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The Nordic countries share a tradition of universal, tax-financed eldercare services, centred on public provision. Yet Nordic eldercare has not escaped the influence of the global wave of marketisation in recent years. Market-inspired measures, such as competitive tendering and user choice models, have been introduced in all Nordic countries, and in some countries, there has been an increase of private, for-profit provision of care services.

This report is the first effort to comprehensively document the process of marketisation in Sweden, Finland, Denmark and Norway. The report seeks to answer the following questions: What kinds of market reforms have been carried out in Nordic eldercare systems? What is the extent of privately provided services? How is the quality of marketised eldercare monitored? What has the impact of marketisation been on users of eldercare, on care workers and on eldercare systems? Are marketisation trends similar in the four countries, or are there major differences between them? The report also includes analyses of aspects of marketisation in Canada and the United States, where there is a longer history of markets in care. These contributions offer some perhaps salutary warnings for the Nordic countries about the risks of increasing competition and private provision in eldercare.

The authors of this report, representing seven countries, are all members of the Nordic Research Network on Marketisation in Eldercare (Normacare). The report has been edited by Professor Gabrielle Meagher, University of Sydney and Professor Marta Szebehely, Stockholm University. Our hope is that the report will provide both a foundation and an inspiration for further research on change in Nordic eldercare.



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Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences

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Preface

This report represents findings of research by members of the Nordic Research Network on Marketisation in Eldercare (Normacare). This interdisciplinary network brings together Nordic researchers to investigate the emergence and extent of market-inspired steering principles and new market actors in eldercare. Normacare members work in a range of disciplines, including social work, social policy, political science, political economy, sociology and economics. They include senior and younger scholars and PhD students. The network consists mainly of Nordic researchers but, to put study of the developments in the Nordic countries in an international context, several Anglo-Saxon researchers also take part in the network's activities (see <http://www.normacare.net/network-members/>). Reflecting this international membership, Normacare is convened by Marta Szebehely from Sweden, Anneli Anttonen from Finland and Gabrielle Meagher from Australia.

In biannual meetings, Normacare members discuss papers and develop research ideas. One such idea was to collaborate on creating a shared foundation for future work within each country and for comparative research. The result is presented in this volume, in the form of a set of reports that explain the legislative and regulatory frameworks that have enabled marketisation, and the state of current knowledge on its extent and consequences in Sweden, Finland, Denmark and Norway. This report also includes contributions from three of Normacare's members from English-speaking countries. These chapters give a sense of the consequences of marketisation in societies where this process is advanced, namely the United States and Canada. Their evidence and arguments sound some warning bells for Nordic policy-makers about differences in quality between for-profit and non-profit providers and about the unintended negative consequences of the regulatory systems that emerge when mixed economies of service provision are dominated by for-profit providers.

We gratefully acknowledge funding for Normacare for 2011-2014 from Nordforsk and the Swedish Research Council for Health, Working Life and Welfare (FORTE), as well as from the Nordic Centre of Excellence REASSESS – Reassessing the Nordic Welfare Model. And while the chapters are the work of their authors, they have been extensively discussed at Normacare meetings, by colleagues acting as formally appointed discussants, and less formally by members of the group. Thus, the chapters

embody the ‘wisdom of the crowd’ that is the broader, and very generous, Normacare membership.

We hope that the report will inspire further research on change in Nordic eldercare. The facts, concepts, arguments and resources assembled in the report may also be useful for informing research into marketisation of other social services, and thereby contribute to social policy analysis more broadly. Just as important to us is our hope that the report will inform *public debate* about the development of eldercare in the Nordic countries. In this regard, the differences between the Nordic countries themselves, and the insights from the experience of marketisation in North American eldercare are particularly relevant.

The report can be downloaded from www.normacare.net and purchased from the Department of Social Work, Stockholm University (see information at www.normacare.net).

Gabrielle Meagher, University of Sydney
Marta Szebehely, Stockholm University
September 2013

Chapter 1

Mapping marketisation: concepts and goals

Anneli Anttonen and Gabrielle Meagher

1. Introduction

Social service models have been reframed and reshaped by marketisation in most advanced welfare states, including in the Nordic countries. Given their long history of universal provision of tax-financed, publicly provided social services, it is important to understand how and why marketisation has taken hold in the Nordic countries. In this report, our focus is on marketisation in eldercare. Our aim is to understand how this process has been enacted and what its effects have been. What kinds of market reform have been carried out in Nordic eldercare systems? What mechanisms and instruments have been implemented? What has the impact of marketisation been on users of eldercare, on care workers and on eldercare systems? Are marketisation trends similar in Sweden, Finland, Denmark and Norway or are there major differences between them?

We approach these questions and issues in two ways. First, the report presents four chapters about marketisation trends and market instruments in Sweden, Finland, Denmark and Norway respectively (Chapters 2–5). Second, an international perspective is offered on some central concerns raised by marketisation, including the tendency for the share of for-profit provision to increase, and the challenge of regulating publicly funded social services when they are privately provided. Three chapters by experts on eldercare in Canada and the United States present research on the problems of quality regulation in highly marketised systems (Chapters 6 and 7) and on quality differences between different types of public and private providers (Chapter 8). The concluding chapter compares developments in the Nordic countries, reflects on what might be learnt from the experience of regulation in English-speaking countries and points to many areas in need of further research.

2. Why study marketisation?

Marketisation of eldercare is part of a wider societal transformation arising from the liberalisation, internationalisation and globalisation of policies and politics in rich democracies during the last three decades (Streeck & Thelen 2005).¹ Part of this wider transformation is significant change in public social service provision. These changes have been pushed ahead with the aid of successive reform movements, such as New Public Management (NPM), in pursuit of economy, efficiency and effectiveness (Hood 2000).

Social researchers have described these changes to the public sector with concepts such as marketisation, privatisation, liberalisation and commercialisation. These concepts capture and seek to explain profound reorganisation i) of the boundaries between, and the relationships of, the public and private sectors, and ii) of the internal structures and practices of the public sector itself. Reformers have favoured techniques taken from the private business sector as a solution to a wide range of perceived problems of public sector service provision. Instead of hierarchical and large organisational forms, preference has been given to lean, flat and small organisational forms; and an array of market-type instruments, including outsourcing, competitive tendering and performance-related pay, have been recommended for use in public sector (Pollitt & Bouckaert 2011). NPM discourses have also put some emphasis on public service *users*, reframing them as ‘consumers’ or even ‘customers’, who should have more choice (Clarke 2006; Newman et al. 2008; Rostgaard 2006). This reframing of the role of service users has informed policies that seek to ‘individualise’ or ‘personalise’ services through consumer choice and voucher models of various kinds. The benefits of co-ordination through competition – or ‘market discipline’ – have been advocated, through policies that re-organise the supply side or offer consumer choice on the demand side of the service system.

Although other logics and ideas have been introduced during public sector reforms, for instance ‘network governance’, public-private ‘partnerships’ and the ‘mixed economy’ of welfare, marketisation and the creation of ‘managed markets’ have gained a very strong foothold among politicians and administrators. In different public policy fields, these ideas have been implemented in various kinds of market reform (Gingrich 2011; Brennan et al. 2012). In the process, arrangements underpinned by civic or associational logics – including democratic decision-making, citizen-voters acting collectively to create a good society and an institutionalised preference for collective welfare provision – have tended to be displaced by arrangements underpinned

¹ This section briefly canvasses some of the key arguments of a large and rich literature in social policy research on this topic. For further discussion, see Anttonen and Häikiö (2011).

by calculative and technical logics of the market and industry (Boltanski & Thévenot 2006).

The market shift is rooted in neo-liberalism, but the political Left has given some support to marketising reforms in many countries (see, for example, Gingrich 2011; Lavelle 2005). Economic crises have also played a part, leading policy makers to seek ways of cutting costs, often through increased targeting of services and cuts in social welfare programs (Gingrich 2011; Meagher & Szebehely 2013). Changes in citizens' values and expectations have also played a part. To sum up, there seem to be strong global and individual drivers behind commercialisation of welfare and citizenship (Crouch 2004).

Overall, marketisation and the adoption of market-like mechanisms shapes social care institutions, care-related responsibilities and production of care both in the public sphere of the state and local administrations and the private sphere of households (Szebehely 2005). In addition, the sphere of voluntary sector (private, non-profit) service provision may also be touched by the logic of the market. This process could have major consequences in countries that have relied on voluntary and other welfare associations as important partners in their national or local service provision models (Anttonen et al. 2003).

The resulting changes to the ideas and practices of the welfare state have led some scholars to ask if the 'welfare state' is, in fact, turning into something else, such that a new regime of producing welfare and social goods has emerged (Cerny 1997). Others argue that market-politics relations are changing, such that politics is shifting away from an orientation towards maximisation of general welfare within the nation towards the promotion of enterprise and profitability in both public and private sectors, on a global scale (Crouch 2004). If the earlier idea of the welfare state was captured by a slogan 'politics against markets', as Esping-Andersen (1985) phrased it, the more recent idea is captured in a slogan of 'market-driven politics' (Leys 2001).

