Exploring gender equality among caregivers: a sub-study based on the Nordic network[1]

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1. Introduction

This study is part of an ongoing project, "Understanding gender inequality among caregivers in the ageing sector in the Nordic countries" (short name: NIKK-AGE-Caregivers), which is funded by the Nordic Council of Ministers' Nordic Gender Equality Fund (NIKK). The purpose of this project has been to develop a broader research network and at the same time to conduct a small study on gender equality amongst caregivers within Finland, Sweden, Norway and Iceland. An additional aim has been to promote new knowledge that contributes to the enhancement of gender equality in the eldercare sector.

Care has been discussed in an extensive range of feminist, social and political research (Pritlove et al., 2019; Zechner 2010) and it has been identified as a multifaceted and complex concept that encompasses the emotional, economic, personal and social aspects of care. Researchers have revealed that "despite its universality, the worlds of caring and the ways of providing it vary depending on time and culture" (Anttonen & Zechner, 2011, p.15). Care includes both informal (family-based) and formal (services-based) care (Heintze, 2013). Informal care is given by family and or other close persons, such as neighbours and friends, and formal care is attainable from the care services, which may be public or private (Zechner, 2010). The Nordic countries share comparable welfare policies as well as similar socio-

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economic, cultural and political features. The primary responsibility for providing care and assistance for the disabled and the ageing lies with the municipalities (Heintze, 2013, p.20). An ageing population is one of the major concerns in the Nordic region, and the demand for caregivers is increasing in all of the countries. At the same time, each country pursues a policy of gender equality at all levels in its policies.

1.1 The aim and objectives of the NIKK-AGE-Caregivers project and Nordic added value

The project aims to bring about an environment in which researchers in the four countries establish networks, cooperation and collaboration. Sharing experiences and convening forums for dialogues on the substantive issues bring added value in knowledge building, which will help to identify concrete challenges and develop a research platform and research agenda. These efforts also serve to broaden the network and highlight the needs related to the proposed theme: care work, caregiving and gender (in)equality. In this light, the project will prove to be highly significant, creating added value for Nordic knowledge. The main purpose of the project, which it has succeeded in realising, has been to form a network of scholars in order to strengthen cooperation amongst its members, who have met not only virtually but in two face-to-face workshops during the project period. The workshops conducted brainstorming exercises on the following issues and questions:
Comparison the caring politics, gender segregation in the field, and the position of immigrant employees in different Nordic countries. In what way are women as caregivers in the elderly service sector multiply vulnerable? Do they suffer from inequality and social injustices from diverse perspectives? How do the dynamics in the care sector create a complex situation? How do the policies prevailing in the labour market interact in the Nordic welfare model when compared to other job sectors?

This study is mainly based on a synthesis of existing literatures, small data sets from interviews and discussions, and suggestions by the project participants made in workshops during the period from 2019 to 2021. This paper proceeds as follows. Section 2 discusses the definition of gender equality and some examples of (in)equality practices in the Nordic countries. Section 3 goes on to describe the context of the study and Section 4 the data collection processes. Section 5 examines caregiving and gender

equality based on the literature reviews and interview data. Section 6 concludes the study and puts forward salient policy recommendations.

2. Conceptualising Gender Equality with Nordic perceptions and practices

There is no absolute definition of gender equality, given that equality is a changing phenomenon influenced by the transformation of societal functions. It is argued that gender equality is a matter of removing unfair obstacles and ensuring that everyone, regardless of gender, has the same opportunities (Elomäki et al., 2021; Bettio and Sansonetti, 2015, p. 11). In the legal context, the rule of law is the source of gender equality (World Development Report, 2012). Gender equality is context dependent even though one finds uniform legal prescriptions of equality before the law. Hence, for meaningful gender equality, one needs to invoke the concept of gender justice.

Gender equality entails not an only equal distribution of men and women in all domains of society, but also refers to equal rights, responsibilities and opportunities for women and men and girls and boys (UN Women). In social justice theories, it has been stated that inequality occurs when the status, rights and opportunities of individuals or groups are not equal (Svensson, 2021; Alkire et al., 2015). The notion is linked to fairness, and what is fair depends on maximisation of happiness or wellbeing in the experience of the majority of people.

Previous research has asserted that to create a fair society and to diminish gendered hierarchies it is essential to establish gender equality, which involves considerations of sameness and difference (Elwér et al., 2012). From the sameness standpoint, men and women are fundamentally the same and fairness is achieved through equal opportunities, which eliminate socially constructed gender differences (Verloo and Lombardo, 2007; MacKinnon,1997; Moller, 1989). From the difference standpoint, women and men are basically different and fairness is created by valuing (Elwér et al., 2012; Verloo & Lombardo, 2007) and embracing the differences or taking them into account. Therefore, equality does not mean that everything is the same for everybody, but rather that everyone (despite differences in gender, ethnicity, sexual orientation disability and age) has similar chances to participate. Among other things, there should be no structural barriers hindering access to or participation in

the care sector; it is not equality to assume that care is a task for women.

Differences in gender roles and unequal treatment in society create discrimination against women (Svensson, 2021; Begum, 2019; Svensson and Gunnarsson, 2012; Parvikko, 1992, p.93). This is very visible in the care sector, where the eldercare sector, for example, is characterised by a high proportion of women and low pay. Social justice contributes to equality with a particular emphasis on fairness and change (Kalsem and Williams, 2010).

Historically, the Nordic countries have been more progressive in addressing gender equality than the other European countries (Kantola et al., 2020; WEF, 2021). Efforts to address gender issues in the Nordic region (Finland, Sweden, Norway and Iceland) began more or less in the same period. The goals of gender equality in the countries were described as follows: "a kind of nationally encapsulated journey, a linear process of evolvement where everyone together continuously strives towards the goal of equality between women and men vis-à-vis power and resources, participation and influence" (Lane and Jordansson, 2020). It has been also discussed that changes are taking place in the Nordic welfare society, threatening its ideals regarding gender equality (Eräranta and Kantola, 2016; Hirsto et al., 2014).

