angie Gago, Arnlaug Leira, Pau Mari-Klose, Francisco Javier Moreno Fuentes, and Eloisa del Pino.

Introduction

Welfare states have been criticized in recent years for being more adequate for economic protection than for "the new social risks", which are not primarily rooted in class, but are more closely linked to life phases, demography, and gender (Alber 1995, Esping-Andersen 2002). Central among these risks are the needs for long-term care, which are human universals, but are in many countries only recently included as a Welfare State responsibility, and are as such representing an expanding area of many modern Welfare States.

Long-term care (LTC) is here defined as practical and personal assistance in daily life to people with physical or mental disabilities over sustained periods of time. Thus, LTC refers to long-term needs, and to activities of daily living, not to specialized health care. We start our lives as totally dependent upon others, and most of us shall end our lives after a period of dependency in old age. Thus, needs for long-term care may appear at any part of the life course, but this paper concentrates on later life and older persons.

Long-term care has traditionally been a family, indeed a household, responsibility, but has increasingly been taken up by the Welfare State, and is today some mix of public and private responsibility in any Welfare State, but differently balanced from one country to the next. Similar problems are likely to attract similar interventions, but as policies have legacies, they tend to follow the roads already taken. Countries are therefore attracted to different solutions even when circumstances are similar. Some tend to look for solutions in the state, others in the family, and yet others in the market or in civil society. Scandinavia is the prototype of the statist approach, and tend to stand out as a distinct "statist model" in Welfare State typologies. Continental and southern countries will more likely look towards the family, whereas liberal Welfare States are inclined towards the market. Path dependency is, however, only part of the story. History has shown that longer periods of consolidation and path

dependency are broken up by periods of reform and path departure (Esping-Andersen 2002). We may now again be at such a cross-roads, when a new welfare vision is needed, that responds to population ageing, to equal opportunities, to expanding individualism, and to new family forms.

Each Welfare State represents a balancing between ideals, and some form of historical compromise. There is hardly one single solution, a one form fits all. Similar needs pressures, such as population aging, may pull models closer together, but changes must also accommodate to the already established order, and need resonance and legitimacy in the population.

This paper will therefore first locate Norwegian long-term care within a larger context, the so-called Scandinavian model: Can we indeed identify a Scandinavian welfare regime, and within this, a distinct long-term care model? If so, what are the defining characteristics of this model? The second section describes Norwegian long-term care more specifically in terms of services and benefits, eligibility and standards and how these patterns have developed. The third section identifies recent trends and controversies in governance and funding mechanisms, and the extent to which these trends represent a convergence towards other models, or is better seen as revisions within the model, and so to speak as changes in the service of stability. The sustainability issue is addressed in the fourth and final section, including equity issues and the legitimacy of current policies and priorities in the population.

1. A Nordic model?

Welfare state regimes

To extract a few welfare models from a large variation of national policies is a familiar exercise. Among the most successful is the three Welfare State regimes suggested by Esping-Andersen (1990): the social democratic, the conservative, and the liberal regimes. The defining character of the social democratic model, represented by the Scandinavian countries, is the active role of the state, and the protection of citizens against dependency on the market (de-commodification). In response to feminist critique for being preoccupied with economic protection, and being less observant of social protection and care, Esping-Andersen (1997, 1999) later included social services in his model, and thus the degree of protection against dependency on the family (de-familization). This expansion could be accommodated nicely within the already established model, and did not have him add or re-arrange his original typology. A southern welfare regime has, however, later been added as a more rudimentary variant of the conservative model, or as a distinct Mediterranean welfare regime (Leibfried, 1992, Ferrera 1996).

The Esping-Andersen typology is grounded in a combination of structural and political factors, indicating that a certain welfare regime has developed in response to some similarity in external pressures on the one hand, and internal preferences on the other. The active role of the state in Scandinavian welfare policy has, for example, been attributed to the strong social democratic parties in these countries during the constituting years of the Welfare State. Trust

in government and the state were then high, populations were quite homogeneous, and universal, tax-financed services had high legitimacy as they referred to people like oneself.

Family cultures

Other typologies are rooted in a cultural more than a political soil. As welfare policies seem to cluster geographically, Castles (1993, Castles and Obinger 2008) suggested that these clusters refer to a "family of nations", with a common background in history, language or religion. The geographical location of these clusters is evident in the labels assigned to them, such as the Scandinavian model, the Continental model, the Mediterranean model, and the Anglo-Saxon model. An Eastern (Post-communist) model was added later. The fact that the structural (Esping-Andersen) and the cultural (Castles) typologies overlap so closely, suggests that they are rooted in a common ground.

The southern family is tighter and more collectivistic than the northern according to Reher (1998). The same goes for the eastern vis-a-vis the western family, according to Hajnal (1965, 1982). They both argue that European family cultures are quite stable and are basic features upon which social policies are formed rather than vice versa. The strength and character of family norms are, however, hardly produced by geography, and are more likely rooted in history and religion, such as the location of Christianity and Islam, Catholicism and Protestantism (Höllinger and Haller 1990). Family values may also be influenced by political conflicts, such as the two great wars, and the iron curtain thereafter. The suppressive communist era may, for example, have forced people in eastern Europe to seek protection in the family, and then most likely in more traditional family values (Szydlik 1996, Daatland et al. 2011). In contrast, the north and west of Europe have a long tradition for more independent relationships between family generations (Laslett 1983). When Britain and Scandinavia were early in the development of social services on traditional family ground, this was therefore not by chance or opportunity only, but also by inclination.

Scandinavian countries eventually allowed the state a more active role and responsibility than in Britain – a policy that reduced dependency on the family even further in Scandinavia, and later on probably had favourable repercussions for gender roles and female labor participation. Scandinavian countries have today comparatively high fertility rates and high levels of female employment. Both patterns are responses to equal opportunities and a successful policy for the reconciliation between family and work (Daatland et al. 2010). Birth rates are lower in southern and post-communist countries, where also female employment is lower and indicates that welfare policies have left the main responsibility with the family, and therefore with women.

