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Access to rights through relations: Older home care clients' experiences in Finland

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Abstract

This study explores how older people receiving home care in Finland access their rights through relations at the micro, meso, and macro levels. Drawing on a mixed-methods design combining survey data and qualitative interviews collected among older adults receiving home care services, it examines how legal entitlements are shaped and mediated by interpersonal, institutional, and societal relationships. While many older adults report adequate care, a notable minority experience unmet needs, limited influence over their care, and social isolation. At the micro level, family members often help older people navigate services, reflecting both expectations of familial support and gaps in formal provision. Those without close ties are particularly vulnerable. At the meso level, encounters with professionals vary, with time pressures and staff shortages limiting opportunities for respectful, person centred interaction. At the macro level, societal views on ageing and available opportunities for participation shape older adults' sense of belonging. Overall, access to rights in home care is relational, requiring supportive policies, sufficient resources, and everyday practices that foster stable, respectful relationships.

Key words

Older adults, home care, access to services, relational rights

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Resumen

Este estudio analiza cómo las personas mayores que reciben asistencia a domicilio en Finlandia hacen valer sus derechos a través de las relaciones a nivel micro, meso y macro. Basándose en un diseño de métodos mixtos que combina datos de encuestas y entrevistas cualitativas con personas mayores que reciben asistencia a domicilio, examina cómo las relaciones interpersonales, institucionales y sociales determinan y condicionan los derechos legales. Aunque muchas personas mayores afirman recibir una atención adecuada, una minoría notable experimenta necesidades insatisfechas, una influencia limitada sobre su atención y aislamiento social. A nivel micro, los familiares suelen ayudar a las personas mayores a orientarse en los servicios, lo que refleja tanto las expectativas de apoyo familiar como las carencias en la prestación formal. Aquellas personas que carecen de vínculos cercanos son especialmente vulnerables. A nivel meso, los encuentros con los profesionales varían, y las presiones de tiempo y la escasez de personal limitan las oportunidades de una interacción respetuosa y centrada en la persona. A nivel macro, las opiniones sociales sobre el envejecimiento y las oportunidades de participación disponibles determinan el sentido de pertenencia de las personas mayores. En general, el acceso a los derechos en la atención domiciliaria es relacional y requiere políticas de apoyo, recursos suficientes y prácticas cotidianas que fomenten relaciones estables y respetuosas.

Palabras clave

Personas mayores, asistencia a domicilio, acceso a los servicios, derechos relacionales

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1. Introduction

The number of older people living at home is rapidly increasing, not only in Finland but also across other European countries. As a result, the demand for home care services has grown significantly. However, previous studies have shown that the coverage and resourcing of formal home care in Finland have become particularly inadequate (Kröger and Leinonen 2012, Rostgaard *et al.* 2022). Similar trends have been observed across Europe, where population ageing is increasing demand for long-term care, while limited service capacity, workforce shortages, and a continued reliance on informal care remain key challenges (OECD/European Union 2024, Cattaneo *et al.* 2025, Llena-Nozal *et al.* 2025). This raises concerns about the ability to provide high-quality and adequate care for older people living in the community.

The right to care is protected at both European and national levels. At the European level, the European Social Charter recognises the rights of older persons to social protection and adequate services (Art. 23), while leaving member states discretion in their implementation (Mikkola 2010, 541–542). In Finland, these protections are further reinforced by constitutional safeguards. Section 19 of the Constitution (731/1999) obliges public authorities to secure essential care and adequate social and health services for all residents, including older people living at home.

The organisation of eldercare in Finland is primarily governed by two key statutes. The Social Welfare Act (1301/2014) establishes home care as a statutory service based on individual need and requires wellbeing services counties to organise and provide support that enables older adults to live safely at home. These services cover assistance with daily living tasks, such as meals, cleaning, and social interaction including nursing if needed (Section 19a). Complementing this, the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons (980/2012, henceforth the Elderly Care Act) sets out general principles for promoting wellbeing, functional capacity and access to high-quality services. Many of its provisions, however, operate as guiding norms rather than enforceable rights (Hoppania *et al.* 2017, 229–231). Together, these laws define the framework through which older people may claim and access home-based care in Finland.

In practice, many older people continue to live at home despite severe decline in functional capacity, placing increasing strain on the home care system and creating significant challenges in delivering adequate and timely care (Khan *et al.* 2024). In Finland, approximately 13% of older people aged 75 and over receive regular home care services. The largest age group among home care clients consists of those aged 85–94 (Tolonen and Leivonen 2025). Regular home care client status is generally defined as receiving at least one home care visit per week, although services may also be delivered remotely. In 2023, more than half (57%) had home care visits on average at least once per day, and over one-third (38%) had visits on average at least twice per day (Tolonen *et al.* 2024). However, research findings (Ristolainen *et al.* 2024) indicate that approximately 20% of home care recipients in Finland perceive their current support as insufficient, and qualitative findings (Tiilikainen *et al.* 2019, Ring *et al.* 2025, 1–7) show that some older individuals experience ageist attitudes and a lack of personal recognition from professionals providing in-home care. As access to adequate home care has decreased,

there is growing concern that the burden of care is shifting to family members (Colombo *et al.* 2011, Spasova *et al.* 2018).