Nordic feminist legal scholars have asserted that gender equality and human rights law and policies applying to women are blind spots in politics (Gunnarsson and Svensson, 2017). Legislation is the main means to pursue women's rights (Ylöstalo, 2012, pp. 33–37). The public sphere, for example, sectors such as politics and working life, is seen as the central forum for this work but, as Hanna Ylöstalo has noted, structural obstacles in society prevent women benefitting from the possibilities available to them (Ylöstalo, 2012, p. 33). Nordic legal feminist scholars also have emphasised that the state should take every initiative to achieve equality of outcome by establishing an equal distribution of power and influence, economic equality, equal responsibility and the sharing of unpaid and domestic care work (Wennberg, 2008, pp. 339-343; Svensson and Gunnarsson, 2012). Ylöstalo (2012, pp. 44–50) also refers to the concept of diverse equality, asserting that it is not enough to concentrate on gender when analysing gender identities and power relations but rather that other differences must be taken into account as well.

Gender segregation allows for inequality and the Nordic welfare society has a high level of gender segregation (Tanhua, 2020). Segregation separates women's and men's work and teaches women and men different types of skills, which in turn divides power relations so that men are at the peak of economic power, whereas women have the primary responsibility for caregiving (Hirdman, 1988). The possession of power allows one to formulate, to include and exclude within the power structure. Power also relates to representing and giving a voice to, or to subordinating and silencing (Pylkkänen, 2009, p.14). Pylkkänen highlights the following factors for gender equality: political rights, education and wage labour (Pylkkänen, 2009, p. 11). Hence, gender equality is closely linked to a given country's politics, policies and practices (Sinevaara-Niskanen, 2015; Magnusson, Rönnblom and Silius, 2008). Over the past decade, labour market organisations, employers and trade unions have started to focus on individual women's opportunities to pursue careers achieve a work–life balance (Lane and Jordansson, 2020).

In the Nordic countries, the perception of gender equality is largely uniform, and alternative approaches adhered to among ethnic groups are ignored. Feminist experts (Naskali, P., and Keskitalo-Foley, 2017) studied intersectionality in Finnish adult education and revealed that ethnicity and race were not discussed in their data in adult education. Segregation is stronger in education and working life in Finland than it is on average in Europe (Tanhua, 2018; Bettio and Vershchagina, 2009). SEGLI's research provides new insights into the causes of occupational segregation using an intersectional perspective (SEGLI is a new type of equality project that addresses gender segregation based on factors such as ethnicity or social class). Scholar Inkeri Tanhua (2018), who worked in the SEGLI project, mentioned that ethnic segregation is one issue where gender influences career choices. Hence, it is also important to see how educational and social practices influence students' and the young generation's perceptions of their future and to probe the causes of care work-related segregation, especially in eldercare sector.

The Finnish labour market is strongly segregated according to gender (THL, Gender Equality). Women work more in the public sector, and men in the private sector. The most sectors with the highest proportion of women in 2019 were health and social services (women 86%); education (women 68%);

and accommodation and restaurant operations (women 68%). In 2018, only 9.2 per cent of employed persons in Finland worked in equal occupations, that is, occupations with at least 40% men and women (THL, Gender Equality; Statistics Finland, 2018). Previous research has revealed that immigration has alleviated gender segregation in some female-dominated areas, such as in community care, but has increased segregation in some male-dominated areas. At the same time, ethnic segregation has begun to emerge (Kazi et al., 2019). Many care responsibilities are unpaid work, even in the Nordic countries (Tanhua, 2018 & 2020). Here gender equality focuses on age, gender and ethnicity, discussing issues in an intersectional perspective.

3. Context of the Study (Nordic welfare states)

Due to low birth rates and improved life expectancy, the Nordic countries now have a rapidly ageing population. The demand for caregivers and informal help is increasing apace as well (Stone, 2016, p.99; Ladegaard, 2012). Despite this increasing demand, the eldercare sector is not being given the attention it requires. Notable shortcomings are that wages in the care sectors (both private and public) are very low compared to those in other sectors in the job market (Olakivi, 2018; Elwér et al., 2012) and working environments tend to be unattractive (Aalto et al., 2013). Significantly, both the eldercare professions and family care are female-dominated (Karsio et al., 2020). Often family caregivers are women who hold a job and also spend a great deal of time taking care of their children, older parents and relatives. As a result, care management in the Nordic states has sparked some debate and criticism (Esping-Andersen, 1990). It has been argued that the way in which care services in the Nordic states are organised is gendered and imbalanced because of prevailing societal power structures in both family and working life (Anttonen and Sipilä, 1996; Pfau-Effinger, 2005). The overwhelming majority of care providers in these countries are also women, and a significant number have an immigrant background (Armstrong, 2020, p.1).

Budget cuts and reductions in welfare services and social benefits, as well as public-sector employment policies (Kantola & Verloo, 2018; Villa & Smith, 2014), have seriously affected women's prospects of entering the labour market (Karamessini & Rubery, 2014). These changes "may lead to the familialisation of care and hinder

women's access to the labour market" (Sihto, 2019, p.13). The cuts in public service funding and the restricting of eligibility criteria for eldercare also mean that women are further burdened by family/informal care or that they need to restrict their employment for family care reasons (Karsio et al., 2020). Tasks in the educational, economic and certain other occupational sectors are strongly segregated by gender (SEGLI, 2018), which leads to several forms of inequality in the Nordic countries.