Path dependency and path departure

Both the longer lines of tradition, and the more recent influences from current needs pressures and the political and economical climate, are involved in the formation of social policies. The cultural legacy may represent some persistent characteristic, while structural and political factors may be more responsive to current conditions. Thus, even if collective family values are deeply rooted within a country, and this country is therefore attracted to a family care model, it may come to depart from its path and change policies when circumstances are compelling. The cultural, political and institutional heritage of a country still represent a path

dependency on the past, and a resistance to change, and may come to be played out also in the way revisions take. The German long-term care insurance of 1994 is a case a point. The fact that state responsibility for long-term care came late in this country, may at least in part be explained by the familialist inclination in German social policies, whereas the reform itself represented a break with this tradition, but was dressed and legitimized as a support for family care. The Spanish Dependency Law is a similar case of change dressed as tradition.

Long-term care models

The distinctive characteristics of a welfare regime are even more evident when we limit the perspective to a certain policy area, such as social services. Anttonen and Sipilä (1996) explored what they called "social care models" by comparing country levels of services for children (day-care, pre-schools) and seniors (home help, institutional care). On this basis they identified two distinct models, a Scandinavian public services model, where services for both elders and children are universal, widely available, and mainly provided by local governments. The contrasting case was the family care model, typical for Mediterranean countries. These countries had a limited supply of social services for both elders and children, leaving the bulk of these responsibilities to the family. Another two or three models were not equally distinct, such as the British means-tested model, with state responsibility for services, but on a lower level than in Scandinavia and therefore subject to means-testing. They finally added a continental subsidiary model, represented most typically by Germany. The primary responsibility for elders is also in this model located in the family, but service levels are considerably higher than in Mediterranean countries, whereas the state assumes a more indirect role than in Scandinavia by having service provision carried out primarily in the private sector on commission (and control) by the state.

Bettio and Plantenga (2004) have presented a similar typology to that of Anttonen and Sipilä. They start out in the assumption that long-term care policies can be identified in terms of how they help families cope with caring. Different levels of responsibility sharing are then evident, from family dominance to state substitution for family care. Models are identified as various mixes of formal and informal care. Again two distinct models are recognized, the familialist (southern) model and the universalist (Scandinavian) model. In-between are more mixed models of "supportive familialism", represented for example by Germany (balanced familialism), France (children-biased familialism) and the Netherlands (elder-biased familialism). Child care is in all countries mainly a family (i.e. a parent) responsibility, whereas elder care is a mixed responsibility - in most countries heavily balanced towards the family, in Scandinavia balanced towards the state.

Some countries do not fit easily into such types, because they may score high on child care and low on elder care or vice versa. Leitner (2003) suggests therefore, that there are different varieties of familialism. Welfare policies may de-obligate families by providing services as an alternative to family care (de-familialization). Policies may also, or alternatively, support and compensate families in their caring efforts (familialization). Both types of policies are present in any Welfare State, but differently balanced between regimes and sub-areas within each regime. Familialization is more often found in child care, de-familialization in elder care.

Modelling becomes more distinct if we consider long-term care specifically. I shall for this policy area suggest that the most distinctive features between European models are to be found along a combination of five dimensions: the state role (primary or secondary), the mode of financing (taxes or insurance), the major instrument (services or cash), the eligibility criteria (universal or selective), and the generosity of benefits (high or low). On this basis I suggest there are indeed four regimes with (1) the (Scandinavian) public service model, and (2) the (Mediterranean) family care model as the two contrasting cases. The Scandinavian model is rooted in state primacy, the Mediterranean model in family primacy. In-between the two are (3) a state-oriented, means-tested model (e.g. the UK), and (4) a family-oriented, insurance-based model (e.g. Germany).

The Scandinavian and English models are tax-financed, with the state as the primary responsible, but less generously so under the English model. The Continental and Southern models are both based in family primacy, but less so (i.e. policy moderated) under the continental model. We might have added a post-communist, mixed model, as these countries are non-familialist by legislation, but familialist in practice (by default). Countries such as Bulgaria, Hungary, and the Czech Republic have – as in Scandinavia and the UK - no legal obligations between adult family generations (Keck et al. 2009, Daatland et al. 2011), but responsibilities are in practice left to families, because services and pension levels are low and make elders dependent upon their families.

Table 1. Policies and outcomes of long-term care under different models.

Long-term care models	Public service model	Means-tested model	Insurance based model	Family care model
e.g. country	Norway	England	Germany	Spain
State role	Primary	Primary	Secondary	Secondary
Major instrument	Services	Mixed	Transfers	Mixed
Eligibility	Universal	Selective (means-tested)	Universal	Selective (family-tested)
Mode of financing	Taxes	Taxes	Insurance	Mixed
LTC expenditure (percent of GDP) [1] **Public LTC exp.** [1]	2,3 percent 86 percent	1,4 percent 65 percent	1,4 percent 70 percent	0,6 percent 26 percent
User rates: percent65+ [2] **… in institutions** **… in home care** **Total**	5,3 percent 19,3 percent 24,6 percent	3,5 percent 12,6 percent 16,1 percent	3,8 percent 6,7 percent 10,5 percent	4,1 percent[3] 4,2 percent 8,3 percent

1: OECD 2005, 2: Huber et al. 2009, 3: May include younger clients/residents. User rates should be interpreted as approximations; they tend to vary from one source to another.

Table 1 summarizes the distinctive features of each model. The state assumes a primary responsibility for long-term care under the Scandinavian, public service model, a more limited role under the other models. Formal obligations are in southern countries assigned to the extended family, with the state in a subsidiary or residual role. Continental countries tend to confine responsibilities to parents and children, not to the wider family network. Northern countries have no legal obligations between adult generations (Millar and Warman 1996, Hantrais 2004), hence the legal responsibility for long-term care rests with the state, and policies are based on individual needs and rights. In real life, families take on a large, if not a

dominant, role also in Scandinavia. Liberal regimes (e.g. the UK) tend not to impose legal obligations for care on the family, and family relationships are in general not strictly regulated. But as the state is not very generous, the means-testing in practice leaves more responsibility to the family than under the Scandinavian model.

The family is dominant in elder care in close to all countries, perhaps with the exception of Scandinavia. The comparative OASIS survey found an equal family-state balance for long-term care in Norway, whereas the family was the dominant care provider in Spain, with Germany and England in intermediate positions (Daatland and Lowenstein 2005). The SHARE study found family help to be less intensive, but more frequent, in Scandinavia in comparison with continental and southern Europe (Albertini, Kohli and Vogel 2007). Estimates have suggested a 50-50 split in the Scandinavian case, whereas a 75-25 or higher family dominance is suggested for other Welfare States (Huber et al. 2009, Rodrigues et al. 2012, Ervik et al. 2012). These estimates refer to hands-on-care. If also emotional support, practical assistance, and care management were included, then the family (and other informal carers) would probably dwarf the role of the formal care system also in Scandinavia. However, as the Welfare State concentrates on persons with the most extensive needs, the state role will be more prominent when needs are extensive, whereas family care is more prominent when needs are more spaced out (Bettio and Veraschagina 2012).

