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10. Conceptualizing Needs When Allocating Public Long-Term Care Services in the Welfare State

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Abstract The chapter explores and discusses the concept and phenomenon of needs within public long-term care services. A shift from primarily thinking of the welfare state as a safety net securing basic needs to considering it as a "trampoline," not only catching people but bouncing them up and back to an active life, is identified. This shift challenges the welfare state's ethos "... to each according to his or her needs" with its traditional emphasis on service provision, protection, and securing of vital needs.

Keywords long-term care | needs | potentiality | social investment | Norway

INTRODUCTION

In a universalistic welfare state setting, there is an ideal that care services are allocated based on needs and not on resources, merits, or potentiality. Nevertheless, there is no established consensus as to what this means for access and utilization of long-term care (LTC) services. In addition, in the literature there is a lack of conceptualization and theorization over needs regarding this sector, which calls for inquiries and discussions. This chapter aims to explore and unfold the phenomenon and concept of needs in an LTC setting. This will be done partly with a meta-conceptual approach, related to this concrete field of service provision. It will be followed by discussions over which understandings of needs are significant when the welfare state allocates LTC services as well as discussions over possible practical and ethical implications and consequences. Welfare state services and benefits can be understood as arrangements for preventing poverty regarding fundamental needs and mechanisms for securing basic needs when their fulfilment is threatened (White, 2021). A pivotal question behind the allocation of such

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benefits is how needs are understood and operationalized, i.e., conceptualized, content determined, and legitimized in concrete welfare state settings.

The main field of investigation is the LTC services supporting people with frailty, chronic illness, and disabilities (Österle & Rothgang, 2021). I will return to a closer description of this field of welfare services. Conceptualizations of needs in this sector may be observed and assessed from several angles — individual, social, and political. I start by pointing out six different LTC-related needs perspectives or "logics" that may influence the allocation of services. *Firstly*, there is an obvious and expected connection between the health condition of an individual and her or his LTC service utilization. It is well documented that illnesses and injuries affect social groups differently connected to inequality in living conditions, which are often passed on through generations. To some extent, such differences in health conditions may affect both long-term care needs and utilization. *Secondly*, people have different prerequisites and capabilities for advocating their self-perceived needs when encountering the long-term service administration in their local municipality. *Thirdly*, people's social networks vary by size and quality, with implications for the use of public services. *Fourthly*, there can be different normative understandings of what are necessary, adequate, and valid care needs in society among different groups, such as gender, age group, professionals, managers, and politicians. These groups outline the framework of what are considered worthy care needs and which people should be considered worthy care recipients. *Fifthly*, and connected to the previous point, there are various interests and struggles between groups and ideas in deciding what should be considered legitimate needs for receiving long-term care services. *Sixthly*, care needs are based on and developed as a result of the historical, material, and economic context. In this perspective, needs cannot be regarded as isolated from sociomaterial structures, as they are a product of these. Society shapes needs, and needs shape society. These perspectives will be discussed to varying degrees in the chapter.

The widespread use of the word "needs" in everyday language may hide differences in perceptions and result in a "taken-for-grantedness" regarding content and meaning. A conceptualization of a phenomenon is relevant, not because it reflects reality as such but because it is performative and has consequences for practices and manners of action, both within the services, in the population, and for the users of the services. Understandings and conceptualizations regarding needs matter, among other things because they impact what are considered legitimate needs for getting support. Furthermore, there is a lack of theorization over needs related to the LTC sector, and this calls for new inquiries and discussions within this field.

Norway will serve as the concrete contextual case in the chapter, but some Nordic and international comparisons will also be made. The analytical entry point is: Which understandings of needs seem to be important when the welfare state allocates public long-term care services and what are the consequences of those understandings?

To answer these questions, we need insight into the sector's distinctive elements and characteristics. Firstly, in this section, I therefore describe the LTC sector in Norway with some international comparisons. The emphasis here is on access and use of public LTC services. In the next sections I reflect on the phenomenon of needs in a welfare state context and discuss the concept of LTC needs from various perspectives and positions. In parallel with this, I will discuss possible practical and principled implications of the understandings.