The boundaries between male and female work vary historically as well as with class, physical location, racialisation, immigration status and age, among other social locations (Armstrong, et al., 2008). For example, a recently published article in Finland (Hautamäki, 2018) indicates explicit segregation in the choosing of job paths for the second generation of immigrants. The article quoted a Muslim immigrant girl, Pazilaiti Simayijiang. She wanted to study medicine at the university and was qualified to apply, but her student counsellor (*opinto-ohjaaja*) encouraged her to apply to a vocational school and to pursue a career as a nurse or midwife. The girl sensed a discriminatory tone in the attitude and went on to comment "if you have an average grade of nine and blue eyes, no one will question your academic dreams. It's different if you wear a scarf" (my translation).

The Nordic countries differ considerably across different types of care provision, with eldercare being one example (Jakobsson et al., 2013; Rauch, 2007). Caregiving to older people has less of an effect on employment in the Nordic welfare states than elsewhere in Europe (Bolin et al., 2008; Kotsadam, 2011; 2012). Finland offers a form of support for informal care, the informal care allowance (ICA). This provides a combination of cash and time off for carers and replacement services to the person being cared for during the carer's time off (Morgan and Zechner, 2021). It is important to compare informal care for older and people with disabilities because care services for these two groups tend to differ even in the same country (Jeppsson et al., 2009). People with disabilities prefer not to receive care; they prefer to receive help and assistance instead since they see care as patronising (Zechner, 2010). Studies have indicated a decline in intergenerational care, attributed mostly to the expansion of public services. Reductions in these services are sometimes blamed for observed increases in support by adults for ageing parents (Daatland, 2001;

Sundström et al., 2002; Ulmanen and Szebehely, 2015), which also increases gender inequality.

3.1 A general overview of the eldercare system and immigrant- or migrant-related policy and law.

There have been many changes in the governance and organisation of publicly funded eldercare services in the Nordic countries (Meklin et al., 2009; Valokivi, 2019; Armstrong and Armstrong, 2020). Eldercare is mainly delivered as a combination of formal and informal help in Finland, Sweden, Norway and Iceland. There is little knowledge about the distribution between provider types in different service categories (Meagher and Szebehely, 2013, p. 87). Following is a synopsis of the different pieces of legislation and policies with a bearing on the eldercare system. It includes the framework legislation, the share of residential and home-based care, integration of immigrant and related policies, such as recruitment systems, as well as the development trends in Finland, Sweden, Norway and Iceland in recent decades.

Eldercare service provision and policies in relation to immigrant workers in Finland

The Finnish Constitution grants access to healthcare and social services as social rights to all citizens who needed such access. Eligibility for services is based on needs, no means-testing is in use (Morgan and Zechner, 2021). Finnish eldercare policy is a part of the national welfare policy (Valokivi, 2019). *The Social Welfare Act (1301/2014)* remains the major framework for social service provision, including eldercare services. According to the Social Welfare Act, local authorities are obliged to organise social services, provide social assistance and pay social allowances to their residents. From the beginning of 2023 this responsibility will be shifted to 21 newly created wellbeing services counties (and Helsinki, which is an area), with these mostly coinciding with the present hospital districts (Sote-uudistus, 2021). The municipalities and counties have the responsibility to organise services, but actual provision of services is carried out by public actors through outsourcing as well as by for-profit and non-profit actors. The more specific major law on the care of older adults is the *Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons* (980/2012), which contains more specific guidelines on how to support older populations. Especially important is section 14, which states

that long-term institutional care is only provided where there are medical grounds showing that it is necessary for the safety of the client or the patient. This portrays the primacy of ageing in place in Finnish care policies.

Ageing in place is also supported by the informal care allowance, governed by the *Act on Informal Care Allowance* (Laki omaishoidon tuesta, 937/2005). The allowance is used to support informal care for clients of all ages, but it is mostly used for eldercare; often carers are spouses, rather many of them men (Linnosmaa et al., 2014). The allowance offers the carer a monetary benefit, days off and insurance to cover occupational hazards and occupational illnesses, as well as coaching, training and health and wellbeing check-ups (Morgan and Zechner, 2021). In 2020 there were 55,797 informal caregivers who received the allowance, out of whom 38,494 were caring for somebody aged 65 or older (Sotkanet, 2021). Since 1994 the share of women among informal carers has been declining, but it is still 70 % (Linnosmaa 2014, p. 17; Noro, 2018). The gender gap was smaller among older age groups. The financial assistance minimum in 2021 was €413.45/month and the minimum in transition to "more demanding" care was €826.90 /month (Kuntaliitto, 2021; Noro, 2018).

The *Health Care Act* (Terveydenhuoltolaki) 1326/2010 governs healthcare provision as well as preventive measures, which are important given the health issues that older adults often face. In practice, eldercare in Finland consists of informal care and services that are mostly organised publicly and include home care, service housing and care homes. Assistive services and devices are also available, but services such as cleaning and shopping are often bought directly from the market. Despite the rather wide array of services on offer, past decades have seen increasing reports on unmet care needs in Finland (Kröger et al., 2019). There are more reports of older adults who have to choose whether to buy medication or food (Verbist et al., 2012).

Finland, like many other countries, is increasingly relying on foreign-born workers in its social and healthcare sectors (Näre, 2013). Migrant care workers find it difficult to get their qualifications officially recognised. This means that many registered nurses end up working as assistant nurses at lower pay (Vaittinen, 2017). According to Olakivi (2018, p. 14) "the main winners are the employers, who, instead of improving the quality of care work to attract indigenous professionals, can recruit migrants as a

compliant workforce that is willing—or forced—to work in poor conditions" (Näre, 2013; Wrede, 2010). A recent study reports that in Helsinki the percentage of migrants working as registered or practical nurses increased from 4% to 11% in the period from 2004 to 2013 (Olakivi, 2018, p. 14; Statistics Finland, 2016) yet the proportion of migrants working as head or ward nurses remained almost non-existent, that is, below 1% (Statistics Finland, 2016). According to scholars and migrant care workers, such recruitment tendencies misrecognise the true skills, competencies, and interests of migrant workers (Näre, 2013; Adhikari and Melia 2013). These trends in caregiving suggest inequalities with regard to migrant workers.