Of central concern is the impact of these changes on the relationship between *citizens and the state* (Clarke 2006; Newman et al. 2008), and between different *groups of citizens* – in different classes, and of different sexes, ages, ethnicities and migration statuses.² Focusing on the Nordic countries, concern arises because of the critical role that universal, publicly funded and state regulated care services have had in mitigating market and other inequalities (Sipilä 1997). Citizens and decision-makers in these countries have viewed the state and the public sector as the best guarantee of citizens' social rights and of the common good. Accordingly, the welfare state has been considered as functioning against rather than for the market

² See, for example, Rummery (2009) on gender issues and Shutes and Chiatti (2012) on migration status.

(Esping-Andersen 1985). When welfare is delivered through the market, the question arises: how are social rights and the common good to be secured?

These broad questions about the evolution of social policy form part of the background of the research presented here. While this report does not provide answers to them, these questions justify our attention to marketisation in all its complexity and variety, and our findings contribute to the evidence base required to answer them. We approach marketisation as a philosophy, process and model that changes public service systems by importing new principles, practices and regulations into the public sphere. It can be assumed that marketisation will unfold differently in the Nordic countries from in the English-speaking countries where it is well advanced, not least because of the Nordic legacy of service universalism (Vabø & Szebehely 2012).

3. Defining marketisation

As with many other concepts in social theory, marketisation is a complex and context-bound term the meaning of which varies with time, place and academic discipline. As noted above, researchers have used a range of terms to capture change in social service organisation, including privatisation, commercialisation and liberalisation. For our purposes, the tradition of public sector provision is the point of departure in an institutional sense.

Our analysis of marketisation in eldercare uses the following definitional framework, which has two dimensions: whether or not *market practices and logics* (most notably competition) are used in organising services and whether or not *private actors*, particularly for-profit companies, are involved in providing service (see Figure 1). Marketisation is defined by the presence of market rationalities and practices. Whether or not what we might think of as traditional market actors, specifically for-profit private companies, are involved is important, but not definitive. In other words, logics of competition and customer choice are central in marketised service systems.

Figure 1: Conceptualising marketisation

	Private actors involved	Private actors not involved
Market practices/ competition	1 Outsourcing with competi- tion; customer choice models	2 Importation of private sector practices into the public sector
Non market practices	3 Outsourcing without competition	4 'Traditional' public sector provision

Marketisation clearly takes place when competition is used to organise service provision, and private actors are involved (Cell 1). Under outsourcing policies such as competitive tendering, local authorities choose among providers, which compete on price and/or quality for the opportunity to offer services. Under customer choice models, service users choose from a list of providers assembled by the local authority, on the assumption that competition for users will drive quality improvement among providers. Private organisations, alone or in competition with the ‘in-house’ local authority provider, offer services in these variants of marketisation. Private organisations may, in theory, be non-profit or for-profit; the actual profile is an empirical question in different societies.³ However, because for-profit and non-profit organisations tend to have quite different goals and values, we also emphasise the distinction between them, and because of their market orientation, we are particularly interested in understanding the entry of for-profit companies and to understand if there is a relationship between marketising practices and the emergence and growth of a for-profit sector in Nordic eldercare.⁴ We are also interested in different kinds of for-profit organisations; as Chapter 8 shows, some kinds of for-profit providers are associated with significantly poorer quality of care than other kinds. For more discussion about these issues, see Meagher and Cortis (2009).

A second variety of marketisation takes place when private sector rationalities and practices are imported into the public sector, without involving private actors in service provision (Cell 2). Here we refer to a range of organisational changes and management approaches, such as the purchaser-provider split within public organisations and the use of benchmarking. In different ways these practices bring market disciplines to bear within public services.

³ For example, in English-speaking countries, where residential eldercare is overwhelmingly privately provided, and various market instruments are used to organise provision, the proportion of for-profit and non-profit provisions varies widely. In Australia, for example, competitive tendering is used to select publicly-funded, privately provided residential eldercare, with non-profits owning 56% of places, for-profits 36% and remaining 6% is in the public sector. In the United States, 74% of residential places are in for-profit private facilities, 20% are in non-profit private facilities, and the remaining 6% are public (Meagher 2013).

⁴ Meagher and Cortis (2009) distinguish with two main policies that have facilitated growth in for-profit care providers in OECD countries. Firstly, there are vouchers and tax rebates allocated to individuals seeking care services. Secondly, governments in different countries increasingly contract out services instead of being producers of care services. They also point out that the context for these changes is on one hand the expanding demand for paid care due to population ageing and on the other hand an ideological backlash against public provision, most particularly in the liberal welfare states. The first set of policies bolster consumers’ purchasing power and choice, and, the second set of policies most typically decrease public service provision in favour of private provision. In both cases for-profit provision increases.

Cells 1 and 2 in Figure 1 capture two varieties of marketisation that are the main focus in the report. The first model of marketisation includes a clear shift of *provision* of services from public to private organisations, particularly for-profit organisations. In the second, provision remains public, but 'internal markets' are created *within* the public sector. In both, 'user pays' principles may be introduced, strengthened, or reframed part of the marketisation process, which may also be associated with increased private (user) financing of services.

The use of private organisations to provide publicly funded services is not, in itself, a sign of marketisation: in all Nordic countries to some extent, and to a considerable extent in Finland and Norway, local authorities have funded private providers, mostly non-profits, to provide some eldercare (Cell 3). In such cases, associational or pragmatic logics underpin decision-making about service provision and organisation. The model of public provision that was typical – or at least the ideal – in the Nordic countries until the 1980s, based on universalistic financing, production and consumption of care services, is captured in Cell 4.

These concepts and distinctions help us to understand *how* marketisation has emerged in the four countries, and this is our goal in Chapters 2-5. It is much more difficult to explain *why* marketisation happens: this would require a complex set of social, political and economic factors to be taken into consideration. The map of the 'how' is a first and necessary step towards an understanding of the 'why'.

4. Mapping and comparing marketisation in four Nordic countries

To explore some of the big questions raised in section 2 above requires systematic policy research on marketisation developments, both in individual countries and in international comparative research. This, in turn, requires that researchers have access to the most relevant and equivalent documents and statistics for each country. Assembling these documents and data as a foundation for further research is an important goal of this report. This is a significant challenge that we have not been able to meet fully, even though the Nordic countries share many traditions and practices. We have found significant gaps in national statistical collections and very little harmonised comparative data. This is partly because marketisation is still a new and fairly weakly recognised phenomenon among those responsible for national data collection and statistics. In the context of growing private provision of eldercare services with marketisation, one significant issue is that data on the distribution of services, staff and expenditure in eldercare by ownership status (public, non-profit and for-profit) is rarely comprehensive and

systematically provided. Knowing these and other possible limitations of data to be utilised in compiling Chapters 2 to 5, we established some basic questions and guidelines to be followed in reporting the country-specific findings. Not all questions could be answered with the available data and resources for every country; those that could not be answered join others we highlight in Chapter 9 as questions for future research.

Each of Chapters 2 to 5 contains information about the following topics, within the limitations of the available data, and tailored to the specific situation in each country:

- *A general **overview** of the eldercare system*, including the framing legislation, the share of residential and home-based care, coverage rates, and the main contours of its development in recent decades.
- *An account of **legislation** enabling marketisation*, with attention to i) acts specifically introducing marketising reforms in eldercare or social services, ii) acts relating to the duties of local authorities and how they should operate and iii) (related to ii) acts that changed the general operating environment for public sector organisations (most notably procurement acts following EU directives on public procurement). Important here is whether specific legislation has *required* local authorities to introduce marketising measures, or whether they are voluntary. Where possible, information about the political majority of the government introducing a particular reform, and the arguments with which reforms were justified are briefly outlined.
- *An account of the **instruments** of marketisation*, including measures such as purchaser-provider split, competitive tendering, customer choice models, vouchers and so on, that operate within the needs-assessed, publicly financed system, as well as measures such as tax rebates on domestic and care services that are designed to stimulate a private market. Instruments that change the internal operation of the public sector, without introducing private providers, are considered, as well as the measures through which private providers are brought into the system. Where relevant, information is given about the extent of use of different instruments and about the distribution of their use between different local authorities. Chapters also report whether public and private providers compete on the same or different terms in marketised systems in relation to, for example, the opportunity to offer extra services to consumers for a fee.
- *An account of the **regulation and oversight** of providers*, in relation to the quality of services, profit-taking and other aspects of operation, including employment and working conditions for staff. Information about the institutions that regulate and oversee eldercare provision, and the measures they use was sought. Of particular interest is whether there are any differences between oversight of public and private providers. Given

how closely tied the growth of regulation and the growth of private provision have been in English-speaking countries, information about *change* in regulatory practice with the emergence of a private eldercare sector is also given, where relevant and available.

- *An account of the extent of private provision*, in the context of any change in the distribution of provision between public, non-profit and for-profit provision since 1990. Possible measures include the share of services provided, staff employed and expenditure. Local variation in the extent of private provision is also reported, along with information about the extent of concentration of private provision and the size of private organisations.
- *An account of the consequences of marketisation*, on the costs of eldercare provision, the quality of services and the quality of jobs. Advocates of marketising policies argue that these policies will decrease costs and/or increase quality. Has this happened in the Nordic countries? We sought information about the impact of marketisation on service users, in relation to access to services, fees and the quality of care; and on care workers, in relation to their employment and working conditions. We are interested in differences, if any, in the quality of services and jobs between public and private sectors. Also important is whether marketisation is changing the *distribution* of eldercare services between different social groups; for example, are those with more resources better served in a marketised service system?