Services are the main instrument in Scandinavian long-term care, and are provided predominantly by local governments (municipalities). Countries under the family care model are inclined to give higher priority to cash transfers in support of family care (cash-for-care). Cash allowances are also available in Scandinavia, but have lower priority, and are mainly targeted to families with disabled children. Services are in Scandinavia predominantly public, but are increasingly outsourced to private providers. This semi-private sector has doubled in Sweden during the last 20 years, and cover today around 25 percent of long-term services in this country, in some larger cities more than 50 percent. Outsourcing is less prevalent in Norway, where about 90 percent of services are public and provided by local governments, i.e. by the municipalities. Private-for-profit services are few in any of the Scandinavian countries, and have until recently been actively discouraged.

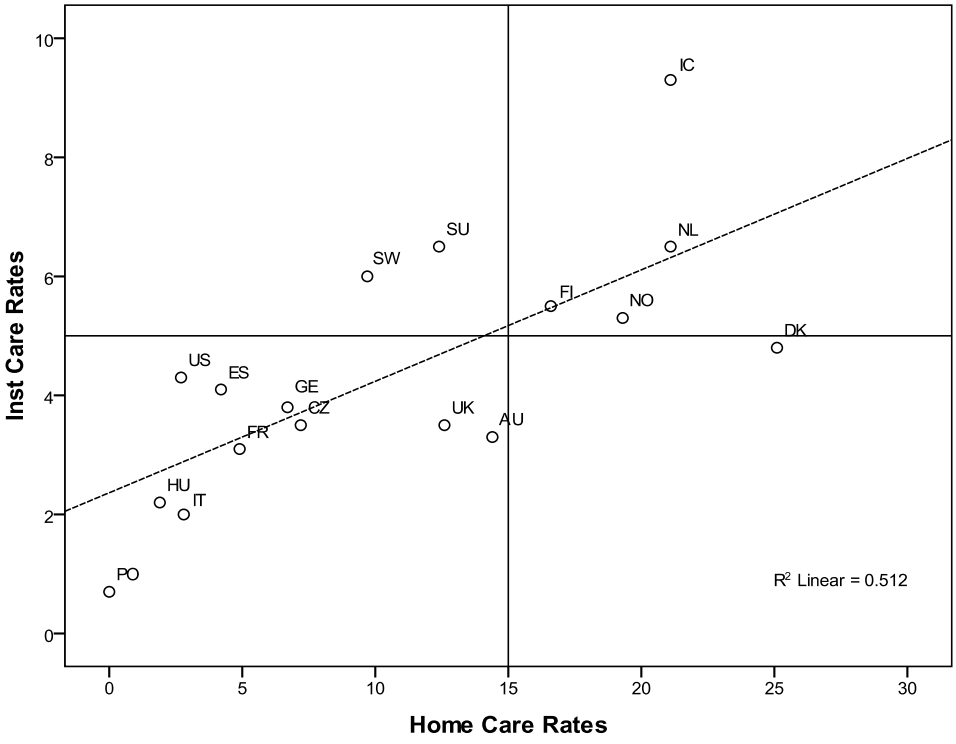
Outlays on long-term care are for these reasons higher in Scandinavia than in liberal and conservative Welfare States, as illustrated in table 1 by the higher expenditures in Norway (2,3 percent of GDP) than in England and Germany (1,4 percent), and lower still in Spain (0,6 percent). The public sector proportion of these expenditures is particularly high under the Scandinavian model. Outlays are even higher in Sweden and Denmark than in Norway, but somewhat lower in Finland and Iceland (not shown here). The Netherlands join Sweden with the highest investments in long-term care as a percent of the GDP (around 3 percent). Readers should recognize that these estimates tend to include health care only, and may underestimate levels in countries where social services stand comparatively strong, such as in Scandinavia.

Finally, the access to services – as indicated by the user rates among the 65+ population - are on average more generous in Scandinavia than under the other models, in particular in home

care, perhaps because familialist Welfare State are more reluctant to intervene on traditional family territory, such as in people's homes. Country variation is less for institutional care.

Country differences are illustrated in more detail in Figure 1. User rates (percent of 65+) for institutional care and home care are here plotted against each other. Scandinavian countries (except Sweden) are located in the upper right cell of the diagram together with the Netherlands, with high scores on both types of services. Note also the positive correlation between the volumes of institutional and community care. Some countries are low on both, some are high on both, only few have a compensatory pattern, where low rates on one are compensated by high rates on the other. The diagram does not include cash transfers that are not directly linked to the purchase of a certain service, and may therefore underestimate the volume for countries with a priority to cash transfers such as Germany and Spain.

Figure 1. Access to long-term care by country: percent 65+ with home care and institutional care.



Source: Adapted from Huber et al. 2009.

In conclusion, Scandinavian countries seem to cluster in their welfare and long-term care policies, but clustering is far from perfect, and there is considerable variation also within Scandinavia, even within each Scandinavian country. Iceland has the highest institutional care volume, followed by Norway. Denmark gives comparatively strongest priority to community care. Sweden has most radically reduced access to services the later years in response to the economic recession (Szebehely 2005). The next section describes the Norwegian case in more detail.

2. The Norwegian long-term care model

Brief history

Some form of public responsibility for elder care has a long history in Norway, but the Welfare State as we now know it, developed and found its form during the first two or three decades after WW II. The war had left deep scars in the population, but also a political consensus on an active Welfare State. The inspiration came primarily from the Beveridge report and the UK, but state responsibility, and tax-financed public services, were taken even further under what came to be known as the "Scandinavian model".

Welfare state responsibility tends to start in financial security. A disability pension for workers had been established already in 1894, whereas a national old age pension had to wait until 1936, long after Denmark (1892) and Sweden (1913), and illustrating that Norway was the poorer of the three at this point in time. Needs-testing was lifted in 1959, and made the national old age pension universally available from age 70, still providing "basic security" only, but raised to "standard security" under the National Insurance Act from 1967 and thereafter.