The authority in charge of residence permits in Finland is the Finnish Immigration Service (Migri). Its web page explains "when you are applying for a residence permit in order to work in Finland, you should notice that there are specific residence permit applications for certain types of work" (Migri). The pre-determined categories of work when applying for a residence permit are restaurant worker, cleaner or childminder; specialist; EU Blue Card; top or middle management in a company; visiting teacher, lecturer, instructor or consultant; au pair; athlete, coach or trainer, or sports judge or referee; working holiday; internship; internal transfer within a company; researcher; volunteer; and seasonal worker in agriculture or tourism. Care work is not specifically mentioned. Despite this there are numerous efforts especially by private companies to recruit migrants care workers for care and cleaning work (Näre, 2013; Koivuniemi 2020; Keränen, 2020). In 2014, the employment rate among persons 20 to 64 years old was 63.7 % for immigrants and 73.7 % for people with a Finnish background (THL, Työelämä).

Eldercare service provision and policies in relation to immigrant workers in Sweden

The views on eldercare have shifted throughout history, changing from a view of it as a private family matter to one considering it a societal and public concern. In Sweden publicly financed and high-quality eldercare services are available to all citizens, that is, all social groups, according to their needs rather than their ability to pay, (Sipilä 1997; Vabø and Szebehely, 2013).

Eldercare in Sweden is regulated in the *Social Services Act* (SFS 2001:453, Section/Chapter 5). The social services (governed by the Social Service Board

in each municipality) are responsible for promoting housing of good quality for the elderly and assisting with domestic help and service if needed. Since the 1980s, the Swedish welfare state project has gradually entered a period of budget cuts. Fewer people get services and care, now often granted in a more limited form, and the definition of needs has changed (Numhauser, 2017).

Today, women are well integrated in the labour market—84.5 % in 2017—but still the labour market is characterised by gendered disparities and gender inequalities. Unpaid care work in the private sphere of the family is still to a large extent a women's concern (Statistic Sweden (SCB), 2018). The public care sector finds itself challenged by demographic changes in combination with large numbers of workers reaching retirement age. The government has responded by appointing a national coordinator for the sustainable supply of skills in publicly financed care (Dir. 2019:77). The mission is to initiate and support change that could promote a good work environment by adopting new welfare technologies, thereby facilitating the work of the staff and providing increased quality for patients and users of welfare services and care.

In 2009 the *Act on System of Choice in the public sector* (SFS 2008:962) came into force in the healthcare and social welfare services. This new approach in Swedish social policy has also found expression in the introduction of choice in primary care, deregulation of the pharmacy market, freedom of choice in childcare, and tax deductions for household services. Privatisation in eldercare means outsourcing, with different care companies competing for contracts; care provision as such remains a public matter, financed through tax revenues (Andersson, 2013, 170-89). The majority of small municipalities have chosen not to introduce the free-choice system, while for the most part the larger ones have adopted it. In 2012 the National Board of Health and Welfare (Socialstyrelsen) took the view that it was too early to draw any conclusions on whether this marketisation has increased the quality in elder services and care. However, for persons with "reduced autonomy" the risk of becoming disadvantaged by the free-choice system and increased disparities among different groups seems tangible (Socialstyrelsen, 2012).

National values for elder services and care, such as living in dignity and having a feeling of wellbeing, were adopted in *the Social Services Act in 2010*, echoing internationally agreed

wellbeing objectives (Svensson et al., 2021). These values, however, do not form the legal basis for assessing whether a person is eligible for services and care. The *Discrimination Act* (2008:567) prohibits discrimination in the social services sectors and private performers of services and care are covered by the prohibition. Municipal autonomy, varying economic conditions and the political priorities established in each municipality entail a risk of discriminatory practices and inequality in outcomes.

Elder services and care provided in the private sphere by family and close persons have increased during the last decades. Even though there is no legal support for denying help and services with reference to the availability of family members and/or close persons, it has been shown that domestic help and services (hemtjänst) have been provided to a lesser extent for those cohabiting with a partner. Domestic help is largely provided by close persons, mostly women, and this practice is significantly more widespread among non-Nordic immigrants (Ulmanen 2016, SCB 2018).

According to the *Social Services Act* (2001:453), social services have to be of a good standard. Appropriate education and experience are required of the staff. (Chapter 3, para 3). The same applies to private domestic services and private residential care in special housing, with providers and performers needing an authorisation to offer services and care from the Health and Social Care Inspectorate (Chapter 7, para 1-2). The *National Board of Health and Welfare (Socialstyrelsen*) has issued recommendations on the basic knowledge that ought to be required for work in the elder services and care sector (SOSFS 2011:12 (S)). For example, sufficient knowledge of the Swedish language is required. The Board (Socialstyrelsen, 2017) also issues national guidelines for care in the case of dementia. The *2010 Introduction Activities Act* (Etableringslagen, 2010:197) sought to achieve faster establishment on the labour market for newly arrived immigrants and their accompanying relatives. The main objective was to create work incentives by making compensation conditional on active participation in establishment measures. Yet another legal reform was introduced in 2018 for the establishment of immigrants on the labour market and in social life (Prop. 2016/17:175). The legal amendments issued in Regulation (2017:820) harmonised the regulations for this group with rules valid for other jobseekers. Collective agreements on the labour market set the level for

wages and set priorities. The salaries are then individually decided in negotiations between the parties at the local level. The procedure is the same for those employed in the private and public sectors. Salary levels for caregiving are low-paid, but quite equal for men and women (See Facts and Figures). Facts about the salary levels of immigrants are not available.