Under Finnish law, family members, including adult children and spouses, have no legal obligation to provide care or support to relatives. In practice, however, they often assume significant caregiving responsibilities, as is common in many other countries. At the same time, intergenerational co-residence is relatively rare in Finland. Older adults typically live independently, either alone or with a spouse, rather than in multigenerational households (Martikainen *et al.* 2019), which increases the need for external support. When family support is available, adult children and spouses are key sources of informal care for older people. Caregiving responsibilities are shaped by family relationships and resources, leading to variation in access to family-based support (Broese van Groenou and De Boer 2016, Cohen *et al.* 2023).

This study draws on the theory of *relational rights*, which understands rights not as static individual entitlements but as achievements dependent on the social, organisational and institutional relationships through which they are realised. From this viewpoint, rights take shape within the relational conditions of everyday life, including interpersonal recognition, the organisation and responsiveness of public services, and the broader societal context (Nedelsky 2011, Harding 2017, 26–27, Herring 2020, Nielsen 2024). A relational rights approach thus directs analytical attention beyond formal legal norms to the relational infrastructures that enable or constrain access to legal entitlements, positioning the study within a socio-legal analysis of how law operates in practice.

This theoretical perspective is particularly suited to analysing contexts in which people rely on complex constellations of relationships to access and exercise their rights. Elder care in the Finnish welfare state provides one such context, where strong legal guarantees coexist with growing variation in how rights are realised in practice. This article focuses on older people receiving home care, a group whose access to rights is profoundly shaped by relational and institutional conditions. Focusing on home care thus allows the study to capture how rights are realised in conditions where support is fragmented and relationally dispersed, while also responding to the broader policy shift towards ageing in place, which has increased the significance of home-based care as access to residential care has become more restricted.

Building on the relational rights perspective, this article explores how older people's rights take shape across interconnected micro-, meso- and macro-levels of social life (Bronfenbrenner 2005). These levels relate respectively to personal relationships, interactions with care organisations and the wider societal environment, and they provide an analytical structure for interpreting how rights are accessed, mediated and sometimes constrained in home care. The study addresses two research questions: (1) How are the rights of older people realised in publicly provided home care in Finland? and (2) What role do relational networks play in shaping access to these rights?

2. Material and methods

2.1. Data collection

In this study, two datasets from the Old-age social exclusion in home care – prevalence, meanings & intervention (SOLDEX) project are used: 1) survey data collected from

recipients of regular home care, and 2) interview data collected from older home care recipients who are socially excluded. The *survey data* collection was carried out in three stages. A first postal communication was sent in early May 2022 to all 65+ aged recipients of regular home care (n=2284) at two study sites in the eastern part of Finland, city of Kuopio and the Kainuu Social Welfare and Health Care Joint Authority. The study sites are characterized by clearly defined urban areas as well as extensive rural areas and remote regions. The post contained an information letter, two informed consent forms, a questionnaire, and pre-paid envelope. A second postal communication was sent at the end of June 2022 to non-responders. A third postal communication was then sent in September 2022, including a reminding letter, study information, two consent forms, and a questionnaire. A total of 559 older home care recipients responded to the survey. The response rate was 24.5%, which is close to national surveys (Kehusmaa *et al.* 2022). The home care recipients were guided to ask for assistance in filling in the survey if they were unable to do so independently. A majority of respondents were assisted by a home care worker, family member, or other person (54%), a third (35%) filled in the surveys by themselves, and 11% were assisted by a researcher at the participant's home or by phone. In addition, home care workers helped the respondents to contact the research team in case of need for further information or assistance. Six respondents were excluded because they had not answered the questions by themselves. A total of 553 respondents were included in the study.

The *interview data* includes 20 qualitative individual interviews with community-dwelling older adults (aged 73 or over) who receive formal home care services on a regular basis. The interview participants were recruited from the survey sample. To gain in-depth understanding of the older adults lived experiences, a group of participants were invited to take part in the project's qualitative interviews during early-spring 2023. The aim was to interview a diverse group of older home care recipients representing different genders (men and women) and residential areas (ranging from urban to remote areas). In total 24 participants were reached by telephone and informed about the possibility to participate in the interviews. At this point three older adults declined due to feeling tired or not being interested. One older adult could not hear the researcher on the phone, so it was not possible to schedule an interview with her. Altogether 20 older adults were interviewed between January and July 2023. The interviews were done by five different interviewers representing senior and junior researchers from the project.

2.2. Description of the data and participants

The *survey* included a wide range of questions regarding the participants current life situation, socioeconomic background and experiences related to social exclusion and living at home. In this study we used the following variables: gender, age, education, living status, residential area, family caregiver, continuing power of attorney, social support, loneliness, adequacy of help and support, being heard, the way being helped and treated, voting, four items on political and social participation, valuing pensioners, age discrimination, and opportunity to influence.

Within the used measurements, age was described in years. Gender had three categories "male", "female" and "other". Education was asked by the question: "What is your highest education?" The response options were recoded into basic (primary school), secondary (vocational school/high school/community college), and higher (university of

applied sciences degree/master's degree/doctoral degree) education. Living status was based on the question: "How many people live in the same household with you?" and was dichotomized into "living alone" and "living with someone". Residential area was recoded into urban area (city center/suburb) and rural area (village/countryside). Informal care was based on the question, "Is your spouse, child or other person your caregiver?", and recoded into "yes" (has or does not have a caregiver agreement with municipality) and "no". The continuing power of attorney had two categories "yes" and "no".