LONG-TERM CARE SERVICES AND THEIR GATEWAY

LTC is an established term covering a heterogenous range of formal and informal care services that may support people with frailty, chronic illness, and disabilities (Österle & Rothgang, 2021). It can be described as a range of services required by persons with a reduced degree of physical or cognitive functional capacity, who are dependent on others' help in basic activities of daily life for an extended period. These persons are not capable of maintaining basic activities of daily life and welfare standards without such services and compensatory help. This includes domestic help, residential care, social support, and nursing care at home, in the community, in assisted living facilities, and in nursing homes. People of any age may need long-term care, although it is a more common need among older adults. The most common type of LTC is personal care, including help with personal hygiene, dressing, using the toilet, eating, and moving around — for example, getting out of bed and into a chair. LTC may also include health and nursing care services, adult day care, assistive technology, and transportation services. In most Western countries, LTC services are a mix of social and healthcare services and financial benefits, wholly or partially funded through the statutory services and social protection system, either at a local, regional, or national level. Aging populations with growing incidences of disabilities, looser family ties, and more two-worker households are all factors driving the increased demand for LTC services (Carrera et al., 2013; Greve, 2017; Österle & Rothgang, 2021).

As a response to this development, the LTC sector is a growing public field in most European countries (Ranci & Pavolini, 2013). However, the user coverage of LTC recipients at home (65+ and 80+) varies widely among European countries, with the highest rates in the Nordic counties, the Netherlands, and Switzerland

and the lowest in Eastern and Southern European countries (Spasova et al., 2018). In an international context, expenditure in welfare services as a percent of total social expenditure is high in the Nordic countries (Kautto & Kuitto, 2021). Austerity policies have put strong pressure on the range and coverage of these services. Priorities and discussions concerning which needs are found valid and legitimate for access to and receipt of public services are high on the professional and political agenda.

There is a general tendency toward reconsidering and tightening the eligibility criteria for access to public LTC services as an effort to ensure fiscal sustainability in the face of aging populations (European Institute for Gender Equality, 2020; Spasova et al., 2018). This development leads to increased financial burden on care recipients who must pay for additional services, and to extra pressure on family caregiver, mainly women, to cover care gaps (Ilinca et al., 2022).

Nevertheless, on a principled and idealistic basis, the European Union has recommended the development of expanded and more flexible formal LTC services in most member states to ensure adequate care, free up beds in hospitals, facilitate employment for both genders, and reduce social exclusion (Dubois et al., 2020). According to principle 18 in the European Pillar of Social Rights, "everyone has a right to affordable long-term care services of good quality, in particular homecare and community-based services. However, despite this right, the reality regarding access, coverage, and quality of LTC services differs considerably between various EU countries.

Let us now turn to the Norwegian context. Norway has, together with the other Nordic countries, been regarded as a flagship of universalism in social policy in general and in elder and LTC policy in particular, with high coverage of public welfare services. The local municipalities have great freedom to organize, prioritize, and allocate resources according to existing local differences and professional traditions. This has led to fairly large differences between the municipalities in terms of organizational structure and service content (Førland et al., 2020).

Historically, LTC in Norway has developed locally in cooperation between voluntary organizations and the municipality. This has been described as a political grassroots mobilization with strong universal and egalitarian patterns (Vike, 2018). Since the 1980s, the gateway to public LTC services has been considered universal, broad, and generous. This has contributed to safety for care recipients and their next of kin and has enabled high levels of work participation by both genders (Christensen & Wærness, 2018). Consequently, the public LTC services are comprehensive and an extensive part of the Norwegian welfare sector. The emphasis on public services rather than cash benefits places Norway within a

public service model (Anttonen & Sipilä, 1996) with services provided within a formally and professionally based care system.

Norwegian expenditure on LTC services as a share of GDP is high in a European context (OECD, 2019), reflecting the government's priority of enabling family carers to stay in the labor force. In 2022, there were about 250,000 LTC recipients (i.e., receivers of home-based care and nursing home care), corresponding to around 5% of the population. Approximately 210,000 of them are using different kinds of home-based care. A total of 29% of the population aged 80+ are home care service users (Statistics Norway, 2023a), and 33% of the municipal budget is spent on them (Statistics Norway, 2023b). In 2022, about NOK 155 billion (EUR 13.3 billion) were spent on LTC in municipalities (Statistics Norway, 2023a).