In presenting information on these topics, national-level data are presented as far as possible and the data and documents used in the country chapters mainly cover time period from early 1990s to the present. In addition to these topics, a range of other organising principles shapes the presentation of the material in Chapters 2 to 5. The tradition of municipal autonomy means that it is important to document *local variation*. Home care and residential care are mostly treated separately, partly because they have often been subject to different marketising policies. For similar reasons, within home care, practical assistance and personal care are also sometimes distinguished.

As we have emphasised, Normacare members embarked on this research knowing that some information would not be available in some or all countries. As far as possible, the chapters identify what can and, crucially, what cannot currently be known from official and other statistics, and document many of the gaps and problems with existing sources and data sets. Our aim has been not just to study marketisation itself, but to explore the possibilities and limitations of research on this important social policy trend, most particularly in the context of systematic cross-country comparison.

In the final chapter (Chapter 9), we begin the process of systematic comparison that we hope to continue, along with colleagues in the Normacare network and others whom we hope will rely on this report as a resource. As

comparativists, we want to know more about similarities and differences between the four Nordic countries. It is of ongoing research and political interest to ask if these countries actually form a fairly unified ‘family of nations’ in regard to the marketisation of their eldercare service systems. While eldercare systems increasingly consist of services-in-cash along services-in-kind, it is important to pay attention also to those reforms that do not directly deal with publicly funded service provision but other type of benefits, like tax reliefs and reductions. Overall, we aim at constructing a broad understanding of marketisation of eldercare. Although this report presents quite detailed data about the processes and contours of marketisation, we also aim at creating – or at least enabling future researchers to create – a deep view of how and why marketisation is happening in Sweden, Finland, Denmark and Norway.

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Chapter 2

Marketising trends in Swedish eldercare: competition, choice and calls for stricter regulation

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1. Introduction

In recent decades, there has been a strong marketisation trend in Swedish social services that has been especially pronounced in publicly financed eldercare. During the 1990s, the private provision of publicly funded care for older people and for people with disabilities (measured as the proportion of employees working in services under private management) increased from 3% to 13% of the workforce (Palme et al. 2002). During the first decade of the 2000s, private provision of eldercare continued to grow and, in 2012, 21% of the beds in residential care and 23% of home care hours were provided by private providers (see Section 4). The entire increase of private provision is the result of the growth of for-profit – in contrast to non-profit – providers.

The aim of this chapter is to present an overview of the marketisation process as it has occurred in Sweden. We give an account of the needs-based and publicly financed eldercare provided by local authorities, or by for-profit or non-profit providers. In the rest of this section we give a short introduction to the general features of the Swedish eldercare system. In Section 2, we present the legislation that led to the marketisation of services and the instruments of various forms of marketisation in the Swedish context. Section 3 covers the regulations and oversight of providers of eldercare services, while Section 4 presents the extent and shape of marketisation since 1990. We then describe, in Section 5, what is known about the consequences of marketisation for local authorities, users of eldercare and care workers, and conclude with a summary and discussion of the findings in Section 6.

⁵ The authors have contributed equally to the chapter.

1.1 Swedish eldercare services: general features

As in the other Nordic countries, eldercare services in Sweden have been characterised as being provided on a universal basis; in other words, comprehensive, publicly financed and high quality services are available to all citizens according to their needs rather than their ability to pay. Also characteristic of the universal welfare model is that the same services are directed at, and also used by, all social groups (Sipilä 1997; Vabø & Szebehely 2012).

Eldercare services, as well as services for people with disabilities, are governed at three levels – national, regional and local. The *national* government's instruments of control are legislation, policy declarations and state subsidies. The state also executes supervision through the National Board of Health and Welfare (Socialstyrelsen) and other bodies. At the *regional* level, the county councils (landsting) or regions (21 in all) are responsible for most health and medical care, regulated by *The Health and Medical Services Act* (1982:763). At the *local level*, the 290 local authorities or municipalities (kommun), which vary in size and character, are legally obliged to make provisions for home care services as well as residential care for everyone who requires care, regardless of age. The local authorities have a high degree of autonomy vis-à-vis the central government (including the right to levy taxes at the local level). Within the limits prescribed by the legislation, locally elected politicians decide on tax rates, establish local objectives and guidelines, and set budgets. Not surprisingly, there are major differences in eldercare between local authorities in the coverage of services as well as the extent of marketisation.

Eldercare services in Sweden are regulated by the *Social Services Act* (1980:620, introduced in 1982).⁶ The Social Services Act is a goal-oriented framework law ensuring a general right to assistance if needs ‘cannot be met in any other way’. The legislation does not include detailed regulations nor does it confer rights to specific services. Everybody has a right to claim services and support at all stages of life, and local authorities have a mandatory responsibility to see to it that these needs are met. The assistance should be provided in a way that ensures a ‘reasonable standard of living’.

In contrast to most other countries, the system of eldercare services in Sweden is distinctive in that all forms of eldercare (from home care to nursing homes) are covered by the same piece of social legislation (the Social Services Act). This has been the case since the ‘Ädel reform’ in 1992, when responsibility for nursing homes was transferred from the health care sector at the county council level to municipal social services, and consequently from a medical model to a social care model. From a legal point of view, there is no differentiation in the legislation or in official statistics be-

⁶ The law has been amended several times and since 2002 it has been called Socialtjänstlag [Social Services Act] (2001:453).

tween the various types of facilities (for example, nursing homes, group homes for persons with dementia and sheltered housing) and there are no prescribed staffing ratios – the Social Services Act only stipulates that staff must have ‘adequate skills’ and that the quality has to be good and ‘monitored on a regular basis’.

A senior citizen enters care after a care manager has assessed his or her needs. A care manager is employed by the local authority as a ‘needs assessment officer’ under authority delegated by locally elected politicians, according to the Local Government Act (Chapter 6, § 33). This local government official (often a social worker) is delegated to assess the needs and to decide if a person is entitled to assistance and, if so, the type and amount of help required. It is a single entry system, which means that the care manager may make a decision on both home care services of various kinds and residential care. A person who is not satisfied with the decision has the right to appeal to an administrative court.

In 2012, 9% of the population 65 years and older used needs assessed home care services and 5% lived in residential care (Socialstyrelsen 2013a). The coverage of both forms of services has declined sharply in recent decades, even among the oldest age groups, and today the service coverage is considerably lower in Sweden than in Denmark and Norway but on par with Finland (Nososco 2011). However, the service intensity (staffing ratio in residential care and the average number of home care hours per user) is comparatively high and, according to the OECD, Sweden is still one of the world’s most generous countries when it comes to spending on eldercare. Approximately 85% of eldercare funding comes from municipal/local taxes, while another 10% comes from national taxes. Accordingly, users pay only a small fraction of the cost (5-6%) (Szebehely & Trydegård 2012).

Independent of whether eldercare services are provided by private or public organisations, users pay the same fee, and that fee is paid to the local authority, not to the provider. The fee is related to income and the amount of help provided and, in residential care, users pay separately for housing and food. None of the services are means-tested, but users with a low income (pension) are exempt from paying care fees and may receive a housing allowance to cover part of the rent in ordinary housing as well as in residential care (Szebehely & Trydegård 2012). A maximum fee reform introduced in 2002 caps user fees in home care as well as in residential care (in 2013, the maximum fee is SEK 1,780 per month, which corresponds to €205 at the current exchange rate (August 2013)). Municipalities still have discretion in setting the fees up to the national maximum and up to the actual cost for providing services. For those with small amounts of help the fees vary considerably between the Swedish municipalities; from SEK 77 to 435 per hour in 2010 (Molin & Karlsson 2010).

2. Legislation and instruments of marketisation

Four pieces of legislation have been particularly important for the marketisation of eldercare and other welfare services in Sweden: a new *Local Government Act* which came into effect in 1991 and which relaxed previous legislation to make it possible for municipalities to set up purchaser-provider arrangements and to outsource services to private providers; the *Act on Public Procurement* (LOU) which came into effect in 1992 and was replaced by a new Act in 2007 regulating the outsourcing process in line with EU legislation; the *Act on System of Choice in the Public Sector* (LOV), which came into effect in 2009, facilitating the introduction of consumer choice models without a process of competitive tendering and procurement; and finally the *Act on tax deductions on household services* (RUT) which came into force in 2007. This latter Act does not regulate needs assessed eldercare services, but, since it interacts with the *Act on System of Choice*, it is relevant in this context. The legislation is described in more detail in the following subsections.

2.1 A new Local Government Act, 1992

Virtually all eldercare services were provided by the public sector until the end of the 1980s, but since then the Swedish eldercare sector has been greatly influenced by the global wave of New Public Management (NPM) reforms which apply mechanisms and ideas from the private market in the public sector (Blomqvist 2004).

During the 1980s, public debate on the municipal sector in Sweden was dominated by ideas about decentralisation, cutting red tape, citizens' involvement and efficient use of resources. According to Government Bill 1990/91:117 (which proposed a new Local Government Act), there was an ongoing discussion in the country about developing the political organisation of the local authorities, and it was becoming increasingly common for municipalities to put NPM ideas into practice by introducing a purchaser-provider model (Montin & Elander 1995).