Household services are to a large extent provided by immigrants and are identified as precarious work in Sweden. One of the objectives for introducing a tax deduction for household services was to make this kind of work "white" and thereby prevent exploitation. The social democratic Swedish welfare state had as one of its objectives to liberate individual persons from family and market dependency, thereby changing class and gender-based structures. Family responsibilities in the law for providing eldercare disappeared. Autonomy in relation to the labour market as well as in relation to the family (defamilialisation) was among the important objectives, not least in social law, and the ambition here was to include women in the labour market.

Eldercare service provision and policies in relation to immigrant workers in Norway

In Norway, local care service provision is influenced by the central government through legislation, regulations, judicial decisions, monitoring and substantial block grant funding. Eldercare is largely a municipal responsibility and health services try to offer the lowest level of effective care. Municipalities regulate the category of services and the volume of care depending on clients' needs. Home healthcare services are defined as the lowest level of care in Norway (Holm et al., 2017). The substantial variety in "the municipalities' demographic, geographic and economic character has resulted in diverse mixes of traditional residential care facilities, home-based care and intermediate solutions" (Vabø and Burau, 2011, Gautun and Hermansen, 2011). Older people's services are regulated mainly by the *Municipal Health and Care Service Act* (Act 2011-06-24-30), which merged, and replaced, the *Municipal Health Act* and the *Social Services Ac*t (Act 1991-12-13-81). In the year 2011, not more than 60% of total expenses in the care sector were spent on older people, but in 1998, 74% of spending went towards services for older people (Kjelvik, 2011).

The governmental reform "Leve hele livet" ("Living all your life") (St.meld.nr 15 (2017-2018) gives the municipalities in Norway a greater

responsibility for eldercare. The reform is a new and different approach to implementing measures for the future elderly healthcare policy. An important factor is the anchoring of the reform in local political consideration of the proposed solutions presented in "Living all your life" and in creating an age-friendly Norway. In order to assist the municipalities in carrying out the reform, the government provides guidance: Kompetanseløftet 2020, Omsorgsplan 2020 and Demensplan 2020. The "Leve hele livet" reform could therefore facilitate municipalities and others in learning from each other and in implementing good and innovative solutions in the services.

The willingness to prioritise financial resources for the elderly sector is very different in the municipalities. In small municipalities with lower populations and many elderly people, there is a greater willingness to prioritise elderly care. Small municipalities often have solutions that involve the whole community in various elderly care activities.

Some urban municipalities in Norway with larger populations often arrange international culture and sporting events that are given high economic priority and attention. As a result, the elderly sector suffers from a lack of attention, poor financial resources and having few permanent employees in full-time positions. A possible solution to this problem is that the state would earmark funding for elderly care.

In general, there are equal salaries for men and women in the elderly care sector. This also applies to immigrants. Salary compensation is dependent on education, competence and seniority. This also applies to immigrants. In Norway the elderly care sector is an arena for integration for immigrants (Eide et al., 2017). Increased immigration, including people with refugee experiences, has highlighted a need for more knowledge on effective integration measures. Within integration policies, the utilisation of ordinary workplaces has received increased attention in recent years. However, measures that utilise the ordinary workplace as an arena for training and qualification are manifold, from variants of work-first approaches, in which the aim is to get refugees and immigrants into work-related activities quickly, to longer programmes that combine job training and formal education, with the aim of building formal competence and human capital. Drawing on a comparative case study of seven local integration programmes, researchers (Eide et al., 2017) examined how the health and social care sector is

used as a component in qualification and training of refugees and immigrants. The study builds on interviews with employees of the institutions participating in the programmes. The researchers focused on how local measures may strengthen the human capital and attachment to the employment market of the participants.

Eldercare service provision and policies in relation to immigrant workers in Iceland

Over the last 20 years, there have been changes in policy regarding the care of older adults in Iceland to keep older people at home for as long as possible (Sigurveig et al., 2016). This is reflected in the *Act on the Affairs of the Elderly*, No. 125/1999. In Iceland, there are few laws and policies that influence caregiving. In *Laws on health care staff* (34/2012), which provide the quality framework for the healthcare professions, there is no mention of staff who do not have a legally valid job title, which caregivers do not have, or of informal staff. In the laws there is a focus on ensuring service, such as health-related homecare and social support services (which are governed by a special law, the *Laws on social service* (40/1991), also service driven), but no mention of how to ensure the quality of care and ethical rights, such as dignity and autonomy. According to *Municipalities' Social Services Act*, No. 40/1991, social care services are to be provided to older people living in normal houses; these services include social home help, day-care services at some centre and the like. Social home help includes help with domestic tasks (IADL), meals on wheels and similar services. Home healthcare offers personal assistance with daily living (PADL) and homecare provides nursing (Sigurveig et al., 2016, p.235).

The *Directorate of Health* oversees the quality of health service in Iceland. There are a number of policies and regulations on the matter of caregivers. In the minimum requirements for the operation of healthcare (2019), there is a stipulation to follow the Regulation on Supervision issued by the Medical Director of Health regarding the operation of health services and minimum professional requirements (2007). The regulation states the following where staffing id concerned: "Only healthcare workers who have an operating license provide the service. The number of healthcare workers must take into account the scope and nature of the service and the circumstances at each time". Another policy in this area is Defining Criteria for manpower in Nursing Homes

(2015), which comes closest to defining the quality of caregiving in the country and includes guidelines describing the requirements for nursing and living space (2007). As regards social services as part of homecare, the area where many caregivers work, there are no formal quality guidelines except for those some local authorities have put together for the standard of care they want to provide. The criteria for labour in nursing homes set the recommended proportion of skilled persons among staff at 77.87% and the minimum proportion at 57.13%. By way of example, a 2019 audit of one Icelandic nursing home, Sunnuhlíð (in Reykjavik, Northeast Region), concluded that the ratio was 45% and that was rather high compared to other Icelandic nursing homes. In this audit it was also stated that just under a third of nurses in Sunnuhlíð, or four of thirteen, were of foreign origin. There was no mention in the audit of the gender distribution among the staff.