There have been escalating costs within LTC services during recent years (Andrews et al., 2021), and a future rise in use is expected due to an increasing aging population. There is an assumption that reduced public revenues in the future, due to a lower ratio of working age people to senior citizens, will cause stricter prioritization and allocation practices of public services in years to come, including LTC services. The aging population has called into question the future sustainability of these services and has led to an increased consciousness on health promotion, preventive measures, and early interventions as potentially cost-reductive measures. Such ambitions of "preparing" before "repairing" in eldercare can also be regarded as a "social investment strategy" in the sector (Lopes, 2017; Rostgaard, 2016). I will come back to this later in the chapter.

In Norway, LTC services are regulated by the Municipal Health Services Act, and day-to-day operational responsibility for these services lies with the municipalities at the local level. The services are primarily financed through tax revenue and block grants from the state, and for certain services, also through direct user payments. At the state level, the authorities govern through legislation, regulations, professional standards and guidelines, and more "soft power"—tools such as recommendations, education, inspection, and targeted grants (Grødem, 2018).

In principle, LTC services in Norway target the entire population with care needs, and the number of users aged under 67 has noticeably increased since the 1990s, while the numbers and proportions within the older age groups have been more stable and even decreased in some age groups over the last fifteen years (Otnes, 2015; Statistics Norway, 2023b). There is no established national consensus for access to LTC services. When persons apply for services, their needs are first assessed by healthcare personnel (a needs assessor), and then she or he is allocated LTC service or refused, based on local municipal criteria and professional discretion (Grødem, 2018), also representing a situation of negotiation between the applicant and the public service (Gautun & Grødem, 2015), which is not yet

much investigated by researchers. The decision to approve or refuse an application normally takes place within a separate allocation office, based on a written application, sometimes followed by a single home visit to the applicant. This is a rapid decision-making process at a distance, conducted by a single needs assessor (Gjerde et al., 2016; Vabø, 2012). The establishing of such practices can be related to the NPM reform and the introduction of a purchaser-provider model, with the aim of standardizing and improving the efficiency of the LTC services (Vabø, 2012).

Both national investigations and previous research have uncovered significant variations, shortcomings, and challenges concerning the entry gate of LTC services for new applicants regarding case management within the municipalities, including the gatekeeper and allocation role of the case managers. The Norwegian Office of the Auditor General's (Riksrevisjonen) concluded that the assessment and case management is often insufficient and deficient, revealing a need for higher competence and development of better allocation practices (Riksrevisjonen, 2018). Research has shown significant variations between municipalities' and front-line workers' assessment and allocation practices in Norway (Førland et al., 2020; Heggestad & Førde, 2019).

In Norway, as well as in the other Nordic countries, it seems that eligibility for public LTC services is tightening and has become more targeted to those with the most needs (Førland et al., 2021; Rostgaard et al., 2022; Sundsbø et al., 2023; Szebehely & Meagher, 2017). Researchers have also indicated that the principle of universalism and equality of access is being violated regarding the allocation of LTC services from the perspective of both gender (Jakobsson et al., 2016) and age (Gautun & Grødem, 2015).

Before I return to the topic of allocation and distribution of public LTC services, I find it necessary to dwell on some general aspects of the phenomenon of need.

THE PHENOMENON OF NEED

A conventional way of marking a distinction between the market and the welfare state is to say that the market centers on the satisfaction of "preferences," "wants," and "desires," whereas the welfare state relates to the fulfilment of "needs" (Goodin, 1988, p. 27). This is undoubtedly a complicated distinction. Preferences and wants are often associated with sheer subjective satisfaction, for instance, the enjoyment of smoking, and constitute too narrow and individualistic a concept to capture welfare as such. The concept of need is, on the other hand, usually associated with something in human nature that is more fundamental, universal, and egalitarian, like food (eating), water (drinking), and shelter (protection), as necessities for all

people at all times. However, there are dimensions of needs less basic and universal than those that are clearly connected to cultural and social contexts. For example, in our current society we are practically dependent on (in need of) bank cards and the Internet to make payments and to communicate with companies and public authorities. People without such resources or skills cannot participate in society on equal terms.