Social assistance remained a local responsibility, but the national pension lifted burdens off local government shoulders, and allowed them to invest in social services, including elder care. Local government old age homes had been introduced around 1900, and remained as more or less the single service until the 1950s, when home help and home nursing were added to promote ageing in place and reduce the demand for institutional care. An explicit state responsibility was recognized by the setting down of the first national commission on elder care in 1955. This report criticized the current state of affairs, and recommended future developments in two directions: First a general priority to ageing in place and to developing community services for that purpose, and second, to replace old age homes with advanced health care in modern nursing homes. State financial support to home nursing came a few years later, in 1959, and to home help in 1969, and even more consequential: Nursing homes were taken in under the hospital act in 1970, and so to speak "elevated" to the county level, one step closer to the state, and stimulated with generous state subsidies. Nursing homes doubled during the following decade, whereas old age homes declined and were phased out, first by the more medically ambitious nursing homes, and later on also by sheltered housing. Legal responsibilities between adult family generations were lifted under the revision of the social services act in 1965, and recognizing the state -not the family - as the primary responsible for social and financial security in old age.

The basic building blocks were in place around 1970. The great expansion followed between 1970 and 1985, when volumes of nursing homes, home nursing, and domiciliary services more than doubled. Voluntary organisations and charities had been active as pioneers, but they urged the state and local governments to make services generally available. Times were favourable for investments in the Welfare State, but expectations were even higher, and concerns were raised about the sustainability of the model for an ageing population. Service volumes levelled off during the 1980s, as a certain level of needs was then met, but probably also in response to the less generous economic and political climate for the Welfare State. Demands were still growing, but mechanisms to moderate and guide expenditures were missing. Earlier segregated services were therefore, between 1985 and 1995, integrated and

decentralised to the local government (municipal) level. The earlier open-ended state subsidy service by service was replaced by a closed-end financing system, where total expenditures were more closely monitored by the state, and transferred as block grants to the municipalities, with considerable freedom to prioritise within these limits. Municipalities should therefore be motivated to select the cheaper mix of services. Similar policies were implemented in Denmark a few years earlier, and in Sweden a few years later. Central in these efforts was a de-institutionalisation policy, with state subsidies for developing sheltered (assisted, special) housing as an alternative to institutional care. Subsidies were also provided for the modernising of nursing homes, including single-room standard in order to normalize life also within institutions. Nursing home volumes (relative to the 80+ population) declined by 25 percent between 1995 and 2010, but sheltered housing increased, and nearly compensated for this decline. As access to community services also declined, eligibility became narrower, and provision targeted to a more selective group of clients.

A more adequate balancing of services was thus achieved, but comparatively fewer were accommodated, and less extensive needs were left unmet or re-defined as private responsibilities. Some re-familization may thus have taken place in this period, but more so in Sweden, where these developments were more radical (Johansson et al. 2003). Trends were less negative in Denmark and Norway, and may more or less have kept pace with needs, if we assume that new cohorts of elders had slightly better health than the earlier and sheltered housing had been able to compensate the decline in institutional care.

Current services and benefits

Long-term care is today provided in nursing homes, in sheltered (assisted, special) housing, and as nursing and domiciliary (practical) help in people's own homes. Old age homes, which used to be the dominant service, are nearly phased out and replaced by nursing homes, representing a medical shift in the balancing of services. Institutional care is provided mainly on a long-term basis, but 20-25 percent of nursing home beds are used on a short-term basis for observation, rehabilitation, or respite. Most nursing homes will also provide some day-care for various purposes.

Home nursing is provided by professional nurses, normally as short visits for designated purposes. Home help (practical, domiciliary assistance) is provided less frequently, on a weekly or bi-weekly basis. A number of specialized services are also available, such as meals-on-wheels, personal alarms, technical aids, and transport services, and may be vital details in the puzzle of persons and activities that are often necessary to make the wheels go around in community care (Sundström et al. 2011). Home care was traditionally provided in small volumes, and left a gap between a spoonful of home care and the full 24 hours package in institutional care. Sheltered housing and around-the-clock home nursing developed to fill this gap and produce more continuity of care and a better fit of needs to services.

Nursing homes provide room and board and professional nursing, and function as "the last refuge" that Peter Townsend described in his seminal work under this title more than 50 years ago (Townsend 1962, Johnson et al. 2012). Standards are far higher today, but Norwegian nursing homes are still a "last refuge" in the sense that most elders - 60 percent of the 80+ -

die in a nursing home, another 30 percent die in hospitals, only few die at home, including sheltered housing.

Institutional care peaked in Sweden and Denmark already in 1970. The de-institutionalisation trend came later, and was less radical, in Norway. Norway had the lowest institutional care volume of the three in 1970, but the highest in 1985, and is today the only country of the three that still operate residential care under two "regimes", an institutional care regime and a special housing and community care regime (Daatland 1997, Szebehely 2005). Institutional care was (in legal terms) suspended in Denmark in 1987. Residential care is today provided in "elder housing" or in "nursing housing," the latter including staff and collective living more or less as in the earlier nursing homes. Sweden suspended institutional care in 1992, when the Swedish decentralization reform (the Ädel-reform) integrated earlier old-age homes, nursing homes, and service housing under one legislation and label, as "special housing" (Paulsson, 2002). How far special (sheltered, assisted) housing are today de-institutionalized, or better described as re-institutionalized, is a matter of definition.

The lower volume of institutional care implies that residents today move in later, stay shorter, and have more extensive needs than in earlier years. The majority suffer from dementia; in fact dementia is the main reason for being admitted to a nursing home (Selbæk 2007). Persons with physical disabilities are easier to accommodate in community care, including sheltered housing, and are themselves more motivated for open care. To what extent nursing homes shall develop as mini-hospitals, continue as a last refuge, or play both roles is an unresolved issue.

Close to 25 percent of the Norwegian 80+ population live currently in some form of "residential care": 14 percent in nursing homes, 11 percent in sheltered housing. Corresponding figures are slightly lower in Denmark (22 percent) and lower still in Sweden (15 percent). Sweden has reduced their "special housing" rates from 20 to 15 percent since 2001, Denmark from 24 to 22 percent, whereas Norwegian rates for the sum total of nursing homes and sheltered housing have been quite stable in this period, varying between 24 and 26 percent (Godager, Hagen and Iversen, 2011).