The government policy on *immigration integration* (2007) states that the work participation rate in Iceland is among the highest in the world, especially among immigrants. This is encouraged with statements about guaranteed access for foreigners who are allowed to stay and work in Iceland and the policy extends to the labour market at large. Measures are taken if immigrants lose their jobs in the domestic labour market, with an emphasis on individualised services and active participation of the individual. How this operates in practice is hard to say. But *Laws on the working rights of foreigners* (97/2002) support this, as does the *Equal Treatment Act*, regardless of race and ethnic origin (85/2018). In the *Laws on matters regarding immigrants* (116/2012) there is no safeguard put forward for job security or recruitment; the legislation only mentions a social framework that applies to services provided by the state and local authorities. A report from the Minister of Social Affairs and Housing of Iceland on the status and development of immigration issues in 2016 states that an increase in possibilities for immigration would necessitate expanded opportunities for continuing education and work-related studies. The report puts forward a proposal for a special plan on the behalf of the government. Implementation planning on important issues of immigrants' population for the period 2016-2019. One additional goal is that immigrants should enjoy opportunities and rights in the labour market equal to those enjoyed by others. No research was found on the progress or outcome of this plan. However, a report from the State Audit from the year of 2018 points

out that unemployment is more common among immigrants than other Icelanders. In this light, it is clear that no exceptions are made for immigrant workers, publicly anyway.

4. Empirical study and the research process

In order to better understand how policies are implemented at the ground level, we carried out a small empirical study, undertaken by the lead author. Twenty caregivers and managers from Nordic countries– Finland, Norway, Sweden and Iceland – involved with elderly care were interviewed using a semi-structured questionnaire. The questionnaire encompassed the following themes and issues: elderly care sector (formal and informal, public and private) in their country; qualifications for caregivers and recruiting polices; impact of the corona pandemic in the care service sector; social problems and professional challenges; implications of marketisation in health and social care services; recognising equality and inequality; present situation of immigrant caregivers; number of men and women working in the care sector; present work atmosphere and future expectation and needs in this sector to promote gender equality among caregivers. To find the caregivers, e-mails were sent to managers of three institutions in Finland, Sweden and Norway. Some of the informants were located using a snowball technique from existing networks. The interviews were conducted between May 2020 and September 2021. A sample of the research questions was sent via e-mail to managers of care homes and to other individual caregivers. Respondents were also called via telephone to explain more about the aim of the interviews. Permission was received for the study by e-mail from the managers of the care homes. In the case of individuals, some permissions were received by e-mail and others orally before conducting the interviews. A total of 20 interviews were conducted, sixteen of care professionals and four of mangers. The distribution by country is as follows: six from Finland, two from Sweden, ten from Norway and two from Iceland. Among the twenty informants, six have immigrant backgrounds; three were men and seventeen were women. The age of the caregivers ranged between 25 and 55 years. Ten interviews were done face to face, the rest via telephone, zoom or e-mail. Not all informants answered all the questions. The discussion below is based on a combination of a literature review and the empirical data from the interviews.

5. Discussions on care work, caregivers and gender equality

In the Nordic countries, although the demand for caregivers is increasing in the care service sector, people are not interested in applying for jobs in the sector. The reasons for this include the relatively low status of the work, the low salary levels, stressfulness of the work and unfavourable working conditions. When older people need care because of their increasing fragility, they need services that provide direct emotional and social support (Brody, 1985). Care work encompasses caring for and caring about others, which entails both physical care and emotional care (Cancian and Oliker, 2000). But this caring work is traditionally ascribed a low status and is dominated by women (Elwér et al., 2012), an observation confirmed by all twenty informants. The managers and all the female informants mentioned that there is need for more male caregivers to balance out the gender distribution in the profession and to make it more gender equal. However, it is good to keep in mind that men are likely to experience downward labour mobility in relation both working conditions and social prestige if they start to work in the female-dominated care sector (Zechner and Anttonen, 2022). Men can do some of the work better, for example, lifting heavy clients. Previous studies show that it is difficult to evaluate gender equality in this sector because of the high proportion of women (Elwér et al., 2012).

Care work and support should not be seen as part of human nature, or something natural for women that does not require professional skills. Yet, it is often considered an instinctive ability of women that does not require skills and training (Tuominen, 2003). One point that was raised with reproach by the 20 informants was that care involves skills and responsibility with a combination of love and affection. Cancian and Oliker's (2000) research revealed the prevalence of this view whereby care work requires little training for caregivers and thus they may be paid less and given little respect (Cancian and Oliker, 2000, P. 9). In this regard. the manager of a nursing home from Norway stated the following: "Women like caring work very much, but the salary is low compared to their job responsibilities; they have too little time to do all work. They are very stressed; we need more people. They (caregiver) can use their education if they have time to read and come up with innovations. Now nurses are just running and running".

Working environments are very important in all sectors. Caregivers informally take on bigger responsibilities and risks when caring for clients, because of the shortage of workers in the healthcare system (George, 2008). Informants from Finland and Norway noted that because of the shortage, some caregivers who work regularly in the sector easily become tired, which impacts their health and wellbeing negatively. All women caregivers believe that wages and the status of care work would improve if society's perception of care work and the working environment improved and more men were employed in the sector. This view is supported to some extent by previous research (Elwér et al., 2012; Kröger and Vuorensyrjä, 2008, p. 225; Korvajävi, 2003).