The following survey items were used to measure participants' experiences, perceptions and opportunities in everyday life. The modified Medical Outcomes Study Social Support Survey (mMOS-SS) was used to measure perceived social support (Hays *et al.* 1995). In this study we used three items: Do you have someone 1) to help you if you were confined to bed, 2) to take you to the doctor if you need it, 3) to prepare your meals if you are unable to do it yourself. Loneliness was asked by the question "Do you feel lonely?" with response options: "never", "rarely", "sometimes", "fairly often" or "all the time". Adequacy of help and support was based on the question "Do you feel that help and support is available less than you need, as much as you need or more than you need?". Question of how the participants perceived their opinions were heard had five response options: "Never", "rarely", "sometimes", "often" and "I do not know". How being helped and treated was based on the item from Adult Social Care Outcomes Toolkit (ASCOT) (Netten *et al.* 2012): "Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?" Voting was asked by the question "Do you have the opportunity to vote e.g. in municipal, in parliamentary or in presidential elections?" with response options "yes" and "no". Political and social participation was asked by the question "To what extent are the following issues true for you?" including items of membership of political society, voluntary work, day activity services and leisure activities. The response options were "often", "sometimes", "never and not interested" and "would like, but have no possibility". The statement of "pensioners are sufficiently valued in Finland" could be answered either by agreeing or disagreeing. An indicator of self-experienced age discrimination was used with response options "yes" and "no". Opportunity to influence was based on the item: "I can influence some things in my living environment" with five response options from strongly disagreeing to completely agreeing.

Basic characteristics of the survey respondents are presented in table 1. The majority of respondents were women (72.3%), the mean age was 83.8 (SD 7.6), most respondents (58.8%) had only completed basic education, and 84% lived alone. More than half of the sample (58.9%) lived in urban area, and others (41.1%) in rural area. For comparison, the age distribution of all older home care clients across Finland in 2022 was as follows: 15,6% were aged 65-74, 35,6% were aged 75-84, 42,3% were aged 85-94, and 6,5% were aged 95 or older. In total, 63,1% of all home care clients aged 65 or older were women (Sotkanet 2022).

TABLE 1

Variable	**Home care clients,** n (%)
Gender	n=553
Female	400 (72,3)
Male	153 (27,7)
Other	0
Age	n=553
65–74	77 (13,9)
75–84	199 (36,0)
85–94	245 (44,3)
95–	32 (5,8)
Education	n=546
Basic	321 (58.8)
Secondary	187 (34.2)
Higher	38 (7.0)
Living status	n=551
Living alone	463 (84,0)
Living with someone	88 (16,0)
Residential area	n=550
Urban	324 (58.9)
Rural	226 (41.1)

Table 1. Basic characteristics of the survey respondents.

The *interviews* lasted between 31 and 169 minutes. They were all recorded and transcribed into text. Altogether the transcribed data were 674 pages (Times New Roman, font size 12). In addition, the researchers wrote research notes after each interview. The research notes consisted of brief descriptions of the interviewee's current life situation, main issues brought up in the interview and observations regarding the interview situation and the interviewee's home. The research notes consisted of 20 pages (Times New Roman, font size 12).

Eight of the interview participants were men and 12 were women. The youngest interviewee was 73 years old and the oldest 99 years. The mean age was 82 years. The interviews were carried out in the participants own homes. 18 were interviewed alone. One male participant had his female spouse present during the interview and in one interview an adult grandchild was present. In one interview an adult child was in the next room but did not participate in the discussion. 17 of the participants lived alone, two with their spouse and one with adult child and his family. All participants received formal home care services provided by the local municipality or joint municipal authority. Home care workers visited the participants regularly, and in some cases during the interview sessions. The interviews were carried out using a thematic interview guide including the following themes: current life situation, housing history, work life, social relations, services and home care, autonomy and access to legal rights, societal participation and living at home.

2.3. Analysis

In the analysis we utilise a mixed-methods approach (Ivankova and Creswell 2009) combining qualitative and quantitative analysis when examining the interview and survey data. The purpose of using two different types of materials and methods was to gain a better and more comprehensive understanding of the lived experiences of older

people receiving home care services. The interview data were used to further interpret and contextualise patterns emerging from the survey, providing a more in-depth understanding of how these patterns are experienced and made meaningful in the everyday lives of older people.

We used the interview data as *primary data* and it was qualitatively analysed by thematic analysis (Braun *et al.* 2019) using flexible coding methodology (Deterding and Waters 2018). The analysis was partly theory-oriented and informed by the relational rights perspective, which emphasises that the realisation of legal rights depends on the relational and institutional conditions through which they are accessed (Nedelsky 2011). To further specify how these relational conditions operate across different dimensions of social life, the analysis also draws on a socio-ecological framework based on Bronfenbrenner's ecological systems theory (Bronfenbrenner 2005). This approach distinguishes analytically between micro-, meso- and macro-levels, referring to interpersonal relationships, organisational contexts and broader societal structures. In this study, this framework is used as a conceptual tool to differentiate the various social contexts shaping the realisation of rights. In addition, this particular version of the socio-ecological framework is well suited to the present study, as it has been successfully applied in previous research on the care of vulnerable individuals (e.g. Ornstein and Caruso 2024, Putri *et al.* 2025). However, we were neither bound to a single theory nor looking to substantiate a priori assumptions but rather aimed to give room for interaction between data driven perspectives and existing theoretical knowledge.

In this study, the data was manually coded by the first author. The analysis process began with reading through the interviews to gain an overview of the data and assign codes that might be important from the perspective of accessing home care services. Codes were then combined to create themes. As a result, codes were grouped into three themes that were related to home care services and relations that affect older people's experiences on accessing services. Concerning this primary data, co-authors provided input to the approach and writing process, including suggesting improvements.