Norwegian developments since 1995 is illustrated in figure 2, separated for three groups of services and users: institutional care (nursing homes), sheltered housing, and domiciliary services to residents in ordinary housing. Institutional care has declined by close to 25 percent during this period, from 19 to 14 percent of the 80+ population. This decline is nearly compensated by a corresponding increase in sheltered housing. The sum total of the two have thus been quite stable (24-26 percent) over these years, but only half of the sheltered housing units are staffed, and as also domiciliary services have been in decline, the sum total of services is clearly lower today. Whereas 58 percent of the 80+ population had some service in 1995, this was the case for 50 percent only in 2009.

Figure 2. User rates for the 80+ population by type of service and year, Norway 1994-2009. Cumulative percents.

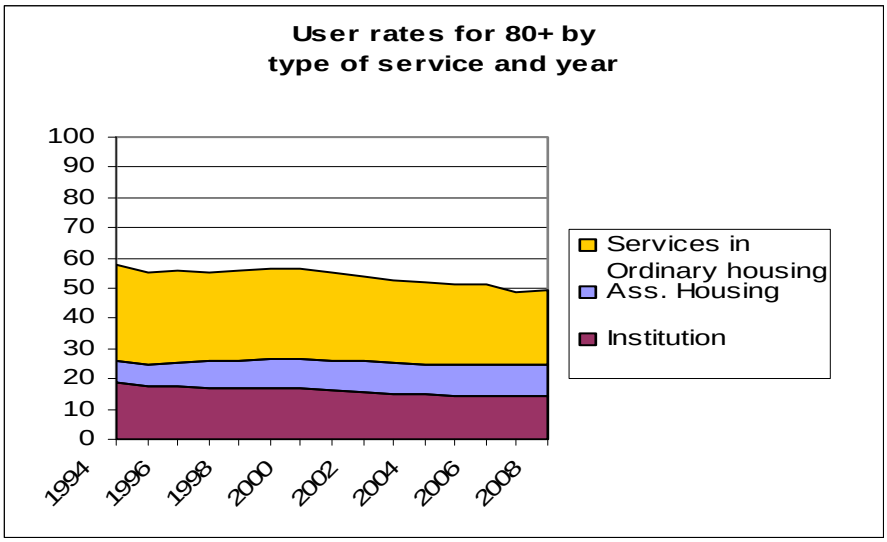


Table 2 summarizes the current volume of the various services as indicated by the number of service users in 2012. This table includes also younger age groups. Sixty two percent of long-term service users (168.600 out of 270.800) are aged 67 and older. Sheltered housing and nursing homes both have around 44.000 units, but nursing homes are used for elders only (90 percent). Younger people with extensive needs are receiving care in sheltered or ordinary housing. To paraphrase Kane and Kane (2005): Why is it that institutions that are considered irrelevant or inhumane for younger people still tend to be seen as appropriate for older ones?

The majority of service users are anyhow in open care, also among elders, and most of them have quite moderate needs. Nearly 25 percent of older service users (38,700 of 168,600) are currently in institutional care, but they consume close to 75 percent of total expenditures for elder care.

Table 2. Services and service users by age in Norwegian long-term care, 2012.

	Total	Younger (<67)	Older (67+)	Percent older
Institutional care	**43 400**	**4 700**	**38 700**	**89**
Short-term	9 200	2 700	6 500	71
Long-term	34 200	2 000	32 200	94
Sheltered housing	**44 800**	**19 200**	**25 600**	**57**
24 h staffed	16 400	8 800	7 700	47
Other staffed	6 600	2 500	4 100	62
Not staffed	19 300	6 600	12 700	66
Not known	2 500	1 300	1 200	48
Services in ordinary housing	**182 600**	**78 300**	**104 300**	**57**
Sum total	**270 800**	**102 200**	**168 600**	**62**

Source: Statistics Norway.

Norwegian long-term care also includes cash benefits, including a "public care salary" and other forms of allowances to carers or care recipients. A recent public commission has suggested to integrate and expand these allowances (NOU 2011:17), but as yet without

sufficient political support, indicating that cash-for-care arrangements are still controversial, and services continue as the dominant instrument under the Norwegian model.

Path dependency is also evident in the financing of long-term care, including the role of user fees and co-payments. User fees are quite moderate in the sense that they constitute around 15 percent of institutional care expenditures, and only 5 percent of home care expenditures. And yet, although user fees are moderate in percent of total expenditures, they may be considerable as judged by their proportion of residents' income. Residents in nursing homes pay around 75 percent of their basic pension, and 85 percent of additional income, for long-term stay, far less for short-term stay, as residents have then also payment obligations for their permanent housing. User fees have, however, not been raised, and wealth is still not included in the payment formula, only personal income from pensions or other sources.

Residents of sheltered housing pay rent and board and user fees for domiciliary help as any other citizen, probably in sum more or less as in institutional care. Residents of sheltered housing have, however, access to housing and medicine allowances - cash benefits which are covered by the state. Sheltered housing may therefore be economically favorable for local governments. As sheltered housing is also less regulated than nursing homes, they may allow more freedom in staffing. Sheltered housing may then be a more flexible service for local governments than institutional care, but as such also more vulnerable for cuts, which is a major argument against sheltered housing among groups in favor of the traditional institutional care model.

3. Recent trends and controversies

Recent trends and controversies refer to the balancing of services on the one hand, and the balancing of responsibilities on the other - between central and local governance, and more generally, between the public and private sectors.

Balancing of services

Sheltered housing developed from the 1960s onwards as part of a general de-institutionalisation ideology. Developments gained pace in the 1990s in response to generous state subsidies for this purpose. Among the motives for sheltered housing were to individualize care (according to needs, not sites), and to separate responsibilities for housing (personal responsibility) and services (Welfare State responsibility). Sheltered housing was also expected to encourage self-help and stimulate family care (Rodrigues, Huber and Lamura, 2012), and therefore to be both cheaper and better. But whereas de-institutionalization was accepted as a general norm for the younger disabled, elder care continued under two regimes, and the balancing between sheltered housing and nursing homes remained politically and professionally controversial in Norway, in contrast to Sweden and Denmark. Part of the reason may be found in path dependency, and more specifically the stronger medical orientation in Norwegian long-term care following the inclusion of nursing homes under the hospital act in 1970. In balance, Norway had correspondingly lower investments in open care (Daatland 1997).