The new Local Government Act (1991:900) came into force in 1992 and introduced several changes which responded to the ongoing discussions. The local authorities were given the freedom to determine their own internal organisation and the Municipal Council was given more freedom to delegate tasks to various boards. Moreover, provisions were drawn up with regard to operations run by private providers, which had not been included in previous legislation. For example, the local authorities were given the legal right to ensure transparency and to inspect and control the procured operations (Government Bill 1990/91:117).

The new Local Government Act codified norms and rules that had, in practice, already been in use in some municipalities that had started to

outsource eldercare services since the mid-1980s (Montin & Elander 1995, p.33; Government Bill 1992/93:43 p. 5). Chapter 3, §§ 16 and 17 of the new Act stipulated how the local politicians should act when they transferred the responsibility of service provision to a joint stock company, trading company, co-operative or a non-profit association.

The new Local Government Act was introduced by a Social Democratic government in the spring of 1991. Later the same year, a new conservative-led government was elected. The new government immediately proclaimed a ‘freedom of choice revolution’ and, a few months later, presented their proposal: ‘Enhanced Competition in Municipal Operations’ (Government Bill 1992/93:43). The Bill proposed further clarifications regarding the municipalities’ right to outsource services and suggested amendments to the Social Services Act and to the Acts regulating health care services. The amendment to the Social Services Act explicitly stated that, with the exception of the exercise of public authority, which includes needs assessments for eldercare, municipalities could outsource services to for-profit companies as well as to non-profit organisations (§4 of the Social Services Act 1980:620). As far as eldercare services are concerned, this legislative amendment was not politically controversial.⁷ As Montin & Elander (1995, p. 38) note, the Social Democratic government had already paved the way for further privatisation (see also Meagher & Szebehely 2013, pp. 67-70).

These changes to the system have led to a reorganisation of the eldercare sector in Sweden so that municipalities now separate needs assessment (the actual exercise of authority) from provision of services. Previously, the same local government official usually assessed care needs *and* supervised the home care workers who delivered services to meet those needs (Blomberg 2008). This division within local authority operations was a precondition for the introduction of competition as a means of outsourcing care services to private providers: non-profit as well as for-profit (Blomqvist 2004; Szebehely & Trydegård 2012). Sweden was the first of the Nordic countries to introduce such a split between needs assessment and provision; a form of purchaser-provider model. In 1993, the model was being used by 10% of the local authorities. By 2003, more than 80% had introduced the new organisational model, although far from all of them had chosen to outsource services to private providers (Socialstyrelsen 2003; Gustafsson & Szebehely 2009).

⁷ Childcare was at that time regulated by the Social Services Act, and opening up the provision of childcare to include for-profit providers was a great deal more controversial (see Brennan et al 2012).

2.2 The Act on Public Procurement, LOU

The Swedish constitution §permits organisations regulated under private law (which includes both non-profit and for-profit organisations) to provide publicly funded welfare services (Instrument of Government [Regeringsformen] RF 1974:152; amended in 2010, see SFS 2010:1408, Chapter 12, § 4). The rights and obligations of local authorities in relation to private actors are regulated in the Local Government Act (see above). The Act on Public Procurement (LOU) and The Act on System of Choice in the Public Sector (LOV) are the two pieces of legislation which regulate the procurement procedures for local authorities and county councils when they decide to outsource activities to private organisations. Both these pieces of legislation also include the EU legal framework for public contracts. Thus, while the constitution enables private provision, NPM ideas and the LOU and LOV have meant a change from the communitarian logic of older forms of outsourcing (for example, to non-profits) towards a competitive logic.

As already mentioned, Sweden began to open up parts of the eldercare services to private providers in the late 1980s and early 1990s. The legislation on public procurement, the Public Procurement Act (LOU) introduced in 1992 (1992:1528) and amended in 2007 (LOU 2007: 1091)⁸, was important for this process. In contrast to many other Member States, Sweden has introduced more detailed rules for public procurement than those required by EU Directive 2004/18/EG. This means that Sweden has opted to also include welfare services in the competition requirement, even though the Directive itself does not require these 'services of general interest' to be included. The Swedish rules are described in the Act on Public Procurement (2007:1091) Chapter 15 and, in practice, mean that a small business or a non-profit organisation is not allowed to be favoured (Shekarabi 2012).

When local authorities opt to outsource care to private providers, the Act on Public Procurement applies, requiring municipalities to conduct competitive tendering using a confidential bidding process. The aim of the procurement process is either to *award a contract* to one provider or to conclude a *framework agreement* with one or more suppliers, the purpose of which is to establish the terms for a later award of contracts during a given period; in this case, suppliers who are party to contracts do not have a guarantee of a certain volume of business (Swedish Competition Authority 2012). In both cases, the winning bids are selected on the basis of a combination of price and quality criteria specified by the local authority. The funding and

⁸ The law was amended in 2007 based on the Government Bill 'New Legislation on Public Procurement and Procurement in the Water, Energy, Transport and Postal Services Sectors' (Government Bill 2006/07:128). The amendments were made mainly based on the EU Directives on Public Procurement (2004/18/EG and 2004/17/EG). The new laws 2007:1091(LOU) and 2007:1092 (LUF) replaced the previous Act on Public Procurement (1992:1528).

regulation of services rest with the local authority; only the actual provision of services is outsourced. The process is initiated by the local authority in the tender documents where the service to be tendered is specified and the terms on which companies will compete are presented.

The Act on Public Procurement does not specify the requirements that the provider must fulfil to be able to provide the service; these are left to the municipality to determine. Requirements may, for example, include decisions about the level of formal training of care workers. Tender documents must also specify how tenders will be evaluated. The supplier who has submitted the best tender will win the procurement procedure and be awarded the contract. In some cases, the price is fixed by the local authority and the prospective providers compete exclusively on quality issues, while in other cases a list of specific quality criteria has to be met and competition is based solely on price; a combination of price and quality is also common (Kammarkollegiet 2011a, Stolt et al. 2011, Almega et al. 2013). Particularly in the early 1990s, competitive tendering was characterised by price competition rather than quality competition (Edebalk & Svensson 2005, Szebehely 2011). Of the 70 cases of competitive tendering of nursing homes in Sweden from January 2011 to June 2012, 55% of cases involved a combination of price and quality criteria, but, in practice, price usually won over quality when the tendering process included both criteria (Almega et al. 2013).

When the procurement procedure has been completed, the municipality concludes an agreement with the winner of the contract and the contractor takes over the running of services. In the case of residential care, the facilities remain publicly owned. However, a private (for-profit or non-profit) provider can also own the facility and ‘sell beds’ to the local authority according to a framework agreement.⁹ The contract between the provider and the municipality is valid for a maximum of 4 years (LOU 2007:1091, Chapter 5, §3).¹⁰ According to the Local Government Act (§ 18 and § 19), the responsibility for monitoring the quality of services and for follow-up activities rests with the local authority (Kammarkollegiet 2012a).

One feature of outsourcing contracts in eldercare services is that the ‘new’ providers must offer continued employment to the existing staff. This is regulated by the Act on Security of Employment (LAS 1982:80, § 6b). However, if the first employer can offer employment at another workplace, the worker can choose to stay with that employer. In practice most workers stay at the workplace and so change employer. Clients also tend to stay with

⁹ In contrast to providers who are awarded a contract after competitive tendering, in these cases the facility has to go through a licensing process, see Section 3.3.

¹⁰ The overview of the 70 cases of competitive tendering of nursing homes shows that, on average, the contract period was 3.5 years and all contracts allowed a prolongation of another 2 years (Almega et al. 2013).

the new provider. Thus the new provider usually takes over existing clients and staff, be they home care users or residents and care workers in a home care district or a nursing home. This means that, generally, the provider does not need to recruit users or staff.

Outsourcing activities in the eldercare sector tends to benefit larger companies, since the tendering and procurement of relatively large units requires comprehensive resources which are hard for smaller companies or non-profit organisations to marshal (Svensson & Edebalk 2010; Meagher & Szebehely 2013).

Until recently, The Act on Public Procurement (LOU) was the most common way for local authorities to contract out eldercare services to private providers. This legislation does not contain any specific rules for the procedure of establishing competition. Thus, the law could also be used to introduce customer choice models in which local authorities make framework agreements with several providers (usually home care providers, but sometimes also residential care providers) which users can choose between. Such models have been introduced over the last 15 years as an alternative to, or in addition to, outsourcing services to a single provider selected by the local authority. The Act on Public Procurement was often perceived as a time-consuming way of outsourcing in this context. This was one of the reasons behind the introduction of *the Act on System of Choice in the Public Sector*.

2.3 The Act on System of Choice in the Public Sector, LOV

In 2009 the *Act on System of Choice in the Public Sector* (LOV in Swedish, 2008:962) was introduced by the right-centre government elected in 2006. The Act regulates what conditions apply when a procuring authority allows individuals to choose the provider of a service from a list of approved providers in a system of choice. The legislation was implemented with the aim of making it easier for the local authorities to introduce a customer-choice (voucher) system. A further argument for introducing LOV was to eliminate differences between the various local authorities with regard to how customer choice was organised (Government Bill 2008/09:29). Since 2008, the national government has encouraged local authorities to introduce customer choice models by offering them financial incentives (see Section 3.1).