In an LTC context and especially within a healthcare context, needs are first and foremost connected to the realization of what are considered to be basic health and social needs. When these are not being fulfilled, human life is inhibited from developing or even surviving—for instance, in nursing, which has a long tradition of focusing on fundamental physical needs (breathing, eating and drinking, eliminating body wastes and staying clean, getting dressed, getting shelter and body warmth, moving and resting), emotional needs (being recognized, esteemed, loved), and social needs (communicating, belonging, learning, being curious, playing, believing); cf. Virginia Henderson's identifying of basic human needs related to nursing (Alligood, 2017). Further, in a healthcare context, needs and LTC eligibility and utilization in European countries are obviously connected to the health outcomes of the users (Carrino & Orso, 2014). We also know that illnesses and injuries affect social groups differently, tied to inequality in living conditions that are often passed on through generations (Arcaya et al., 2015). Social work also takes an interest in basic needs, understood as both basic material conditions for survival, welfare, and well-being, as well as the need to be recognized as social participants.

The term "unmet care needs" is of particular interest from a welfare state perspective and is well-established in the scholarly literature (Kröger, 2022). Williams et al. (1997, p. 102) define it as connected to LTC like this: "Unmet need occurs in long-term care when a person has disabilities for which help is needed, but is unavailable or insufficient." Further, unmet needs can be related to the concept of "care poverty," defined as inadequate coverage of care needs resulting from an interplay between individual and societal factors (Kröger, 2022; Kröger et al., 2019). The concepts are inherently complex and reflect different norms, cultural values, and policies, including underlying difficulty and struggles in society to define what are legitimate needs in different contexts, for instance, a local LTC service context. In a local public LTC service context, this is actualized through professional assessments and subsequently recognition or refusal of the applicant's expressed needs connected to local and national regulations, legislation, and financial opportunities and limitations.

Both perspectives on needs related to healthcare and social work actualize poles, boundaries, and discussions between "natural" and "socially created" needs

and between "basic" and "non-basic" needs that may be complicated, blurry, and controversial (Fitzpatrick, 2011). Despite such blurry relations and distinctions, it is appropriate to make a distinction between basic needs and societally created needs, where the first are understood as preconditions required for a sufficient life in any society and the latter as requirements for a decent life in the specific society to which a person belongs. Thus, eating, drinking, elimination of body waste, and resting are examples of basic needs, while literacy is an example of a societal need in technologically advanced societies (Miller, 1999). Nevertheless, all needs, including those considered as basic, are constructed through social processes and therefore influenced by differences in skills, interests, and cultural norms. One social dimension of this is that some people are unable to control the surroundings and means by which their needs become visible and met while others have the appropriate resources for this.

The Indian economist Amartya Sen is considered the developer of the so-called capability approach. This approach is more concerned with the citizens' actual opportunities to realize needs, welfare, and benefits than rules and principles of fair distribution. That refers to policies and priorities that develop equality in people's basic capability, understood as everyone's actual access to opportunities for and ability to realize basic functions, values, and benefits (Sen, 1980, pp. 217–220). For Sen, basic needs include adequate food and drink, good health, avoiding illness and early death, and more complex phenomena such as happiness, self-respect, participating in society, etc. Basic needs and the experience of well-being are a question of people's functioning in everyday life. Capabilities are an expression of the person's ability and power to realize desires for functioning. It is a question of what power (including conditions, freedom, and opportunities) the person must control in her or his life, as a "positive freedom" (Sen, 1992, p. 40). For example, it does not help that there are enough goods and benefits in society, or rights, if people do not have access to them or are not capable of utilizing them. Accordingly, capabilities are not only individual but also relationally and socially created. The American philosopher Martha Nussbaum has further elaborated the capability approach, among other things by concretizing a set of basic and universal capabilities that should be present and secured in order to realize a good life (Nussbaum, 2011). The capability approach actualizes the significance of actual capabilities and opportunities for all to realize basic functions and welfare (Nussbaum, 2011; Sen, 1980).

Although it can be argued that there are some basic needs and basic functions connected to necessary capabilities, these needs and capabilities are always colored by differences in sociocultural and sociomaterial backgrounds and contexts. Needs are expressed and articulated in different ways in different contexts and

thus create various practices and actions. Such differences in context may be sociodemographic backgrounds, norms regarding needs, political struggles, and sociomaterial and economic conditions. The articulations of care needs are colored, interpreted, and demarcated from material and cultural contexts that have part of their genesis from conditions in history and must therefore partly be considered a product of history. In this context, society forms needs and needs form society. Harold Wilensky's influential *The Welfare State and Equality* illustrates this by arguing that industrialization and demographic changes affected welfare state development by creating new needs (Wilensky, 1975).