Based on the thematic analysis, we found that the experiences of older people in accessing to their rights were largely influenced by the different relationships in which they lived. This resulted in three main categories: close relations (micro-level), being a client in social services (meso-level) and membership of society (macro-level). In the results section, we examine older home care clients experiences of accessing their rights in the light of these different relations. Quotes from the interview data are identified with the number of the participant.

We used survey data as *secondary data* to give a more nuanced picture of the experiences of older home care recipients more generally. Given the study's interpretive orientation and the complementary role of quantitative data to the qualitative interview data, descriptive methods are employed in the analysis. Continuous variables are presented as means and standard deviations, and categorical variables as frequencies and percentages. The data was analysed with IBM SPSS version 27.

2.4. Ethics

The research has received a supportive statement based on an ethical pre-assessment by the research ethical committee of the University of Eastern Finland. Research

permissions have been applied for and granted by the study sites (one municipality and one social welfare and health care joint authority consisting of seven municipalities). The study sites are covered under the ethical approval provided by the ethical committee of the University of Eastern Finland. Participation in the research was voluntary and participants were given detailed information about the study. An informed consent form was obtained and confirmed from each participant individually. Throughout the study, participants were encouraged to contact the researchers if any questions or doubts came up. The data was collected with respect and discretion, and the research reports do not reveal the identity of the participants. The transcribed interview data has been anonymized, and all data has been securely managed according to the GDPR and guidelines of University of Eastern Finland.

3. Results

3.1. Micro-level: Close relations

Finland has a relatively low prevalence of intergenerational co-residence, and living in multigenerational households is uncommon. Nevertheless, as in many other countries, family members frequently provide care and support to relatives, often in situations involving substantial care needs. Informal care may amount to full-time work. More often, however, it takes the form of lighter assistance in everyday home care, meaning that many people provide care without identifying themselves as carers (Verbakel 2018, Kirvalidze *et al.* 2025). Estimates suggest that between 300,000 and 1,000,000 people in Finland are involved in informal caregiving. For example, Kauppinen and Silfver-Kuhalampi (2015) estimate that around 700,000 individuals, approximately one-third of the working-age population in a country of 5.66 million inhabitants, provide care to a family member. Many families experience a strong moral commitment to care for dependent loved ones (Finch and Mason 1993), and gaps in social security and public care provision further contribute to families assuming care responsibilities (Kröger and Leinonen 2012).

While families play a substantial role in care, Finnish law does not impose a legal duty on them to provide it. However, social care legislation explicitly recognises and structures the role of family members in care provision. The concept of a "family presumption" (Kalliomaa-Puha 2017) is embedded in social and health care laws, reflecting an expectation that family members will contribute to each other's care and wellbeing. For example, Section 43 of the Social Welfare Act provides for the mapping of a client's close network, including how relatives or other close persons contribute to their support. Similarly, Section 15 of the Elderly Care Act allows family members to be involved in assessing the need for services. This suggests that Finnish social care legislation is structured in ways that reflect a relational understanding of rights and care.

In practice, close relations function as an important source of support, as also reflected in the interview data. Family members, most often adult children, acted as *helpers in practical aspects* of everyday life. This included tasks such as cleaning and grocery shopping when physical limitations restricted mobility. Together, close relations and home care services formed a support network that enabled older people to manage daily life at home.

> My other son lives here in the same town, so he or his son then, go to the grocery store for me. (6)
>
> My oldest daughter comes here every now and then. Meals are brought to me from the home service. But I like milk and butter, so my daughter brings it from the store. (13).

Based on the quantitative data, most of the respondents had someone available to give support most or all the time if they were confined to bed (66.7%), taking them to the doctor if needed (70.1%), and preparing meals if they were unable to do it by themselves (53.7%) (see table 2).

TABLE 2

Variable	**Home care clients**, n (%)
Help if confined to bed	n=507
Never	49 (9.7)
A little/some of the time	120 (23.7)
Most/all the time	338 (66.7)
Help to take to the doctor	n=526
Never	44 (8.4)
A little/some of the time	113 (21.5)
Most/all the time	369 (70.1)
Help in preparing meals	n=510
Never	85 (16.7)
A little/some of the time	151 (29.6)
Most/all the time	274 (53.7)
Family caregiver	n=534
Yes	156 (29,2)
No	378 (70,8)
Power of attorney	n=533
Yes	221 (41.5)
No	312 (58.5)
Loneliness	n=550
Never/rarely	221 (40.2)
Sometimes	172 (31.3)
fairly often/all the time	157 (28.5)

Table 2. Social support, family caregiver, continuing power of attorney and loneliness.

A particularly important form of support provided by family members was *assistance* with paying bills, "finding out things," and applying for services when needed. Such tasks can be challenging for older people in a digitalised society. An older person may lack both the necessary digital equipment and the skills required to adapt to these changes. This further illustrates how the realisation of rights to services often depends on relational support in everyday practice.

> There was a change in the home care services and direct billings at the same. Now there was a bill [from home care] and a pharmacy bill, so today the son comes and puts them in payment, after work comes to visit... (8).
>
> I haven't learned how to use the computer. The daughter is, well, she's typing and I'm sitting next to her. I'll see that the bills are paid and tomorrow some bills will be paid again. (18)
>
> She has been advising us a lot, my daughter, who now has this difficult situation in life. She knows from work how to do them [paying bills etc.]. (2)

> My daughter is the best one. I haven't applied for anything [myself]. My daughter can apply. If there is [a need for help], she does it. (13)

As the interview quotes above illustrate, opportunities to provide this kind of practical support are shaped by the working-aged children's own responsibilities and life circumstances, as well as by their physical proximity to the person needing assistance. However, counselling and, for example, applying for services were also possible from a distance.