LOV can be applied for basically all social services, home based as well as residential, including those provided in accordance with the Social Services Act, the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) and the Health and Medical Services Act (HSL). The local authorities choose whether they wish to adopt a system of choice for their eldercare or not, but, since 1st January 2010, it has been obligatory for all county councils and regions to have a system of choice in place in the primary health care system in accordance with LOV. LOV does not include any explicit requirements as to how the local authorities draw up

their systems of choice other than that they should be phrased and written in accordance with the fundamental principles of equal treatment and non-discrimination among providers, as well as the principles of transparency, mutual recognition and proportionality which are already enshrined in the EU directive on public procurement.

Customer choice in this system means that, following a needs assessment made by the authorities, a user can choose an authorised provider to perform services (care). The basic idea behind the reform is to ensure that users can exert influence over the services they receive by being able to switch provider if services are not satisfactory. It is presumed that this system will promote competition between different providers. The local authority determines the level of compensation that is equal for all providers, with the goal of creating a form of quality competition which puts the focus on how companies describe the quality of their services. The free choice system is used mainly for home care services, companion services, respite for carers and daily activities for people with intellectual disabilities. Only a few local authorities have adopted the system for various forms of residential care (Konkurrensverket 2012; Socialstyrelsen 2012a).

The system provides a shift from price competition. In contrast to the outsourcing model, the providers, who have established themselves with the support of LOV, have no guaranteed customers. Further, private providers can offer various forms of supplementary services that the senior citizen can buy at market price to 'top up' the subsidised eldercare services they receive (see Section 2.4). According to the Local Government Act (1991: 900), municipalities are not allowed to offer these additional services that would compete with private operators in the market.

In a choice system, applications to become an approved provider are open to all legally recognised organisations, including for-profit companies and non-profit organisations. The tender documents must be published on an ongoing basis at www.valfrihetswebben.se (the Choice Web) and approvals are continuously granted to providers. Regardless of whether a procuring authority enters into a public procurement procedure in accordance with the Act on Public Procurement, LOU, or implements a system of choice in accordance with LOV, the terms and conditions that apply must be included in the tender documents (Konkurrensverket 2012).

In contrast to the Act of Public Procedure, local authorities are not obliged to set a limit on the length of a contract (Kammarkollegiet 2011b, p. 21). All suppliers which fulfil the terms and conditions in the tender documents, and which have not been excluded pursuant to Chapter 7 Section 1 of the Act on System of Choice in the Public System, shall be approved.¹¹ Thus,

¹¹ According to chapter 7, §1 in LOV, the contracting authority may exclude an applicant who, for example, is bankrupt, has been guilty of grave professional misconduct or has not fulfilled their obligations relating to social insurance charges or tax.

it is not possible for the procuring authority to restrict the number of providers to be approved. Following the principle of proportionality, the requirements on providers are not to be unduly high. In the Government Bill preceding the Act, it is also stressed that high requirements would have a negative impact on competition: ‘the higher the requirements are set, the fewer external providers will be interested and able to meet the requirements’ (Government Bill 2008/09:29, p. 73).

According to LOV, it is the users who choose a supplier and for those who do not choose there is a no-choice alternative, which may be the local authority, a specific private provider selected in a competitive procurement process or a set order between all providers (with the goal of distributing customers equitably between them). The local authority is obliged to inform users about the providers they can choose from. The information must be objective, relevant, comparable, easy to understand and easily accessible.

2.4 Other Acts on services

Other legislation has in recent years opened the door for services being provided in other ways than just through a decision on entitlement based on needs assessment. Although local authorities are not permitted under LOV to offer additional, non-needs assessed services to senior citizens choosing a public provider, they are permitted to provide some services to older people. Such services can be provided by local authorities under the *Act on Certain Municipal Powers* (Lagen om vissa kommunala befogenheter, 2009:47, §7). According to the Act, local authorities may provide services (not personal care) without an individual needs assessment having been made in order to prevent accidents for people over the age of 67. The local authority may provide services without cost to the user or may charge reasonable fees which cannot, however, exceed the costs to the local authority of providing the services. Many municipalities offer, free of charge, a few hours a year of help with tasks deemed risky for an older person, for instance help to change light bulbs or to put up curtains. However, services that would compete with private domestic services, such as window-cleaning, are not normally included in the offering.

In 2007, the conservative government introduced a new piece of legislation that gives a *tax deduction for household services* (Lag 2007:346 om skattereduktion för hushållsarbete), in Swedish often called *RUT*. Under this reform, taxpayers are entitled to deduct 50% of the price of domestic services up to SEK 100,000 (more than €11,000) per person per year if the service company has a business tax certificate/business licence. Access to the services covered by this legislation is not subject to needs assessment by local authorities, which means the tax deduction can be claimed by all citizens, and services are not regulated by the state or local authority. The

services may be carried out in the purchaser's own home or in a parent's home. The tax deduction can be claimed for domestic help as well as for personal care (Government Bill 2006/07:94).

This reform interacts with eldercare services in that the tax deduction (in many municipalities) makes it cheaper for older people with higher incomes to buy services in the private market than it would be if they used the needs assessed home care services – at least if they have minor care needs. In municipalities with a system of choice model, the credit halves the cost for the individual of the extra services that a private (but not public) provider may offer the home care user to 'top up' the needs assessed home care (see discussion in Meagher & Szebehely 2013, p 72, and Section 3.2 below).

3. Regulations and oversight of public and private providers

Concepts like governance, control, monitoring and quality have become increasingly important in eldercare services partly as a consequence of marketisation. Responsibility for regulation and control of eldercare is divided between different public authorities. New authorities have been created while old ones have been given new tasks due to marketisation and competition. These authorities can be divided into two main groups – those that focus on procedures with regard to competition and those that focus on the quality of care and the actual care itself. In this section we first discuss the institutions and instruments involved in regulating competition. Thereafter we turn to the institutions and instruments involved in regulating and controlling quality in eldercare.

3.1 Institutions regulating competition

Neither the Act on Public Procurement (LOU) nor the Act on System of Choice in the Public Sector (LOV) regulates in detail how competition and choice models are to be adopted by the individual local authorities. To implement the legislation, a number of authorities have not only been given a monitoring and supervisory role to ensure that competition works, but also a role in encouraging companies to set up operations in the care sector.

Kammarkollegiet, Sweden's oldest public authority was established in 1539, when the Swedish king Gustav Vasa established a 'chamber' to deal with tax collection and the auditing of public accounts. Today the authority is responsible for a wide range of tasks, for instance the authorisation of interpreters and translators, the registration of religious denominations and other matters of public interest (www.kammarkollegiet.se). In 2009, the

authority was commissioned by the government to create a national procurement support system for all authorities involved in public procurement procedures and to offer guidance to local authorities on the procurement procedures of care services that are in line with LOU and LOV (see www.upphandlingsstod.se). The guidance aims to make it easier for local authorities and county councils, as well as for providers who submit tenders, to work within the framework and to support the drawing up of systems for contract monitoring (Kammarkollegiet 2012a; 2012b). When the LOV came into effect (2009), Kammarkollegiet was commissioned to set up and run a national website advertising choice systems (Government Bill. 2008/09:29, p. 68). All local authorities and county councils must advertise their choice systems in accordance with LOV on this national website, Valfrihetswebben – LOV (the Choice Web) (www.valfrihetswebben.se). All the tender documents of all the local authorities are available on this website.

In 2011, Kammarkollegiet published eleven separate documents that give guidance on, for example, framework agreements, contract monitoring and how to draw up tender documents. A helpdesk was also established in 2011 to answer questions on public procurement. Activities dealing with competitive issues form a small but increasing part of the operations of Kammarkollegiet: between 2009 and 2011, the costs for the procurement support system increased from SEK 7 to 17 million (Kammarkollegiet 2012c).

The Swedish Competition Authority (Konkurrensverket) is a much more recently established agency, set up in 1992. The agency is the supervisory body for the LOU and LOV and has the right to bring local authorities to court if they award contracts without following the rules for competition. The agency has more specifically been commissioned by the government to evaluate the competitive conditions of the choice systems according to LOV (Konkurrensverket 2012; 2013). The aim is to ensure that the same conditions apply to all providers in a given local authority. Moreover, the government gave the agency the task of analysing the impact of the dual role of local authorities, since they are allowed to run their own operations and so can act as both purchaser and provider (Konkurrensverket 2013).

The Swedish Agency for Economic and Regional Growth (Tillväxtverket) and the Swedish Agency for Growth Policy Analysis (Tillväxtanalys) were established in 2009.¹² In the context of competition in eldercare services, the two agencies were commissioned jointly by the government to monitor the care sector between 2009 and 2012 and to encourage diversity and entrepreneurship. Altogether 22 reports were published as part of this commission (Tillväxtverket & Tillväxtanalys 2012).

¹² Both agencies were established in 2009 through the merger of the then National Rural Development Agency, Nutek and the Swedish Institute for Growth Policy Studies. In addition, the commercial service operations of the Swedish Consumer Agency were also included in the work of the new agencies. (www.tillvaxtanalys.se)

The Swedish Agency for Public Management (Statskontoret) is responsible for ensuring that the government and ministries are provided with relevant, practical and useful supporting documentation for decisions. The agency has a broad mission to monitor the development of the public sector. However, in 2012 it was also given a specific task related to the marketisation of eldercare services: to examine the impact of LOV on costs and efficiency in local authorities (see Statskontoret 2012).