When sheltered housing was promoted with generous state subsidies from the mid-1990s onwards, the role of sheltered housing, and the balancing vis-à-vis nursing homes, came to be quite controversial, with supporters of each in separate camps (Romøren and Svorken 2003). The social democratic party, then in government, favored sheltered housing, whereas nursing homes had strong support in the political right and in the population, in particular among lobby groups among elders themselves. The result was a political compromise that conceded something to both positions, but gave priority to sheltered housing: 25,000 assisted housing units and 6,000 nursing home units were added between 1995 and 2005. Housing standards were raised also within nursing homes, and service standards raised within sheltered housing. Differences between the two were for these reasons blurred, but most local governments protected the nursing homes, and added sheltered housing as a supplement and not an alternative to nursing homes. Residents were under this model moved from one standardised form of care to another when needs changed. A person centered model would work better (Houben 1997), where services were flexible and adapted to the individual, not the other way around. Unnecessary moves might then be avoided. Sheltered housing could then operate as a continuing care alternative, whereas nursing homes function as semi-hospital for short-term treatment and rehabilitation. The division of responsibility between nursing homes and sheltered housing has remained a controversial issue and is still not settled.

Balancing between the state and local governments

Norway is by tradition a quite decentralized country, where social services and primary health care is delegated to municipalities (n=428), with considerable freedom in how to handle these responsibilities. Counties (n=19) are located at an in-between level of governance, but have the later years lost responsibilities to municipalities on the one side, and to the state on the other. Thus, municipalities have taken over some health services that were earlier a county responsibility such as nursing homes, whereas the state has taken over the hospitals, which are now, since 2002, organised as regional enterprises under the state.

Decentralisation is carried further in Norway as judged by the larger number of municipalities in Norway (n=428) than in Sweden (n=290) and Denmark (n=98). Norwegian municipalities are on average far smaller than the Danish and Swedish, with an average population size around 11 000, and a range from 218 to 630 000 inhabitants. Half of Norwegian municipalities have less than 5 000 inhabitants, and yet, they have in principle the same responsibility as the large cities, including the responsibility for long-term care. A recent government commission has suggested that Norway follow Denmark and Sweden and reduce the number of municipalities in order to reach a critical mass in each municipality. What the implications would be for long-term care is not clear, but as the larger municipalities are more inclined towards outsourcing services, a reform along these line is likely to represent some degree of privatization.

Municipal authority has in reality become more limited than originally intended under the governance reforms in the 1980s, because the state has taken more direct control over total expenditures, and has introduced new, ear-marked subsidies for designated purposes. Higher state ambition is also seen in the introduction of national norms and standards, which would have reduced local authority even further. The long-term consequences of these developments are uncertain, but they indicate a lack of trust in local governance, and reduce the potential for change in the long-term care system.

The public-private balance

A more adequate balancing of services has been achieved via the higher priority given to sheltered housing and community care, but nursing homes still consume the larger part of expenditures in elder care, and comparatively fewer are today receiving services compared to a decade or two ago. Minor needs are in this process left unmet or pushed over on the private sector, in particular on the family. Some re-familialisation of care may therefore have taken place.

The basic corner stones are, however, still in place: the state as the primary responsible, financing by general taxes, services as the main instrument, and universal eligibility, although in a more narrow fashion and therefore leaving a larger space for the private sector (see table 1). Various forms of privatisation have expanded and may represent some convergence towards the liberal and continental Welfare States. Service provision is increasingly contracted out to private organisations or companies, and local governments have in these cases assumed a more indirect role. Competition and out-sourcing of services is expected to give more value for money, and to allow more freedom of choice for consumers.

These developments have been more radical in Sweden and Denmark. The private sector has doubled in these two countries the later 10-20 years, but is as yet fairly low (15-20 percent of total) compared to countries like Germany and the Netherlands, where private service provision dominates. The private sector is even less in Norway, estimated to around ten percent of institutional care (but higher in the larger cities), and mainly on a non-profit basis.

Sheltered housing may also be seen as a form of privatization, in that housing expenditures are then carried by the person him- or herself, whereas Welfare State responsibility is restricted to servicing. This is, on the other hand, a normalising of later life, and include residents of sheltered housing (and nursing homes) as full citizens. There is more reasons for concern about the socio-emotional quality of life in long-term care, as staffing is in general low, and leave socio-emotional needs unmet. These needs can hardly be fully met by professional staff, and need cooperative efforts of staff, family, and civil society.

More than an export of responsibilities to the private sector, is an import of market ideology into the Welfare State, as new public management, implying increased risk of social aims being lost to more instrumental values. The basic characteristics of the Scandinavian model is, however, still in place, but will they be sustainable?

4. The sustainability issue

Having established that Welfare States differ not only in their efforts, but also in the direction these efforts take, we can conclude that modern Welfare States are similar in that they all operate with some form of mixed responsibility between the family and the state, with supplementary efforts from neighbours, friends, civil society, and commercial services. How adequate the various models are for an ageing population is a controversial question, not only because welfare policies are rooted in political and ethical normsbut also because countries are differently located as far as population ageing is concerned. Some convergence may be observed in terms of less state in parts of Scandinavia, and more state in parts of continental

and southern Europe, in the latter case mainly via the introduction of national, mandatory long-term care insurances.

Sustainability is a matter of the future balancing of demands and resources. Future demands may be illustrated by population ageing and changes in the family structure. Some countries face a more radical population ageing than others. Germany and Spain are cases in point, and are expected to increase their 65+ populations from around 16 percent today to around 30 percent in 2040 according to OECD estimates (Huber et al. 2009). Even more radical is the expected change for countries such as Italy and Japan. Scandinavian countries were early in the demographic transition, but future ageing will be more moderate. The ironic thing is that countries with the strongest and most collectivistic family culture are today the very countries where people are now most hesitant to establish new families (Esping-Andersen 1997). The more individualistic north and west of Europe, with a tradition for weaker family ties, is currently a more favourable territory for family formation.

Demands are also subject to health variations, and may be less than expected on the basis of population ageing only, if new cohorts have better health than the earlier. Developments to date, as measured for example by institutional care rates, indicate that they will, but demands will anyway increase in response to the larger number of elders. The role of family change is also uncertain. As life expectancy of men close up to that of women, partner care will probably increase, whereas care from children may decline, in response to the higher labor participation rates of women (daughters)(Gaymu et al. 2008). Family ideals are also in change, and indicate a growing reluctance to becoming dependent upon the family, and instead directing demands towards the Welfare State.