In addition to the informal arrangements described above, some older home care recipients had more permanent care arrangements in which family members assumed *legally recognised supportive roles*. Based on the quantitative data (see Table 2), 29.2 per cent of respondents reported having a family caregiver. This included carers with a contract under the Act on Support for Informal Care (937/2005) as well as family members providing care without financial compensation. Some participants had also made formal plans for the future, for example regarding who would manage their affairs if they were no longer able to do so. Anticipating a potential loss of capacity, individuals may engage in legal planning through continuing powers of attorney or advance health-care directives. A continuing power of attorney allows a person to appoint a proxy decision-maker to act on their behalf should they later lose decision-making capacity. Among the home care recipients, 41.5 per cent had prepared for the future by making a continuing power of attorney. As one interviewee described, such planning can bring "a little security". While a continuing power of attorney ensures that someone will manage practical matters if needed, individuals continue to make decisions about their own lives for as long as, and whenever possible.

> So, these two daughters are the ones who take care of my affairs and advise me. Yes. I can decide for myself. I can make the decisions. They don't interfere in that way. They just said that in these certain things, where I cannot or don't know how to do it, they are happy to help. But I get to decide for myself where I put my own money, what I spend and what I want to do. They don't interfere in that way. (2)

Nevertheless, a majority of respondents (58.5 per cent) had not undertaken such formal preparations. In many cases, financial and practical matters seem to have been handled through informal family arrangements, while awareness of formal legal options may also have varied. This suggests that informal relational arrangements often formed the primary framework for managing everyday affairs.

Both quantitative and qualitative findings show that, despite the law's family presumption, not everyone has a safety net of support when needed or close social relationships that sustain mental well-being. These older people can be understood as experiencing *informal care poverty* (Kalliomaa-Puha 2017), referring to a lack of sufficient close family support. Some survey respondents reported never having anyone to help them. For example, 16.7 per cent did not have any close person who could prepare meals for them if needed. Around a quarter of respondents had help available only rarely or occasionally. Almost one third (28.5 per cent) reported feeling lonely often or all the time (see Table 2).

> I am a lonely person. I feel such loneliness, that you can't understand how much it is. (17)

> There's nothing else. It's pretty quiet. Nothing really, other than the occasional, pretty rare calls to the children. (1)

For some participants, carer poverty was related to the absence of family. For others, contact with family members was sporadic. Some older people expressed an unwillingness to burden family members who had their own lives and responsibilities to manage. In other cases, family members lived far away, making distance a challenge for providing care and support in everyday life.

Taken together, at the micro level relational rights draw attention to the pivotal role of close family members and other significant ties. The system's implicit reliance on family support functions as a silent gatekeeper: it can amplify rights for those with strong networks and mute them for those without. When supportive relationships are present, older adults are more likely to access timely adjustments in home care or navigate administrative procedures. When such ties are fragile, distant or absent, rights that formally exist may remain inaccessible, creating relational gaps in the system. The micro level thus reveals how rights depend on interpersonal relationships that enable communication, advocacy and everyday assistance. Recognising this dynamic is essential for designing remedies that do not presuppose family availability.

3.2. Meso-level: Being a client in social and health care

In the Finnish welfare state context, public home care forms the backbone of long-term support for older adults. Services are organised and funded by the wellbeing services counties and provided either directly or through publicly subsidised contracts. Private or third-sector services exist but are used mainly by the wealthiest or those purchasing supplementary assistance beyond public provision. Access to *adequate care* for most older adults therefore depends on the functioning and resources of the public system.

In addition to requiring that care be adequate, legislation also sets standards for its *quality* and for how clients and patients must be treated. Social care legislation requires that clients receive good-quality care without discrimination and in a manner that respects their dignity, convictions, privacy, and individual needs (Social Care Customers Act 812/2000, section 4). Correspondingly, health care legislation guarantees the right to necessary and good-quality medical care without discrimination and with respect for dignity and privacy (Patient Act 785/1992, section 3).

The right to adequate and high-quality services is, however, not always realised in practice. Based on the quantitative data, a majority (79.9 per cent) of home care clients considered the help and support available to be *sufficient*, while one fifth (20.1 per cent) held the opposite view (see Table 3).

TABLE 3

Variable	**Home care clients**, n (%)
Adequacy of help and support	n=538
Not adequate	108 (20.1)
Adequate	430 (79.9)
Opinion has been heard in terms of treatment and services	n=548
Never	16 (2.9)
Rarely	59 (10.8)
Sometimes	99 (18.1)
Often	286 (52.2)
I don't know	88 (16.1)
The way being helped and treated	n=534
Makes me think and feel better about myself	236 (44.2)
Does not affect the way I think and feel about myself	236 (44.2)
Sometimes undermines the way I think and feel about myself	56 (10.5)
Completely undermines the way I think and feel about myself	6 (1.1)

Table 3. Adequacy of help and support, being heard and the way being helped and treated.

Similarly, according to the interviews, some older home care clients considered that they did not receive all the services they felt they needed or received them too infrequently. Barriers to accessing or using sufficient services could be physical or financial, for example.