INTELLECTUAL ROOTS FOR ALLOCATING BENEFITS ACCORDING TO NEEDS

"From each according to his ability, to each according to his needs" is an often-quoted expression connected to what is commonly considered a basic ethos and principle of the welfare state. The phrase was a popular slogan as far back as in the nineteenth century within the socialist movement and was, among other things, used by Karl Marx in his 1875 "Critique of the Gotha Program" as an expression of a higher state of communist society (Marx, 1977 (originally 1875), p. 569). For Marx, this was the last stage of socialism where there will be enough to satisfy everyone's needs, while in the transition to a classless society, the goods should be distributed based on effort. Another source of this "creed" is the Acts of the Apostles in the New Testament describing the community of believers in Jerusalem where the "distribution was made unto every man according as he had need" (Acts 4:35).

There are several other newer intellectual roots for such thinking. One is the governmental Beveridge Report for healthcare provision from 1942 (Beveridge, 1942), which served as the basis for the development of a publicly funded healthcare system in the United Kingdom, the National Health Service (NHS). In an access and need perspective, the NHS was launched in 1948 based on three Beveridge-inspired principles: 1) that it meets the needs of everyone; 2) that it be free at the point of delivery; and 3) that it be based on clinical need, not the ability to pay. The Beveridge Report became an influential background for the development of welfare states in the European postwar period strongly emphasizing universalistic thinking with needs as the starting point.

Another influential root is Richard Titmuss and his book *Commitment to Welfare* (1968). Titmuss represents a strong voice for a principle of universality regarding access to publicly provided services allocated solely based on needs instead of income or status. He wrote: "… the aim of making services

available and accessible to the whole population in such ways as would not involve users in any humiliating loss of status, dignity, or self-respect. There should be no sense of inferiority, pauperism, shame, or stigma in the use of a publicly provided service; no attribution that one was being or becoming a 'public burden'" (Titmuss, 1968, p. 129). This approach may be regarded as a solidarity project, stressing that universal access to services will prevent stigmatization and humiliation in the encounter with welfare services. All should be in the same boat and the same class, not divided into different classes according to income or other differences. Thus, according to such logic, access to services should be activated based on needs, regardless of background and resources.

The welfare state can be viewed as a redistributive project to prevent domination and oppression. In this way, welfare policy can be regarded as a device for preventing relationships of vulnerability that would otherwise give rise to exploitation (Goodin, 1988). It is an egalitarian concern of government responsibility to reallocate life chances and shield an arbitrary distribution of goods from a birth lottery, in a way that equalizes equality of opportunity. Equal access to healthcare and LTC is both an aim and a means for that.

NEEDS AND PRINCIPLES FOR PRIORITIZATION AND DISTRIBUTION

Claims have been made for several principles of fair distribution of goods both in welfare and political theory and in public governance (Fitzpatrick, 2011; Goodin, 1988). This is not the place for a comprehensive discussion over this topic; nevertheless, I would like to highlight some points of departure. One of them is by David Miller, who argues for three general principles of distribution: need, equality, and desert (i.e., what one deserves) (Miller, 1999). For Miller, the principle of need stands in contrast with what is deserved and merited. What is deserved and merited may be considered controversial due to unequal terms and preconditions for obtaining goods and benefits. On the other hand, a principle of distribution based on need positively takes into account such differences, for example, the ability to pay in a market. While the meritocrats take their starting point from performance and ability-related differences often resulting in larger differences between people, the point of departure for a needs-based approach is the difference in needs. The needs-based approach often results in an equalizing of those needs.

A needs-based approach regarding welfare states actualizes challenging discussions over the so-called sufficiency question. Different need theorists (Brock, 1998; Doyal & Gough, 1991; Miller, 2013) have listed both "life essentials" and

"society-conditioned" needs. This leads us to the question of which needs and which level of fulfilment of such needs are sufficient for a decent life.