These are among the reasons why European countries face different dilemmas. For Scandinavia the challenge is one of high costs and solidarity between age groups: Will younger workers continue to support the Welfare State and the high taxes needed to sustain it? If not, a less generous Welfare State will allow more inequality, and threaten one of the basic ideals of the Scandinavian welfare model, that of equal opportunities. For Continental and Southern Europe the challenge is more likely related to family solidarity and gender roles: Is the dominant role of family care feasible, and reasonable, when populations are ageing and women shall enjoy equal opportunities to those of men?

The Scandinavian Welfare States need stronger solidarity between age groups when populations grow older. The good news is that European populations are still very supportive to the Welfare State and to provisions for older people in particular (Taylor-Goobie 2004, Marcum and Treas 2012). Older people score high on deservingness; they so to speak embody the most honourable of clients, and attract more support in popular opinion than any other group (van Oorschot 2006). Long-term care is therefore still protected in public opinion and as such in democracy, but further population ageing may add to these demands and put intergenerational solidarity at risk on both the societal and family levels. Will younger cohorts and younger family generations be able and willing to respond?

The challenges are thus located both in demography and the Welfare State. Population ageing is general, but challenges differ from one country to the next because the rate of change

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

The familialist Welfare States need larger and stronger families when they in fact grow smaller and weaker. Family dominance in care is therefore hardly feasible when the older generations are increasing in numbers, whereas the younger are decreasing. Italy is currently trying to fill the gap with close to one million migrant carers from post-communist countries. Other low-service countries are doing likewise, if not yet as radical, but the Italian solution can hardly be made into a general norm.

The financial crisis has added an extra burden on the very same countries that have already less developed Welfare States. As many Welfare States found their form when old people were few, but their needs many, they were often biased to the benefit of elders (Esping-Andersen 2002, Lynch 2006). Sustainability is therefore also a question of a fair distribution between generations. Sustained support for an elder-friendly Welfare State will likely require that also the needs of younger people and future generations are met.

Interestingly, each welfare model seems to have a resonance in their populations. Whereas family care is the preferred choice in familialist Welfare States, public services are preferred choices in countries where such services are available and of a decent standard (Huber et al. 2009). Elders in the northern regions of Europe live by the ideal of intimacy at a distance. They prefer independence for themselves, and fear to be a burden on their families. Other ideals prevail in more familialist countries, where family care is expected, if not wanted, from both sides of the relationship (Daatland 2009). Recent findings indicate that also southern Welfare States, such as Spain, have considerable and increasing support for the Welfare State and public service provision.

Thus, ideals have legacies, but are also in motion, and more likely towards some form of public responsibility than back to the family. Naturally, families will also have their stake in future care systems, together with the Welfare State and civil society. Personal responsibility likewise, including self-care and the financing of sheltered housing. Modern technologies may also help older people and their families, as suggested in a recent governmental report on the modernisation of long-term care (NOU 2011:11).

But finally, sustainability is probably first of all a matter of political and popular will to support the Welfare State. The new welfare vision is then an old one, where the Welfare State once again is regarded as an investment and a promise for the future, not as an alien burden. After all, what is a better use of our common resources, and how can we better cope with our uncertain futures?

References

Alber, Jens. 1995. "A Framework for the Comparative Study of Social Services." *Journal of European Social Policy* 5(2): 131-149.

Albertini, Marco, Martin Kohli, and Claudia Vogel. 2007. "Intergenerational Transfers of Time and Money in European Families: Common Patterns - Different Regimes?" *Journal of European Social Policy* 17: 319-334.

Anttonen, Anneli, and Jorma Sipilä. 1996. "European Social Care Services: Is It Possible to Identify Models?" *Journal of European Social Policy* 6(2): 87-100.

Bettio, Francesca and Janneke Plantenga. 2004. Comparing care regimes in Europe. *Feminist Economics*, 10(1), 85-113.

Bettio, Francesca and Alina Veraschagina. 2012. *Long-term Care for the Elderly. Provisions and Providers in 33 European Countries.* European Commission, Luxembourg Publication Office.

Blome, Agnes, Wolfgang Keck, and Jens Alber. 2009. *Family and the Welfare State in Europe: Intergenerational Relations in Ageing Societies.* Cheltenham: Edward Elgar.

Castles, Frances (editor). 1993. *Families of Nations: Patterns of Public Policy In Western Democracies.* Aldershot Hants, England: Dartmouth.

Castles, Frances, and Herbert Obinger. 2008. "Worlds, Families, Regimes: Country Clusters in European and OECD Area Public Policy." *West European Politics* 31(1-2): 321-344.

Daatland, Svein Olav (editor). 1997. *De siste årene. Eldreomsorgen i Skandinavia 1960-95*. Oslo: NOVA, report 22-1997.

Daatland, Svein Olav. 2009. "How to Balance Generations: Solidarity Dilemmas in a European Perspective." In *Valuing Older People: A Humanist Approach to Ageing*, edited by Ricca Edmondson and Hans-Joachim von Kondratowitz. Bristol: Policy Press, 123-138.

Daatland, Svein Olav, and Ariela Lowenstein. 2005. "Intergenerational Solidarity and the Family-Welfare State Balance." *European Journal of Ageing* 2(3): 174-182.

Daatland, Svein Olav, Marijke Veenstra, and Ivar A. Lima. 2010. Norwegian sandwiches. On the prevalence and consequences of family and work role squeezes over the life course. *European Journal of Ageing*, 7, 271-281.

Daatland, Svein Olav, Katharina Herlofson, and Ivar A. Lima. 2011. Balancing generations: on the strength and character of family norms in the east and west of Europe. *Ageing & Society*, 31, 1159-1179.

Ervik, Rune and Tord S. Linden (editors). 2013. *The Making of Ageing Policy. Theory and Practice in Europe*. Cheltenham: Edward Elgar.

Esping-Andersen, Gosta. 1990. *The Three Worlds of Welfare Capitalism.* Princeton: Princeton University Press.

Esping-Andersen, Gosta. 1997. "Welfare States at the End of the Century: The Impact of Labor Market, Family and Demographic Change." In *Family, Market and Community: Equity and Efficiency in Social Policy*, edited by Patrick Hennessy and Mark Pearson. Paris: OECD, 63-80.