> It could be getting a wash more often. Before, there used to be more opportunities for washing and going to the sauna. Now I haven't been in the sauna for many years. (14)

> For example, like when I hit my head on the corner, when I went to the toilet at night. I called the home care nurse, the nurse came and. said that now that there is no doctor or emergency services here, I should go to the other city for this. She said that I should get two or three stitches [to the head]. I said no, it'll get better without the stitches, it's a small problem. When you start to calculate that first, even with the transportation covered by Kela [Social insurance institution of Finland], it's fifty euros, and then the polyclinic fee, it's over forty. It is such anugly expense when you are retired. If there is a strict need, that something I need, then you must think about it. (4)

Beyond being adequate, care must also be of *good quality*. The survey and interview data show that quality in home care is experienced through the ability to shape one's daily life, exercise autonomy in everyday decisions, and through the way one is encountered and treated by carers. Just over half (52.2 per cent) of the survey respondents felt that their views on care and services were often heard. Interview data likewise suggest that in good-quality home care, older people experience a sense of control over their daily lives and decisions.

> Q: What does living at home mean to you? A: Well, at least it seems to be a kind of personal security that you can be as you like. I can take a nap or not. And it's not up to others to decide what time I get up and what time I eat and so on. (9)

Yet experiences of quality were not limited to decision-making and autonomy. They were equally grounded in everyday interactions with carers and in how older people felt they were treated. In the survey, most respondents (98.2 per cent) reported that the way they were helped and treated had a positive effect on how they thought and felt

about themselves. By contrast, 11.8 per cent reported negative experiences: the way they were helped and treated sometimes or completely undermined how they thought about themselves (see Table 3). Interview data further suggest that in quality home care, clients are treated well, their well-being is inquired about, and their need for help is taken into account. In some cases, older people even described carers as friends with whom they shared their lives.

> We have such wonderful home care workers. And another one is a boy who is, I think he is 24 or 25 [years]. That's what he always asks me: 'Do you need any more help? I can help you with this.' He's so sweet, that boy who always comes... I've been quite satisfied with the service, at least with what we've had so far. They are very nice people. They are happy to help when we need it. (2)

> I have, in my opinion, good relations with all the carers. With some, we have become like friends, we tell each other our own things. In a way it's a big group of friends. (6).

> Nurses, they ask 'Is this all right?' and 'Call me if anything happens at night'. They don't say 'Don't call at night' [laughs]. No. They say... Some say, 'If anything happens, call me.' (13)

However, not all experiences of home care were positive. Respondents who expressed *dissatisfaction* described shortcomings in being listened to and treated with respect. This was also reflected in the survey data: some older adults reported that their opinions were only rarely (10.8 per cent) or never (2.9 per cent) heard (see Table 3). Interviewees described feeling that their views did not matter, that their well-being was not taken into account, that they were being ordered around, or that decisions were made on their behalf.

> Q: Do you have the feeling that your own opinion is listened to? A: It's just what they decide. Q: Yes. Your own opinion doesn't matter. How does it feel? A: Distressing. It feels like that when they ask, why did you come here. Yes. That kind of feeling. (2)

> It's, it's just that, when you're dependent on home care, your own opinions are not taken into account [laughs]. You have to live a bit like other people's terms here. And you can't really leave here because you don't have anyone to assist. (16)

> Some people don't listen. They just go and do their job and leave, and that's it. They don't listen to anything I have to say. They're in a hurry. Of course, they have a schedule that says you must be there and you must be there. Their schedules are tight. (11)

In some cases, the lack of listening was linked to the busyness of carers and tight scheduling practices in home care. In others, the problem related to a lack of information about available services and how to access them: "Where to get help? Where can you go and get? You just have to be content with your fate" (2).

To conclude, at the meso level relational rights focus on interactions between older people and the service organisations responsible for assessing, delivering and adjusting care. Access to rights depends not only on legal entitlements but also on how institutions interpret needs, allocate resources and respond to individual circumstances. Organisational structures of home care, such as staffing continuity, time use and communication patterns, shape the relational conditions within which rights are enacted. Relational rights at this level highlight that the lived experience of rights relies on relational responsiveness: the capacity of professionals and their organisations to listen, adapt and create continuity.

3.3. Macro-level: Older people in societal and structural contexts

At the macro level, the realisation of older people's rights is shaped by societal norms, legal frameworks, and prevailing understandings of citizenship and participation. For older people receiving home care, opportunities to participate in society are not determined solely by individual capacity or formal entitlements, but by how ageing, dependency, and care are framed in public policy and social discourse. Mobility limitations, the availability of assistance, and the organisation of care within the private home create conditions in which participation becomes contingent on relational and practical support that enables engagement beyond the home.

The EU Charter of Fundamental Rights states that "the Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life" (Art. 25). This provision not only affirms older persons' entitlement to autonomy and inclusion but also falls within the Charter's broader commitment to equality, reinforcing the principle of age-related non-discrimination. Our data reveal differing possibilities and challenges in forms of participation, including political participation, such as voting and belonging to a political association, and social participation, such as hobbies and day activities.

Based on the survey results, most respondents (92.3 per cent) reported having the opportunity to vote, but only 12.5 per cent were members of a political association. Participation in voluntary work was limited (13.2 per cent), although 10.9 per cent would have liked to participate but lacked the opportunity. A fifth of respondents participated in day activity services (21.4 per cent) or other leisure activities (22.2 per cent), while a substantial proportion (18.7 per cent and 16.1 per cent, respectively) reported that they would have liked to attend these activities but did not have the opportunity (Table 4).