Caregiving is generally thought to be a female duty in any society but this perception could differ between societies of distinct character and culture (Abellan et al., 2017). In this regard, a care manager from Finland stated that the most influential things shaping caregiving services are caregivers' family, financial situation and education, as well as government policies. Sociologist Stefánsson Kolbeinn in his interview (2019, published online) points out that the strong family ties of Icelanders and the culture that prevails there can have an effect. "I cannot rule out that this is strong in our culture as well, I think there is an interplay of these views and it can be difficult to realise which comes first. Is there is a strong culture for this and that is why we have not developed these resources well enough or has the culture been shaped in this way because the resources have been inadequate"? (Google translation from Icelandic)

In their research on the care service in the UK context, Hussein, S. and Christensen, K. (2017, p.763) note the following: "Personalisation and marketisation in particular create niche markets for migrant men where new roles that embrace gender diversity are created. Despite these circumstances, care work remains women's work and some migrant men who want to access this sector face by several challenges". One might rather say that there is nothing in care work which would prevent from men taking it up. It is not valued and low paid and can cause lower status in hierarchies (Hussein and Christensen, 2017; Palle et al., 2019). In stating the importance of male care professionals' role in a nursing home, women caregivers from Norway and Iceland mentioned that men can be good caregivers when this care work

reinforces a valuable identity for them and if it fits prevailing cultural beliefs about gender. Men will focus on caregiving work more intently than on other work when they know and realise that caring work is morally more meaningful than other work (Cancian and Oliker, 2000, P. 6-7; Palle et al., 2019).

Women do most of the unpaid and paid caregiving (Elwér et al., 2012). All twenty respondents talked about the low salaries in the care sector. Informants also mentioned how difficult it was for them to manage during the last year with the Covid-19 restrictions. They were separated from the social community since they were giving services to older people who were in a vulnerable situation. In this regard, an informant from Finland commented, "though relatives of the clients and Government have praised our work during this pandemic, it is not enough; the salary needs to be increased and the work environment should be improved". In the care sector, equality requires sharing the satisfactions and burdens of caregiving. All the care professionals interviewed mentioned that quality care work requires qualified and highly motivated people who give enough time to fulfilling the needs of care receivers.

Both the literature review and informants' experiences gave rise to a striking observation: for the most part, women remain the primary caregiver at home even when they are employed in a poorly paid caregiving job. These issues continue and exacerbate gender inequality in the public sector and politics, as well as at home. Informants also mentioned that individuals, communities and society are convinced that women are better at caring, partly because the gendered pattern has been so resistant to change (Cancian and Oliker, 2000, p.132). Policies in this regard are most likely to reinforce gender inequality, which encourages men to specialise in earning money and women to focus on unpaid family caregiving. The success of care worker policies in effecting gender equality depends on how well the policies, along with other social forces, bring men actively into domestic and paid care (Cancian and Oliker, 2000, p. 121).

Caring for others has also been considered natural in the Nordic tradition. The caregivers' main goals are to relieve the care receivers' sufferings and to support the health and wellbeing (Arman et al., 2015) of older people. To deliver quality services and to support older peoples' health and wellbeing, it is important to ensure caregivers' socio-economic

position and wellbeing. Caregivers' issues are essentially neglected, discussed less than they should be and not researched sufficiently. For example, Martinsen (2006) and Dahlberg (2008) have emphasised the lack of a caring consciousness regarding care receivers. This claim is also relevant for caregivers. An OECD report (Colombo et al., 2011) indicates that size of the working-age population is expected to shrink. Women between the ages of 25 to 54 years with a higher education are most likely to be employed as care workers (Stone, 2016; International Labour Office, 2013). Since care work is physically stressful and predominately low-paid, the availability of care workers has become more challenging in the Nordic countries, a point clearly articulated by care professionals from Finland, Sweden, Norway and Iceland. Based on informants' comments, it can be said that the situation and status of an occupational nurse (s*airaanhoitaja)* in Norway is better than in Finland. Many Finnish nurses have gone to work in Norway. Five interviewees (nurses) cited two reasons: the higher workload in Finland and higher salary and more free time in Norway. A female informant from Finland (s*airaanhoitaja*) remarked, "our union in Finland does not work properly for our wellbeing. We also had to do practical nursing in Finland, which is a waste of our valuable education. Here in Norway we have received proper recognition".

However, the Government has already carried out an extensive reform in Finland, namely the "family leave reform" (perhevapaauudistus), which will make the care done at home more equal and help women to get back into and stay in the labour market. Recently, a trend has emerged whereby immigrant women and men both are involved in the care sector in the Nordic countries, especially in long-term services and support. Many Finnish care professionals are also working in Norway. According to previous research and informants from the four countries, more immigrant men and women are being recruited in this sector. Many private family care receivers rely on private migrant workers (Bednarik et al., 2013), a trend which was cited by an immigrant male caregiver from Sweden. Among my informants were two male immigrant caregivers and one female caregiver who were giving services with just a few weeks' training. They do not have any nursing-related education. Informants from Norway mentioned that the proportions of native and immigrant care professionals in their institution are about 60 and 40, respectively. The migrants are from

Finland; from Asian and African countries, such as the Philippines, Thailand and Eritrea; Eastern Europe; Russia; and other countries. Most of the immigrants do practical nursing work. Language is the main barrier for some, hindering them from performing their job like native workers.

The empirical study elicited mixed comments from native care professionals about their immigrant colleagues. According to native caregivers, for example, "some men are working very fast, which shows lack of love and devotion for the work, whereas women caregivers from Asia show more respect, which older clients like it very much". A Muslim immigrant caregiver from Norway stated that she was a doctor in her native country but had not received a license to practice in Norway. She was working as a nurse in a private institution where I care for a disabled man and older people. When she went to another institute for a job interview, she had to face the prospect that she could not use the hijab if she were hired, which she found to be a violation of her human rights. She stated: "I am working in a private institution; because of the language barrier I could not apply in many places. I have an immobile client who is in wheelchair; it is difficult for me to move him from one place to another. I am receiving a very small salary, and the attitude of the clients' relatives toward me is not nice. This may be because I am Muslim; especially last Christmas his sister's attitude was racist".