The Sufficientarianism approach emphasizes that priorities should lead to as many people as possible getting enough goods, subjectively assessed, but not equally objectively distributed (Frankfurt, 2015). If people experience that they have enough, i.e., sufficient, for instance, of welfare (Crisp, 2003; Huseby, 2010) or basic needs (Page, 2007), it is, according to this approach, not a problem that someone has more than others of the current good. Central to this thinking is thus not equality but ensuring that everyone has enough. When you experience that you have enough of the basics (for example, healthy food, good health, attending a good quality school, having access to safe health and care services, etc.) why then compare yourself with others, they argued. Instead, social policy should primarily aim to ensure "adequacy" and raise the welfare level from the bottom up. This approach claims that comparison and equality approaches take away the focus from the central point, namely, what we need to live a good life, experienced subjectively. Followers argue that if everyone has enough, it is not a moral problem that someone has more. Further, they claim, when people react negatively to inequality, it is not because they react to inequality per se, but because someone has not enough, for example, when someone has insufficient economical resources to send their children to football training or lacks skills to understand public rules and regulations necessary for access to welfare services. Thus, Frankfurt problematizes key aspects of the egalitarian self-understanding. Several objections can be raised. One is the problem of defining what is good enough. Should the threshold be placed at a minimum standard, an average standard, or higher? What is good enough will vary from person to person, group to group, and society to society and is thus relative. Further, it can be asked: when the goal is to lift as many people as possible above the threshold for a good life, welfare, and welfare services, is it rational to sacrifice those who are far below the threshold and prioritize lifting those closest to the threshold level?

The so-called Prioritarianism approach is in some way related to Sufficientarianism, but emphasizes that decisions of prioritization should first and foremost benefit those who are worst off or who are in greatest need, i.e., leveling down (Parfit, 1997). Parfit agrees with Frankfurt that equality has no value in itself: there are only good reasons to remove inequality if it benefits someone. From a need and welfare state perspective, several objections can be raised even here. Inequality often leads to relations characterized by dominance and secondariness between people with exploitation as a result. It often leads to stigmatization and status differences, weakens the self-esteem of the most disadvantaged, with servile and submissive actions, and undermines social contact and trust in society.

In public governance, there are ongoing discussions over which care needs should be prioritized, both within the operative service level and at the management and policy levels. We find such discussions both locally in municipalities, nationally, and internationally. In Norway, at the state level, there has been a long-lasting discussion regarding what should be the main criteria for prioritization in the health service. Several Official Norwegian Reports have proposed criteria, and in 2016 the government and parliament concluded that interventions in the healthcare services should be assessed and prioritized on the basis of three main criteria: the benefit criterion, the resource criterion, and the severity criterion (Norwegian Ministry of Health and Care Services, 2015). In 2021, the Norwegian government presented a new white paper regarding prioritization, now with the main focus on the municipal health and care services (Norwegian Ministry of Health and Care Services, 2021). The same three priority-setting criteria were approved, but with an addition of a mastery approach emphasizing that coping is as essential as curing and recovering. Further, they agreed with the Blankholm Committee's recommendation that society must accept the cost necessary to cover a minimum level of services concerning basic needs (Official Norwegian Report 2018:16). Does that mean that the resource criterion is not relevant when it comes to the fulfilment of basic needs? An operationalization of basic needs is not concretized beyond the fact that it should entail an obligation concerned with the care and safeguarding of human dignity. Sundsbø, Fagertun, and Førland (2023) demonstrate that the municipal LTC services are continuously working on adjusting their services by pushing the limits of what can be regarded as sufficient care down to a minimum level in accordance with the formulation "necessary and justifiable health care" in the law (Health and Care Services Act, 2012, § 3–1). Consequently, the scope and standard of services are becoming narrower and are operating at a minimum level. In most cases, only the very most necessary services are provided, and that is in particular medical follow-up tasks (Fjørtoft et al., 2020); cf. the Prioritarianism (Parfit, 1997) and the Sufficientarianism approaches (Frankfurt, 2015).

THE STRUGGLE OVER LEGITIMATE CARE NEEDS

Regardless of whether, or to what extent, individual needs are rooted in human nature as fundamental and universal, there is an ongoing debate, discussion, and struggle in society over the interpretation of needs, connected to which are legitimate and worthy enough for recognition and public support. Fraser (2012, p. 163) has called this discussion "the politics of need interpretation," in contrast to a perspective related to subjective need satisfaction or the existence of universal needs. Needs are always connected to several understandings and interpretations and are