TABLE 4

Variable	**Home care clients**, n (%)
Possibility to vote	n=543
Yes	501 (92.3)
No	42 (7.7)
Member of political society	n=520
Yes	65 (12.5)
No, not interested	438 (84.2)
No, but would like to	17 (3.3)
Participate in voluntary work	n=520
Yes	69 (13.2)
No, not interested	395 (75.8)
No, but would like to	57 (10.9)
Participate in day activity services	n=524
Yes	112 (21.4)
No, not interested	314 (59.9)
No, but would like to	98 (18.7)
Participate in other leisure activities	n=522
Yes	116 (22.2)
No, not interested	322 (61.7)
No, but would like to	84 (16.1)

Table 4. Political and social participation.

Similarly, interview data show that older home care recipients wish to have better opportunities for *social and cultural participation*, but that participation is often difficult without adequate support and assistance. In Finland, older adults may be eligible for mobility support services under the Social Welfare Act (Section 23), which typically includes six to ten one-way taxi trips per month. However, using this benefit is not straightforward if assistance to leave the home is not provided, as the following quotes illustrate:

> I don't use it that much. I can't go by myself. I can't even get dressed. And besides, I need to have my wheelchair with me. (5)

> It's hard to get out without a personal assistant. When I had a personal assistant, we went to the theatre and concerts. Now I can't really go anywhere. A personal assistant is absolutely essential for going out. The [taxi] driver just takes us there and picks us up. He doesn't come along. I used to go to quite a few concerts, and I've been to the theatre too. But now I've stopped going because I don't have an assistant. I don't get out of the house much. (16)

Personal assistance is provided under the Disability Services Act (675/2023, Section 9). An older disabled person may be entitled to personal assistance, but in practice they do not receive this support on an equal basis with other disabled people (Hoppania *et al.* 2017).

Some interviewees had participated in *day activity services*, which are support services covered by the Social Welfare Act (Section 19) and provided by the wellbeing services counties. These services are intended for individuals whose functional capacity has declined due to old age, illness, disability or other similar reasons. The aim of day activity services is to enhance home care recipients' wellbeing, social inclusion and ability to live at home for as long as possible. These services include activities such as physical exercise, group discussions and handicrafts. It is therefore important that individuals feel able to influence the services they receive (Luonsinen *et al.* 2024).

At the same time, there are substantial differences between wellbeing services counties in how day activity services are organised and accessed, and in the criteria used to define eligibility. In some counties, queues for day activity services are long, indicating inadequate coverage. One interviewee described participating in day activity services for four years, but having to stop when eligibility criteria became stricter:

> There were three of us who were kicked out because we had been there too long. It was time to give others a chance […] They always say that they care and there is room, people fit [there]. The space was built for eight people. Very rarely – let's say two or three times a year – there were eight people there, so there could have been four more at most. It would have been fine to have more. […] It was the city, I don't know who said that it we wouldn't fit there, but I think it was the law. (9)

Participation in society is not only shaped by the availability of concrete support services and accessible environments, but also by broader *cultural attitudes* towards older people and their place in society. Experiences of inclusion or exclusion are therefore intertwined with perceptions of how older people are valued in the wider community.

The vast majority (78.7 per cent) of respondents thought that older pensioners in Finland are sufficiently valued and not discriminated against because of their age (89.5 per cent).

About half of respondents (51.7 per cent) also felt they could influence their living environment (see Table 5).

TABLE 5

Variable	**Home care clients**, n (%)
Pensioners are sufficiently valued in Finland	n=527
Agree	415 (78.7)
Disagree	112 (21.3)
Age discrimination	n=543
Yes	57 (10.5)
No	543 (89.5)
Able to influence some things in living environment	n=528
Strongly/somewhat disagree	129 (24.4)
Neither agree nor disagree	126 (23.9)
Somewhat/strongly agree	273 (51.7)

Table 5. Age discrimination and opportunity to influence.

At the same time, many interviewees described positive or neutral experiences of older people being valued and included in Finnish society. Living conditions for older people were seen as having improved compared to the past, and limited resources made some shortcomings in care understandable.

> Well, whatever counts as sufficient, but when you compare it to some of the old days. Let´s say, in my own childhood 60–70 years ago, not all older people's living conditions were that good. (6)

However, some interviewees expressed strong views that older people are not valued, that the situation may be better in other countries than in Finland, and that older people are seen as "the scum of society, lazy bunch" (5) or "surplus scrap" (16).

> Well, I've thought about it quite a lot and concluded that sometimes it seems like older people, who have built this country, are now like the outcast group, burden on society. This does not feel good to me. When I, too, have played my part in building it. (4)

> I don't know if it's the livelihood or what it is about appreciation, or whether modern young people have been taught from childhood that they should appreciate older people too. That's the appreciation. The appreciation of older people is perhaps gone, quite a lot. Even though we are garbage like this, we still have feelings and everything. (11)

It was considered unfair to treat older people who had contributed to building society as a burden or to patronise them. As the latter quote suggests, perceptions of the social value of older people were seen to have declined across generations.

At the macro level, relational rights extend to the broader societal and policy environment that structures participation, recognition and belonging. Political participation, social inclusion and protection from ageism are formally available to all older adults, but their realisation depends on the relational and structural conditions within which older people live and receive support. For home care recipients, mobility limitations and the organisation of services can create barriers to participation in civic and social life. From a relational rights perspective, these constraints reflect gaps in the wider environment that supports or inhibits the exercise of citizenship in later life. Rights

at the macro level are therefore not only constitutional guarantees, but also outcomes of relational conditions.