The workforce in the care sector is also becoming more diverse nationally, as a growing number of people with immigrant backgrounds are being recruited. Such diversification is, however, far from evenly distributed (Olakivi, 2018). In 2001, only 1% of all employees in health and social services in Finland had an immigrant background, and by 2013 this had risen to 3% (Statistics Finland, 2016). It is difficult for immigrant care workers to get their qualifications recognised, a problem acknowledged by the care managers and all immigrant informants. Managers and immigrant informants made the same point. In this kind of situation, private organisations are making more profit and immigrants are facing more inequality than other workers.

In the health and social services in Helsinki, the percentage of employees with an immigrant background grew from 3% in 2001 to 9% in 2013 (Olakivi, 2018). In health services in Helsinki in 2013, 9% of all employees were foreign-born, whereas in social services, the

same proportion was 12%. In residential care for older and disabled people, the proportion of foreign-born employees was 19%. At the same time, the proportion of migrants among all employees in Helsinki was 10%. Immigrant care workers are underrepresented in managerial positions (Olakivi, 2018; Aalto et al., 2013: 66; Näre, 2013). Finland has courses specifically planned for migrants to attain the qualification of practical nurse (Nieminen, 2011). In Norway, the elderly care sector is an arena for immigrants (Eide et al., 2017). Increased immigration, including people with refugee experiences, has actualised the need for more knowledge on effective integration measures.

Immigrant care workers need work permit from the authorities. Of the people working as nurses, some have a degree, some have completed various courses, and some have at least taken language courses. Those who do not have nursing degree, are working as assistants to nurses. Temporary workers can work as caregivers but they do not have a permanent contract. Those who have no skills or education are paid much lower salaries and do not receive long-term work-related benefits, as they have short-term contracts. According to researcher Antero Olakivi (2018), migrant care workers are presented in diverse ways as active, independent and enterprising but also as cheap and disposable labour. He observes. "The recruitment of migrant care workers can also violate the interests of older clients if the language (or other) skills of migrants are conceived as deficient."

Many researchers in the fields of law and gender have found that unequal power is most often rooted in age, gender, ethnicity and class (Gunnarsson and Svensson, 2017; Ylöstalo, 2012; Svensson and Gunnarsson, 2012; Stenström, 1997, p. 45), which, according to some caregivers, is because of reduced budgets in municipalities. Additionally, some of the Norwegian caregivers stated that nursing homes and care institutions recruit people for care work from the street without requiring any education.

Previous studies on the role of managers in the care sector have revealed that the increasing tendency to recruit migrant workers is a practice guided by illegitimate, managerial and economic interests and managers' biased, stereotypical conceptions of migrant workers (Carter, 2000; Näre, 2013). However, most developed countries, including the Nordic

countries, have managed well with immigration schemes for recruiting foreign workers, but such schemes are relatively rare when hiring migrant workers in care services (Spencer et al., 2010). People without an immigrant background who have other options in the job market have rather little interest in the care profession. This trend gives a different picture of gender inequality in Nordic society. Care workers, especially immigrant women in practice, at times do two full-time jobs, one at home, the other at work. On many occasions, the societal mindset and expectations suggest that the care profession is the easiest one, and mainly meant for women.

6. Conclusion

The political situation is changing all the time and countries are cutting their welfare provision because of their current economic conditions and politics. Care includes strong professionality, responsibility and affection. It is very depressing that care work has not been seen as skilled work and thus has not been valued and respected properly. Women have remained the primary domestic caregivers. Today, women still do more of the caregiving, with society trying to maintain that they are more likely to understand care receivers' needs. Women continue to dominate the caregiving sector, even though many women are breadwinners in the Nordic countries. Women's majority in formal and informal care affects gender inequality; they lose paths to justice. It is also very disappointing that there are no signs that men are becoming caregivers in equal numbers. Gender-neutral policies seem to have intensify the distinctions between men's and women's employment. Law and government policy and programmes affect cultural beliefs and families' private struggles. Men can be effective caregivers if they have adequate resources of time and money and if they have learned appropriate skills and standards of caring.

In the empirical data respondents raised the point that the value of care work and the compensation offered are a mismatch; salaries remain low. Lack of sufficient workers often results in extreme pressure on existing caregivers, which affects both their physical and mental wellbeing. As a result, the quality of the work may suffer and it may fail to be as effective as desired. Because of overload and tiredness, some caregivers decide to take early retirement. This again brings other negative incentives for them: a low salary throughout their career, followed by a lower pension due to

early retirement, amounts to multiple vulnerabilities. As in other countries, in the Nordic countries being a wage-earner remains a source of respect, privilege and social power.

It is essential to hire properly qualified and well-paid care professionals in eldercare service institutions. Since most of the caregivers are women, this approach should go hand in hand. It has been stated that in all domains "of welfare an anti-racist dimension must become inseparable from promoting a feminist perspective" (Langan, 1992). We need to find the causes of and means to mitigate gender segregation. Pursuing this goal will not only be thought-provoking but also one possible way to promote equality. Based on the foregoing discussion, some recommendations and suggestions may be put forward:

- There should be some initiatives with a focus on the organisational level to mitigate segregation in educational institutions, in particular those that teach courses and give training leading to qualifications as care professionals.

- Revising the gendered images of care would help to encourage men's caregiving and improve caregiving in general. Labour market organisations and relevant unions should make care work more respected and rewarding, which would influence gender patterns in the sector.

- To improve both the rights and responsibilities of both men and women, a combination of measures should be used, such as better working conditions, higher status and salaries for the work, and sharing the responsibility for care giving.

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