thus contested. Needs interpretations are embedded in the parties' construction of their identities, evolved from their specific interest positions and in society. One should therefore move from putting the attention solely on fixed and finished needs to the discourses of needs. A key issue regarding this is who has the authoritative power to define people's needs. In our context, who has the authoritative power to define people's legitimate care needs within the LTC sector? And further, which needs are legitimate and illegitimate LTC needs applicable for getting support from these services? See also Chapter 6 by Christensen and Wærness in this volume discussing the struggle for getting older and disabled people's everyday care needs recognized by the public municipal health and care services in Norway, and Chapter 7 by Peterson and Brodin in this volume discussing the silencing of specific elements of care needs and care work in the home care sector of Sweden. Those questions and problems are not only related to the needs of the care recipients. In a feminist view, by defining care for a person's need of LTC as a public responsibility, welfare services, and especially LTC services has been and is an emancipatory project that makes it possible for women to take part in labor and other parts of society.

INVESTMENT IN POTENTIALITY AND ITS CONSEQUENCES

The tension in resource use in the Norwegian LTC sector between compensatory care services toward those with the largest care needs on the one hand and preventive services and other early intervention measures on the other (Førland et al., 2021) can be viewed in such a struggle perspective. Several government white papers and reforms in recent decades have called for a reprioritization and shift of resource use in health and care services towards more prevention and "early intervention" (Norwegian Ministry of Health and Care Services, 2009, 2012, 2015a, 2018, 2021a). The justification for this is the desire to strengthen public health and self-mastery and make users and the general population less dependent on public services in the future. The backdrop is the taken-for-granted official perception that the demographic development, with an increasing number and proportion of older people in relation to the working population, and reduced public (oil) income will threaten society's economic sustainability if the preventive strategy is not intensified and successful. At the local municipal level in Norway, it seems to be a distinct ambition to turn around the services, by prioritizing preventive, rehabilitative, and early effort services and by strengthening so-called mastery approaches. These ambitions for a "left shift" of the services at the system level and increased mastery approach at the individual level seem to be an established ideology (Førland et al., 2021).

I consider this development to be an expression of an increasing investment ideology with potentiality as a criterion regarding prioritization of care needs.

Social investment is a perspective on investment intending to produce social and public benefits rather than only financial returns in the future. Such an approach can be viewed as central to the overall aim of all social policy. It comprises investments that aim to develop the potential and capacity of the human capital, to enable people to live independent lives and facilitate societal participation (Hemerijck, 2015). The term social investment is now commonly used in European social policy (Greve, 2022) and in the EU as a response to demographic change and economic pressures: in 2013, the European Commission launched its "Social Investment Package" (de la Porte & Natali, 2018). The EU social investment package also addresses how this perspective could be applied in the analysis of LTC for older people (Lopes, 2017). Social investment in LTC refers to policies aiming to support and activate frail persons and users of care services towards self-care and independent living, to prevent more severe illness, and thereby to attempt to reduce their need for care and make LTC services more economically sustainable in aging societies (Knapp, 2017). In line with this, governments try to turn their LTC politics away from a focus on "repairing" toward strengthening attention on "preparing" individuals and families to prevent and deal with such events. This implies a greater emphasis on preventive measures, health promotion, coping strategies, and enabling of resources and rehabilitative services.

The social investment perspective is an approach emphasizing the potential/potentiality of disabled and older people. Potentiality, in this regard, appears as a highly political and moral concept that demands action towards realizing the potentiality of individuals more than their fulfilling their perceived needs. Further, the focus is not on the current capabilities of individuals but rather on maximizing their possible future capabilities. This is in line with a new elder care paradigm with a distinct active aging approach, supported by international organizations (Kildal & Nilssen, 2013), focusing on maximizing older people's bodily potential (Nørskov Bødker, 2018). Such approaches have received substantial criticism from some scholars for placing the sole responsibility of successfully aging on the individual (Dillaway & Byrnes, 2009). Older people are not only expected to use their capabilities to stay active and independent, but also expected to engage in efforts to regain lost capacities, regardless of frailty and age. According to this, it has been shown that some older people feel they are forced to adapt to governmental and professional expectations of mastery and active lives, even if they feel unmotivated, weak, and powerless (Hansen et al., 2015). Consequently, needs and potentiality not only are a question of individual and psychological aspects, but are also imbued with social and cultural processes of "potentialization" in a needs-interpretation logic as part of a "politics of needs interpretation" (cf. Fraser, 2012). Due to costly LTC needs, this health promotive "potentialization" approach at

both the state and municipal levels is considered more promising for the economic sustainability of society than traditional public elderly care and has thus been prioritized, at least rhetorically, in public white papers and care plans.