The mission of the *National Board of Health and Welfare (Socialstyrelsen)*, as regards eldercare, has mainly do with the supervision and the monitoring of the quality of the operations, and is therefore described in more detail in Section 3.3. However, when LOV came into force, the Board was also commissioned by the government to allocate state funds to the local authorities for the development of choice systems, a function that is directly linked to the promotion of competition. Between 2008 and 2010, SEK 307.5 million were allocated; in 2011 and 2012, a further 21.5 million and 20 million respectively were allocated (Socialstyrelsen 2012b); and in 2013 another 15.5 million were allocated for the same purpose (Socialdepartementet 2013). By the end of 2012, the state subsidies have been taken up by 88% of the Swedish municipalities (Socialstyrelsen 2013b), although not all of them have decided to introduce choice models (see Section 4.2).

In contrast to the above mentioned organisations, the *Swedish Association of Local Authorities and Regions (SKL)* is not a public authority but a politically steered, employer and interest organisation for the local authorities and county councils in Sweden. However, it has an important role in the marketisation process of Swedish eldercare. The organisation offers legal advice and process support, and organises networks and conferences for local authorities that are considering implementing choice models; it has published several reports summarising the experiences of ‘choice forerunners’ (see, for example, SKL 2009a;b and SKL 2010a; b) and it publishes a bi-weekly newsletter on competition and choice (*Aktuellt om konkurrens och valfrihet*); see www.skl.se/vi_arbetar_med/valfrihet. SKL also has a central role in quality regulation via Open Comparisons (see Section 3.4).

3.2 Are the conditions for choice and competition equal between private and public providers?

There has been quite a lot of discussion in Sweden on whether the public and private providers are competing on equal terms. One issue that has come up in conjunction with the introduction of customer choice is whether the care managers would remain neutral with respect to service users when users are making their choices, in particular whether care managers (as public employees) would favour the public home care alternative over the private providers (Charpentier 2004; Edebalk & Svensson 2005). There are a few

studies and agency reports on the role of care managers in the customer choice system (Hjalmarson & Norman 2004; Norman & Schön 2005; Hjalmarson & Wånell 2013; Konkurrensverket 2013). The studies discuss the problems experienced by the care managers when it comes to guiding users in their choice, in particular, how to give information about services when the older person is in a vulnerable and acute situation, and how to support users who find it difficult to make a choice (see also Section 5.1.1). This research has, however, not found that care managers would recommend public providers over private actors, but both the National Board of Health and Welfare (Socialstyrelsen 2010a) and the Swedish Competition Authority (Konkurrensverket 2013) argue that care managers need guidelines and training in their role as advisors in order to provide information to users in a competitively neutral way.

LOV stipulates that local authorities must have a system for assigning a service provider to users who do not make an active choice, but does not regulate how this is to be managed. Of the municipalities which had introduced a system of choice in eldercare in accordance with LOV by December 2012, 49% had their own operations as the non-choice alternative, 45% had applied a system of rotation among the authorised providers and 6% used a proximity principle or some other decision model (Socialstyrelsen 2013b). In the concluding report evaluating choice models in home care services (Konkurrensverket 2013), the Swedish Competition Authority argues that having the local authority's own provider as the default provider is an entry barrier for private companies, and that local authorities should instead use a rotation system that includes all providers in order to ensure competitive neutrality. The authority also stresses that the purchasing and providing roles of the local authority should be more clearly separated; that the tender documents should be less detailed and that the remuneration for public and private providers should be more transparent both to increase competitive neutrality and to encourage the entrance of private providers. Similar arguments have also been put forward by the Association of Private Care Providers (Vårdföretagarna 2011; 2012a) – the trade and employer organisation for private care providers – which contends that competition is distorted by the stricter requirements placed on private providers compared to those that apply to public providers.

Others argue that it is actually the public care providers that are at a disadvantage in competition with private providers. This is because private, but not public, providers have the opportunity to offer *additional services*. Additional services are services which are not included in the decision for care granted under the needs assessment process, and which individuals pay for out of their own pockets subsidised by the tax deduction on household services (RUT) (Socialstyrelsen 2007; Meagher & Szebehely 2010). Home care users choosing a private provider for their needs assessed home care services can purchase such 'topping-up' services (for instance, more frequent

cleaning) from the same provider and from the same care workers. As municipalities, according to the Local Government Act, are not allowed to offer services that compete with the private sector (see Sections 2.3 and 2.4), home care users who choose a public home care provider do not have the same opportunity to top up their needs assessed offering with services from the same staff.

The issue of whether this is a disadvantage for the public providers was discussed in the Government Bill which resulted in the Act on System of Choice in the Public Sector, LOV. However, in the Bill, the government highlighted that if public providers were allowed to offer additional services, it would have a negative impact on business, something that both LOV and the RUT tax deduction for household services were supposed to encourage. According to the government, an important aspect of the choice model is that it gives private providers the ‘possibility to offer extra services and hence increase their operation and reach a higher profitability’ (Government Bill 2009/09:29, p. 123).

All in all, this means that public providers cannot compete for users in the same way as private companies. Being able to offer additional services has proven to be important when there is tough competition between providers (SKL 2011a). The majority (70%) of private home care providers in the LOV system offer such extra services (Konkurrensverket 2013, p. 88; Tillväxtverket & Tillväxtanalys 2012, p. 40). Many private home care providers are selling domestic services to the general public as well as to their home care users. There is, however, not a clear picture about the use of ‘topping up’ services among home care clients. In an interview study, the Swedish Competition Authority has found that only 8% of home care clients have purchased such extra services from their home care provider, and that the ‘extra services’ correspond to only 6% of providers’ total turnover (Konkurrensverket 2013 pp. 87-88). On the other hand, a report by Tillväxtverket & Tillväxtanalys (2012 p. 40) notes that the use of ‘extra services’ has increased over time, and that half of the companies they studied got a ‘significant proportion’ of their turnover from selling extra services to their home care clients.

3.3 Local and national institutions regulating quality

Both the local authorities and the state are responsible for monitoring the quality of eldercare. The overall responsibility for ensuring that eldercare is organised and provided in such a way that it achieves the objectives set out in the Social Services Act lies with the politicians in the local council in charge of the services, regardless of whether the services are run by a private or public sector provider.

As mentioned in Section 1.1, the Social Services Act stipulates that eldercare services should be of a good quality and that the quality should be improved and assured on a systematic and continuous basis, but the Act does not stipulate how quality management should be carried out. This means that local authorities are at liberty to develop their own procedures and methods for quality management. When eldercare services are publicly provided, the local authority may go in and directly govern the operations. When services are provided by private organisations, the requirements that a local authority may set are included in the agreements concluded between the local authority and the provider. Research reports and public investigations indicate, however, that local authorities' monitoring of eldercare, whether publicly or privately provided, often leaves a great deal to be desired (see, for example, Riksrevisionen 2008; Winblad et al. 2009; Svensson & Edebalk 2010). This has been noted by the government and, as a consequence of a media and public outcry about poor quality care by a private care corporation during the autumn of 2011, the Ministry of Health and Social Affairs commissioned the National Board of Health and Welfare (Socialstyrelsen) to produce guidelines for local authorities on procurement and how to monitor quality in eldercare. In one report, the Board presents an analysis of a number of tender documents (Socialstyrelsen 2013c) and a final report presents the guidelines stressing the responsibility for the local authorities to systematically review the quality of care and to formulate the requirements in the tender documents so that they can be followed up, not the least to make sure that a contract can be ended if the requirements are not met (Socialstyrelsen 2013d).

This guidance forms part of the state's supervision of eldercare, a responsibility that lay with the *National Board of Health and Welfare* until 1 June 2013, when the supervisory role was allocated to a new agency, *Inspektionen för vård och omsorg, IVO* (Health and Social Care Inspectorate) (see www.ivo.se).

The National Board of Health and Welfare and the new Health and Social Care Inspectorate are government agencies under the Ministry of Health and Social Affairs, with a wide range of activities and many different duties in the fields of social services, and health and medical services. The two agencies are responsible for monitoring and evaluating services, compiling and passing on knowledge and information, developing standards based on legislation and the information compiled, and exercising supervision to ensure compliance with the law. The Health and Social Care Inspectorate is also responsible for the licensing of privately owned residential care (Socialstyrelsen 2011a; www.ivo.se).

Such licensing is not needed when a private organisation (for-profit or non-profit) takes over the management of a nursing home or other residential care facility after competitive tendering, but organisations which own the facilities and enter a framework agreement with a local authority have to go through the licensing process. Home care providers in the choice models which have

similar framework agreements with the local authorities do not have to be licensed by the Health and Social Care Inspectorate. In the case of residential care that is outsourced after competitive tendering and home care services, the responsibility to ensure the quality standards rests with the local authorities and the requirements in the tender documents (Socialstyrelsen 2013d).