Esping-Andersen, Gosta. 1999. *Social Foundation of Post-Industrial Economies.* Oxford: Oxford University Press.

Esping-Andersen, Gosta (Editor). 2002. *Why We Need a New Welfare State.* Oxford: Oxford University Press.

Ferrera, Maurizio. 1996. "The 'Southern Model' of Welfare in Social Europe." *Journal of European Social Policy* 6(1): 17-37.

Godager, Geir, Terje P. Hagen, and Tor Iversen. 2011. *Omfang og sammensetning av omsorgstjenester i de tre nordiske land*. Universitetet i Oslo: Helseøkonomisk forskningsprogram, HERO, 2011:2.

Gaymu, Joëlle, Patrick Festy, Michel Poulain, and Gijs Beets (editors). 2008. *Future Elderly Living Conditions in Europe.* Paris: Institut National D' Études Démographiques.

Hajnal, John. 1982. "Two Kinds of Pre-Industrial Household Formation System." *Population and Development Review* 8(3): 449-494.

Hajnal, J. 1965. "European Marriage Pattern in Perspective." In D.V. Glass & D.E.C. Eversley (eds.), Population in History. Essays in Historical Demography (pp. 101-143). London: Edward Arnold.

Hantrais, Linda. 2004. *Family Policy Matters: Responding to Family Change in Europe.* Bristol: The Policy Press.

Huber, Manfred, Ricardo Rodrigues, Frédérique Hoffman, Katrin Gasior, and Bernd Marin. 2009. *Facts and Figures of Long-Term Care: Europe and North America.* Wien: European Centre.

Houben, P. 1997. Challenges in the Modernization of Dutch Housing and Care for the Elderly. *Housing Studies*, 12, 3: 355-366.

Höllinger, Fritz, and Max Haller. 1990. Kinship and Social Networks in Modern Societies: A Cross-Cultural Comparison Among Seven Nations. *European Sociological Review*, 6(2): 103-124.

Johansson, Lennarth, Gerdt Sundström, and Linda Hassing. 2003. "State Provisions Down, Offspring's Up: The Reversed Substitution of Old-Age in Sweden." *Ageing and Society* 23(3): 269-280.

Johnson, Julia, Sheena Rolph, and Randall Smith. 2010. Residential Care Transformed. Revisiting "The Last Refuge". Basingstoke: Palgrave Macmillan.

Kane, R.L., and R.A. Kane. 2005. "Long-term Care", in Malcolm L. Johnson (editor), *The Cambridge Handbook of Age and Ageing* (pp. 638-646). Cambridge: Cambridge University Press.

Laslett, Peter. 1983. "The Significance of the Past in the Study of Ageing." *Ageing and Society* 4(4): 379-389.

Leibfried, Stephan. 1992. "Towards a European Welfare State: On Integrating Poverty Regimes in the European Community." In Zsusa Ferge and Jon E. Kolberg (eds.), *Social Policy in a Changing Europe*. Frankfurt: Campus Verlag, 245.

Leitner, Sigrid. 2003. "Varieties of Familialism. The Caring Function of the Family in Comparative Perspective." *European Societies* 5(4): 353-375.

Lynch, Julia. 2006. *Age in the Welfare State. The Origins of Spending on Pensioners, Workers, and Children*. Cambridge: Cambridge University Press.

Millar, Jane, and Andrea Warman. 1996. *Family Obligations in Europe.* London: Family Policy Studies Centre.

NOU 2011:11. Innovasjon i omsorg. (Norwegian governmental report: Innovations in care).

NOU 2011:17. Når sant skal sies om pårørendeomsorg (Norwegian governmental report:

Supportive OECD. 2005. *Long-Term Care for Older People.* Paris: OECD.

Oorschot, Wim van. 2006. "Making the Difference in Social Europe: Deservingness Perceptions and Conditionality of Solidarity among Citizens of European Welfare States." *Journal of European Social Policy* 16(1): 23-42.

Reher, David S. 1998. "Family Ties in Western Europe: Persistent Contrasts." *Population and Development Review* 24(2): 203-234.

Rodrigues, Ricardo, M. Huber, and Giovanni Lamura (2012). *Facts and Figures on Healthy Ageing and Long-term Care. Europe and North-America*. Vienna: European Centre.

Romøren, Tor Inge, and Borghild Svorken. 2003. *Velferdsstat og velferdskommune. Iverksetting av Handlingsplan for eldreomsorgen i kommunene i Nord-Trøndelag*. Oslo: NOVA, rapport 12-2003.

Stortingsmelding 29 (2012-13). Morgendagens omsorg (Governmental report to the Parliament: *Future Care*. Ministry of Health and Care Services).

Sundström, Gerdt et al. (2011). Diversification of Old-age Care Services for Older People: Trade-offs Between Coverage, Diversification, and Targeting in European Countries. *Journal of Care Services Management*, 5, 1: 35-42.

Szebehely, Marta. (editor). 2005. *Äldreomsorgsforskning i Norden. En kunskapsöversiki.*: København, Nordisk Ministerråd, TemaNord 2005: 508.

Szydlic, Mark. 1996. Parent-Child Relations in East and West Germany Shortly After the Fall of the Wall. *International Journal of Sociology and Social Policy* 16(2): 63-68.

Taylor-Gooby, Peter. 2004. "Open Markets and Welfare Values: Welfare Values, Inequality and Social Change in the Silver Age of the Welfare State." *European Societies* 6(1): 29-48.

Titmuss, Richard M., Brian Abel-Smith, and Kay Titmuss (editors). 1974. *Social Policy: An Introduction.* London: Allen & Unwin.

Recommended citation

Daatland, Svein Olav (2015): Norwegian long-term care: Legacies, trends, and controversies. GIGAPP Estudios/Working Papers. Grupo de Investigación en Gobierno, Administración y Políticas Públicas. Instituto Universitario de Investigación Ortega y Gasset. Madrid. Num. WP-2015-02. 20 pp.

Grupo de Investigación en Gobierno, Administración y Políticas Públicas

Fundación José Ortega y Gasset-Gregorio Marañón
Instituto Universitario de Investigación Ortega y Gasset

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Instituto Universitario de Investigación Ortega y Gasset. **(ISSN: 2174-9515)** http://www.gigapp.org/