Some scholars have referred to the shift from so-called passive to active social policies designed to "activate" a larger proportion of those dependent on welfare assistance through the metaphoric expression "from safety net to trampoline," indicating a paradigm shift in thinking about the welfare state (Cox, 1998; MacLeavy, 2010). Consequently, the welfare state is to a lesser extent viewed as a safety net, but is restructured as a means for supporting individual efforts at rehabilitation. It aims to function like a trampoline, not only catching people but bouncing them up and back to a productive life. However, it is time to question the limitations of such an activation approach in the LTC. Many users of these services have limited potential for recovery and will realistically still be dependent on long-term compensatory and resource-intensive follow-up measures.

CONCLUSIONS

A key question in this chapter has been how the needs for LTC services are understood, legitimized, and operationalized. This has been elucidated from different angles — individual, social, and political. Health conditions and functional status regarding basic activities of daily living are obvious starting points, but are not the only ones. Differences in sociocultural and sociomaterial backgrounds and contexts color how needs are expressed and articulated and thus create different practices and uses. These differences include sociodemographic characteristics, prerequisites for advocating needs, social networks, norms for assessing necessary needs, political struggles between parties, and sociomaterial and economic contexts.

Normative talk over needs is of particular centrality, both regarding the welfare state idea and the long-term care policy. Welfare states may be considered as mechanisms for securing basic needs and preventing poverty in a broad sense, including care poverty, but there is no universal consensus over what should be considered legitimate needs for receiving LTC in such settings. In Norway, the gateway to public LTC services has traditionally been universal, broad, and generous. We see a reconsideration of the traditional broad and generous approach among the local municipalities by raising the threshold for what is legitimate LTC needs and targeting the services toward those with the most comprehensive needs (Førland et al., 2021; Rostgaard et al., 2022), i.e., basic care for survival. They push the limits of what should be regarded as sufficient care down to a minimum level (Sundsbø et al., 2023). Declining rates of coverage of both nursing home and

home care services among the elderly population may be a result of this (Statistics Norway, 2023b).

On the other hand, and in parallel, we see a distinct ambition to turn around the services, by prioritizing preventive, rehabilitative, and early effort services and by strengthening so-called mastery approaches. This approach emphasizing the potential of disabled and older people appears as a highly political and moral concept demanding action towards realizing the potentiality of individuals, and not primarily encountering their acknowledged care needs in particular. These two trends both have consequences for the political interpretation of needs, the first by narrowing the sphere of interest regarding public LTC services to minimum standards of needs, the second by broadening the interest sphere to also include care needs that have not yet or have recently arisen, focusing on preventive and early interventions as well as a distinct "potentialization" ideology from a social investment perspective.

Both developments seem to be driven by an increasing austerity policy within the welfare state that intends to redefine the scope and borders of legitimate care needs. Consequently, care needs not only are about individual aspects but are influenced by processes over cultural and political discussion of need interpretation. Furthermore, both the increased necessity approach (i.e., narrowing and targeting of LTC services toward those with the greatest basic need) and the self-management and "potentialization" approach (i.e., targeting of services toward those with the possibility for rehabilitation) move the boundary between the public sector and civil society in the direction of increased responsibility for care needs to the service recipients, their families, and volunteers.

The ambition to prioritize mastery approaches through preventive, rehabilitative, and early effort services can be regarded as an expression of an investment ideology with potentiality as a criterion of prioritization. This thinking seeks to maximize possible future capabilities and promote individual independence and responsibility related to a duty to engage in efforts to recover lost capacities, regardless of frailty and age. It indicates a shift from primarily thinking of the welfare state as a safety net that ensures basic needs to considering it as a trampoline, not only catching people but bouncing them up and back into a productive life. This may appear to be a sensible shift of thinking in many contexts. However, it is time to question the appropriateness of such an approach in the LTC sector, where many users have limited recovery potential due to old age and long-term disabilities. In addition, a state governed by an ideology of "potentialization" is in tension with the welfare state's ethos characterized by "… to each according to his or her needs," with its traditional emphasis on service provision, protection, and ensuring of basic needs. This raises professional and ethical debates and struggles

regarding the relationship between basic needs and the potentiality of improvement as criteria for allocation in the long-term care services of the future.

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