In its role as the supervisory body, the Health and Social Care Inspectorate carries out both announced and unannounced inspections. These inspections are sometimes the result of complaints by service users that are filed with the agency, which then decides whether that complaint will result in an inspection or other supervisory measures. The agency also makes determinations on filed reports on malpractice or irregularities in eldercare according to lex Sarah, see Section 3.5 below).

3.4 Open Comparisons

As has already been mentioned, in recent decades, market-oriented management methods, often grouped under the term New Public Management, have had a significant influence over the public sector in the industrialised parts of the world. A central part of NPM is the focus on measuring results and efficiency. Once markets are created where welfare services are purchased and sold, demand for information and for 'competitive neutrality' emerges. Thus a consequence of marketisation is an increasing focus on the development and implementation of standardised systems for the continuous monitoring of the quality and efficiency of publicly funded operations (Lindgren et al. 2012). Sweden conforms to this trend.

In 2007, the newly elected conservative government commissioned the National Board of Health and Welfare to work with SKL, the Swedish Association for Local Authorities and Regions, to develop a national monitoring system for *Open Comparisons* of eldercare services. The aim was to create better preconditions for the control and development of care services and to make it possible to compare the quality of services, both over time and between various providers and local authorities (Socialstyrelsen 2010c).

The commission consisted of five subprojects: a survey of local authorities and county councils, the development of statistics based on personal identity numbers, the development of a national framework for the description of needs and services and the development of national quality and financial indicators. In addition, the National Board of Health and Welfare was commissioned to carry out annual nationwide user surveys in order to follow up on the quality and accessibility of eldercare (Socialstyrelsen 2010c). The coordination committee for Open Comparisons consists of representatives from the National Board of Health and Welfare, SKL, the Association of Private Care Providers (Vårdföretagarna) and Famna (the interest organisation for non-profit care providers) (Socialstyrelsen 2011b).

The comparisons enabled by Open Comparisons are based on national registers, official statistics and survey data. The data sources are the Swedish Prescribed Drugs Register, the National Patient Register and the register of municipal social services; public population statistics and financial statistics and the national quality registers Riks-Stroke (a national register containing information on patients in stroke care (www.riks-stroke.org)), the Swedish palliative register describing the final week of care before a person dies (palliativ.se) and Senior Alert which is a register of work carried out to prevent falls, malnutrition, pressure sores and oral ill health (www.senioralert.se) (Socialstyrelsen & SKL 2013).

Beyond information from these registers, Open Comparisons are also based on two annual surveys carried out by the National Board of Health and Welfare: one of local authorities and public and private eldercare providers (Socialstyrelsen 2012d) and one nationwide survey on users' perceptions of the quality of eldercare (Socialstyrelsen 2012e).¹³

Open Comparisons for eldercare are published in two ways: the web-based *Äldreguiden* (the Elderly Guide) and the printed and web-based publication *Öppna jämförelser - Vård och omsorg och äldre (Open Comparisons – Eldercare)*.¹⁴

Äldreguiden (the Elderly Guide) contains information on residential care, home care services and adult day centres under both public and private management. The guide can be used to compare municipalities (on a larger number of indicators) or specific operations in a municipality, for example, residential care facilities or home care services (on a smaller number of indicators) (www.socialstyrelsen.se/aldreguiden). The information on specific operations can also be used to compare public and private eldercare services (see Section 5.2.1). Initially, the guide was aimed at both decision makers and elderly people who need care and their relatives, but from 2013 onwards its only aim has been to make it easier for older people who need care and their relatives to choose home care services or residential care (Dir. 2012:91). At present, those who wish to compare residential care facilities in a municipality can find information on ten indicators: (i) the number of people with an up-to-date care plan; (ii) the number of people who have been involved in drawing up their care plans; (iii) the level of formal training among permanently employed care workers; (iv) staff turnover; (v) housing standard; (vi) meals (nightly fast); and the existence of risk assessments for (vii) falls, (viii) pressure ulcers and (ix) malnutrition, and (x) medication

¹³ Commissioned by the Government, the Board has conducted the survey in 2008, 2010, 2011 and 2012. In 2011, 61,600 older home care users and 33,400 older people living in residential care filled in the questionnaire (Socialstyrelsen 2012e).

¹⁴ The user survey is also reported in printed publications (for example, Socialstyrelsen 2012e).

review (Socialstyrelsen 2012d).¹⁵ Between 2011 and 2012, several indicators were removed, including indicators on staffing ratio and the proportion of care workers employed by the hour (Socialstyrelsen 2012a).

Open Comparisons – Eldercare is aimed at politicians and civil servants working at the local authorities and has been published yearly since 2007 (initially by SKL alone and since 2010 jointly by Socialstyrelsen and SKL). This report gives an account of eldercare at the municipal level and, for each indicator, local authorities are ranked from best to worst. In 2012, 35 indicators of the quality of eldercare were reported, including several of those presented in the Elderly Guide, some results from the user satisfaction survey and some measures of costs, services and the population's health condition. As in the Elderly Guide, staffing ratios and forms of employment (permanent vs. on an hourly basis) are no longer reported (Socialstyrelsen & SKL 2013).

3.4.1 Unintended consequences of Open Comparisons

The overarching aim of Open Comparisons is to improve service quality by providing information to local authorities and individual services users in order to enhance competition and drive change. A review of international research on quality measurement systems shows, however, that there is a risk of negative side effects such as levelling (adapting to the average), or that organisations may focus too much on the quality indicators themselves, so that those measures shape the objectives of their operations (Lindgren et al., 2012).

There are indications that these side effects also exist in Sweden. In Open Comparisons there is no defined standard for what is a sufficiently good score for the different indicators. Instead the local authorities are divided into groups where the 25% with the best scores are marked in green and those with the 25% worst scores are marked in red. The 50% in the middle are marked in yellow. Thus the comparisons are relative and do not reveal anything about the actual quality – if there is a general reduction of quality 25% of the municipalities would still be reported as 'green' (Lindgren et al. 2012).

A study in three municipalities shows that two of the local authorities have changed their eldercare objectives to make them measurable with indicators from Open Comparisons. Moreover, they admit to using the average score on certain quality indicators in order to set objectives for their own operations; in one case by adapting their staffing levels to the national average and in another case by setting the goal of general quality level at the national average as reported in Open Comparisons. In both cases, this entails a decrease in the quality of eldercare, since they previously scored above the average on the relevant measures. In both municipalities, it seemed more important not to score 'red' than to actually improve service quality. Despite

¹⁵ For home care services, only five of these indicators are reported (Socialstyrelsen 2012d).

adapting to Open Comparisons in this way, the respondents in the three municipalities were sceptical about the scores on the quality measures; they questioned the validity of the measures and they expressed their concern about having answered the questionnaire correctly, when others might submit the wrong information on purpose and thereby score higher points. Similar tendencies can be seen in health and medical care. Nevertheless, Open Comparisons has become an important part of management control, despite the widespread scepticism regarding the relevance of the quality indicators (Lindgren et al. 2012).

Open Comparisons can also have an impact on operations because of the uniform documentation requirement. Comparability requires uniform documentation such that all care managers and providers must register users' needs and the services provided in the same way. Within the framework of Open Comparisons there is a project focusing on the development of a model for structured documentation (Socialstyrelsen 2009). In the area of medicine, where there is more experience of quality measurement systems, the problems with detailing a complex reality in a standardised form have been noted (Lindgren et al. 2012).

Despite the relatively limited knowledge about the use of Open Comparisons, there seems to be a risk for an increased focus on what is possible to measure and what actually is measured. Aspects of care which are difficult to measure, like care relationships and other social aspects not included in the quality indicators, tend to fall by the wayside. Even if there is doubt among municipal civil servants and providers about the value of the quality measurements, providers and local authorities are ranked according to the measured outcome. It is thus impossible to remain outside the quality measurement systems.

The Ministry of Health and Social Affairs expresses very high hopes about Open Comparisons, which it believes will 'contribute to world class quality and efficiency'. Confidence in the Elderly Guide as a form of support for individuals in their choice of provider is expressed like a vision statement: 'With Open Comparisons as a basis, citizens, patients and users will be so well-informed that they can freely choose the best care providers' (Socialdepartementet et al. 2009, p. 3). However, it is not known whether the information is actually used in this way (Lindgren et al. 2012) and, in fact, international studies indicate that this is rarely the case (Glendinning 2008). Pollitt (2006, p. 48, quoted in Lindgren et al. 2012, p. 26) claims that: 'Grand statements about the importance of performance information ... sit alongside extensive if patchy evidence that ministers, legislators and citizens rarely make use of the volumes of performance information now thrust upon them'.

3.5 The role of users and staff in quality control – differences between public and private providers

Users of care services (or their family members) and care staff are increasingly regarded as important players in the process of maintaining and improving the quality of care services (Kjellberg 2012). There are certain differences in how the involvement of users and staff is regulated in publicly and privately provided care services, and these differences are discussed in this Section.