4. Discussion

This study contributes to current debates on ageing, home care, and legal rights by examining how older people's access to care and support is embedded in relational contexts. Using a micro–meso–macro analytical framework, the findings demonstrate that the everyday realisation of rights in home care is shaped not only by legislation or service provision, but by the quality and availability of relationships within families, care organisations, and society more broadly. By bringing together interview and survey data with relational and rights-based perspectives, the study illuminates the gap between formal guarantees and lived experiences of social rights in the Finnish welfare state, thereby positioning the analysis within a socio-legal understanding of law in action.

At the micro level, the findings highlight the central role of close family relationships in shaping access to care and support. Consistent with previous research in Nordic welfare contexts (Broese van Groenou and De Boer 2016, Verbakel 2018), family members often act as practical, emotional, and administrative supporters, supplementing formal services and helping older people navigate complex systems. However, the results also reveal a tension between the implicit "family presumption" (Kalliomaa-Puha 2017) embedded in Finnish social legislation and the lived realities of many older people. Not all have nearby or reliable relatives, and some are reluctant to rely on family support due to concerns about burdening others. In such cases, unmet needs arise not simply from service gaps but from the simultaneous absence of relational and structural support. This points to challenges in the realisation of rights such as access to adequate care, autonomy, and the right to receive necessary support in everyday life. The concept of "informal care poverty" (Kalliomaa-Puha 2017), distinct from "care poverty" understood as a situation of unmet essential care needs due to insufficient formal and informal support (Kröger 2022, Kröger *et al.* 2025), captures this vulnerability well. It underscores how autonomy in later life is relationally contingent: the ability to live independently and exercise choice depends on access to supportive relationships as much as on individual capacity.

At the meso level, the study draws attention to older people's position as clients within administratively managed service systems and as citizens entitled to social rights. Previous Nordic research has shown how efficiency pressures, staff shortages, and standardised procedures constrain personalised care (Szebehely and Meagher 2018, Van Aerschot *et al.* 2022). The present findings reinforce these observations while adding a relational dimension: organisational routines, time pressure, and professional discretion shape the relational conditions within which rights such as dignity, autonomy, and equal access are enacted, including the right to be heard in decision-making, to receive appropriate information, and to be treated without discrimination in access to services. In this way, institutional logics do not merely affect service quality but also structure how rights are realised in everyday care practices.

At the macro level, the findings point to a broader paradox in ageing policy and societal discourse. European legal and policy frameworks strongly affirm older persons' rights

to dignity, participation, and inclusion (Spanier *et al.* 2016, EESC 2024), yet everyday experiences do not always reflect these commitments. This highlights gaps in the realisation of fundamental rights such as dignity, participation, and non-discrimination in practice. While many participants felt valued and respected, others described feelings of marginalisation, ageism, or limited influence over their living conditions. This ambivalence echoes European research on ageism showing that the symbolic recognition of older persons' worth has not consistently translated into structural, cultural, or legal inclusion (Ayalon and Tesch-Römer 2018, Doron and Georgantzi 2018). From this perspective, relational rights, understood as rights realised through interactions within families, organisations, and communities, offer a useful conceptual lens for analysing how societal values, governance structures, and institutional responsiveness shape whose rights are recognised in practice, and how gaps emerge between formal recognition and the everyday realisation of those rights.

The findings allow for a more explicit reflection on the relational theory of rights applied in this study. Overall, the results support its core premise that the realisation of rights depends not only on formal legal entitlements but on the quality and availability of social and institutional relationships. At the same time, the findings refine this perspective by showing how different types of relationships generate distinct forms of vulnerability at the micro, meso and macro levels. The absence of supportive family networks, organisational constraints within care services, and broader societal attitudes towards ageing each shape whose rights are realised in practice and how.

Taken together, the findings demonstrate that the realisation of older people's rights in home care is inseparable from the relational and organisational contexts in which care is delivered. Rights are experienced not as abstract legal entitlements but as lived practices shaped through everyday encounters with family members, care professionals, and public institutions, with intersecting vulnerabilities emerging across the three analytical levels.

From a policy perspective, the findings suggest that strengthening older people's rights requires more than legislative reform or increased funding. It calls for institutional cultures that value time, trust, and relational continuity, alongside clearer accountability for ensuring that rights articulated in law are implemented in practice. Recognising relational continuity and sustained care relationships as core quality indicators in home care governance may help reduce inequalities in access to rights.

This study has some limitations that should be acknowledged. Firstly, the findings are based on data from the Finnish context of publicly provided home care and may not be directly generalisable to other care systems. Secondly, the study relies on older people's self-reported experiences, which provide valuable insights into the realisation of rights but may not capture all organisational or institutional dimensions of care. Third, as the analysis focuses on older people's own experiences, it may not fully reflect the situations of those in the most vulnerable positions, who are less likely to participate in research. In addition, reliable information on the representativeness of survey sample is not available. However, when compared with all Finnish home care recipients aged 65+, the age distribution was similar, but women were overrepresented in our sample, which may have introduced bias.

Future research could further examine the realisation of rights across different care settings, including residential care, and explore how changes in health status and care needs over time shape access to rights. Further research is also needed on individuals with limited family support to better understand inequalities in access to care.

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