The role of users in safeguarding the quality of eldercare is stressed by the National Board of Health and Welfare, which points out that local authorities have a responsibility to have procedures in place for users to lodge complaints in order to note deficiencies and problems (Socialstyrelsen 2013d). Such complaints can be made to a member of staff or the management. In publicly provided, care complaints can also be lodged directly with the political board of the municipality. In private care facilities complaints can be made to the supervisor or someone who represents the managing director. In both management forms, a complaint can also be made directly to the national supervisory body, the Health and Social Care Inspectorate (before June 2013 to the National Board of Health and Welfare). To supply eldercare providers with the tools they require to develop quality management systems, the National Board of Health and Welfare published an updated version of its binding guidelines on general advice for management systems for systematic quality management (SOSFS 2011:9). The aim of the ordinance is that it should be used in social services to systematically, and on an ongoing basis, assure the quality of their operations.

There is no uniform definition of what a complaint may be. The fact that it is often senior citizens themselves, or their relatives, who have to pursue complaints clearly sets eldercare apart from medical care in which, according to the Law on the Patients' Advisory Committee (1998:1656), there must be a committee in every county council which can help individuals lodge a complaint. In eldercare, this varies between municipalities and is often divided between different professional functions. In some municipalities a Senior Citizens' ombudsman can provide help and support for citizens in the process but there are no statistics on the number of local authorities which have introduced such an ombudsman.

Several reports have indicated that there is a need to develop systems for the handling of complaints. According to the National Audit Office (Riksrevisionen 2008 p. 81), there is usually no designated part of the local authority that manages complaints. This means that it is often up to users, relatives and care workers to pursue and follow up complaints (Kjellberg 2012). The National Board of Health and Welfare (Socialstyrelsen 2010b) has identified this as an area where quality management has not emerged. In a study of 100 Swedish local authorities, Harnett (2010) found that 90% of

the local authorities had some strategies for receiving complaints but that only 40% had any procedures in place for how to manage feedback on complaints to the person complaining as well as within the organisation. Moreover, since the complaints were lodged with different professional categories, there was often no systematic registration system for complaints received.

The role of staff in safeguarding quality of care and to report problems is more clearly regulated than the process of lodging complaints from users. But even here there is a difference between medical and social issues, and publicly and privately employed care staff are treated differently. If deficiencies arise, or if there is a risk that they will arise, staff working in social services have a duty to report incidents occurring at their own workplace. This applies both to deficiencies in everyday care and to work that falls under health and medical care. This duty is regulated by two pieces of legislation, the Act on Patient Safety (PSL, 2010:659) and the Social Services Act (SoL2001:453).

If a user of eldercare or a patient is, or could have been, subjected to *medical* malpractice in conjunction with care, treatment or an examination, this must be reported and investigated (Chapter 3, § 5, the Act on Patient Safety). This clause is called *lex Maria* and encompasses all health and medical staff. This means both registered medical staff and staff to whom professionals may delegate tasks, for instance eldercare workers (Socialstyrelsen 2010d; SOSFS 2005:28).

If a deficiency arises in *social care*, this must be reported in accordance with *lex Sarah*, the colloquial name for Chapter 14 § 3 of the Social Services Act. This chapter obliges everyone working in social services to report any deficiencies and grave risks for deficiencies arising in the workplace. The provider must also take immediate action to remedy the situation. The provision, which entered into force in 1999, was named after an assistant nurse, Sarah Wägnert. She reported to media about maltreatment and a lack of staff in a private nursing home. She did this when the management of the nursing home refused to listen to her (Socialstyrelsen 2010d). According to Fransson (2012), *lex Sarah* can thus be regarded as a form of protection for the employee's freedom of speech.

Since its introduction in 1999, *lex Sarah* has been amended several times, and the latest amendment came into force on 1 July 2011. Now *lex Sarah* encompasses the whole social services sector, not just care for older people and people with disabilities. Moreover, it is now emphasised that *lex Sarah* shall be an integrated part of systematic quality management, that care staff therefore must report *all* deficiencies and that all *serious* deficiencies should also

be reported to the national supervisory body, the Health and Social Care Inspectorate (previously to Socialstyrelsen) (Government Bill 2009/10:131).¹⁶

Publicly and privately employed care staff are treated differently in lex Sarah. Publicly employed eldercare workers are required to report deficiencies to the political board responsible for eldercare in the local authority, while privately employed care staff reports deficiencies to a person within the private organisation who in turn informs the political board about the reports received. In the next step, serious deficiencies in publicly run eldercare services are to be reported to the Inspectorate by the political board, while the responsibility to report serious deficiencies rests with the private provider (Socialstyrelsen 2013e).

It is not clear to what extent these differences affect how lex Sarah is used in private and public eldercare services, but the difference between the two management forms may be smaller in practice than it appears. In publicly run care, the responsibility for investigating a deficiency is often delegated from the political board to a head of the care unit or even the immediate superior which may act as an obstacle for staff wishing to report deficiencies. The Government Bill for the new lex Sarah emphasised that, irrespective of the management form, it should not be the immediate superior who carries out the investigation, but whether this has been implemented is not known. In the debate of the public investigation preceding the Bill, several actors argued that all lex Sarah reports (regardless of whether they involve a public or private provider) should be submitted directly to the political board, but this is not what was decided (Government Bill 2009/10:131).

In any case, available information suggests that many deficiencies go unreported, and that under-reporting has become more prevalent in the increasingly competitive environment, since lex Sarah reports can be regarded (for example by the media) as a criticism of a nursing home or a home care unit rather than as a sign of successful quality management (Kjellberg 2012).

The difference between publicly and privately employed care staff is probably larger when it comes to the right to act as a whistle-blower and the protection of informants. The right to act as a *whistle-blower* refers to the rules that apply in the Fundamental Law on Freedom of Expression that ensures that every citizen has the right to express his or her thoughts, views or feelings. It also means that it is possible, to a certain extent, to disclose information that is confidential (Riksrevisionen 2008). *Protection of informants* refers to the right for a person who discloses information to remain anonymous, and under this protection, authorities (and thus the public eldercare employers) are prohibited from looking into who disclosed the information.

¹⁶ Previously care staff had to report only serious deficiencies and only those serious deficiencies that were not immediately resolved at the local level had to be reported to Socialstyrelsen (Government Bill 2009/10:131).

It also means that authorities are not permitted to retaliate by, for example, giving notice (Riksrevisionen 2008).

As the protection of informants only covers public employees, private employees are not guaranteed the same right to act as a whistle-blower and to have informant protection as public employees. Nor do private employees have the same protection when it comes to action taken by the employer. If a local authority wishes to ensure that the right to act as a whistle-blower also includes private employees, this must be included in the agreement between the local authority and the provider. If this is not done, there is nothing to prevent private employers from seeking to find out who disclosed information or taking disciplinary action against the informant (Riksrevisionen 2008).

The fact that private employees have less protection with regard to retaliation when they act as whistle-blowers has been the subject of several inquiries and was commented on in, for example, the Government Bill that formed the basis for the Act on System of Choice in the Public Sector (LOV). The Bill notes that the reduced protection for private sector employees may 'have a negative impact on transparency', but that regulating an enhanced right for these employees to act as whistle-blowers could weaken a company's competitive edge and would be in conflict with the fundamental principle that agreements (for example non-disclosure agreements) must be adhered to (Government Bill 2008/09:29 s 79-80). This is still a topical issue and the Ministry of Justice has recently appointed a commission of inquiry to look into the issue of reinforcing the protection of privately employed informants in the publicly funded welfare sector. The point of departure is that the protection of these informants should, as far as possible, be equal to the protection given to public employees (Dir. 2012:76).

There are also differences between public and private care with regard to transparency vis-à-vis the general public. Freedom of information has long characterised Swedish public administration (Strömberg 2002). The basic idea is to give the general public access to documents and information, and thus to give a certain level of guarantee of transparency to ensure that an authority does not misuse its power (Riksrevisionen 2008). The right to have access to public documents and the limitations on that right are regulated by the Freedom of the Press Act (1949:105).

However, documents drawn up in a private business are not to be regarded as public documents, which means that a citizen does not have the given right to request such a document (Riksrevisionen 2008). This was highlighted, for example, by the Social Democratic Government Bill 'Democracy for the New Century' (Government Bill 2001/02:80). The bill describes the democratic risks that exist when some parts of the publicly funded services provided by a private company do not allow the citizen the constitutional right to transparency. This led to an amendment to the Local Government Act in 2002 as regards contracts between the local authority and a company, such that local authorities must ensure that they are able to exert

sufficient control and monitoring of contracted companies (Chapter 3 § 19 Local Government Act) and that contracts must ensure that the local authority or county council has access to information enabling the general public to have access to information about how the company is run (Chapter 3 § 19 a Local Government Act). As this rather vague wording suggests, the transparency of eldercare services run by a private company is still quite limited.

4. The extent of marketisation in Sweden

4.1 Trends

Over the last two decades, there has been a marked increase in privately provided eldercare in the two main forms of services, home care and residential care, as shown in Table 1. At the beginning of the period, the development in residential care was faster, probably due to the form of marketisation which started off the process, namely the outsourcing of municipal facilities. It was easier to expose residential care units to competitive tendering, while the marketisation of home care only accelerated after the introduction of customer choice models in some municipalities at the beginning of the 2000s. Today, both forms of services are more or less on a par – according to official statistics from the National Board of Health and Welfare, 23% of home care hours and 21% of the beds in residential care are provided by the private sector (Socialstyrelsen 2013f).

Table 1. Distribution of the private provision of publicly funded eldercare services in Sweden, 1990 – 2011 (per cent)

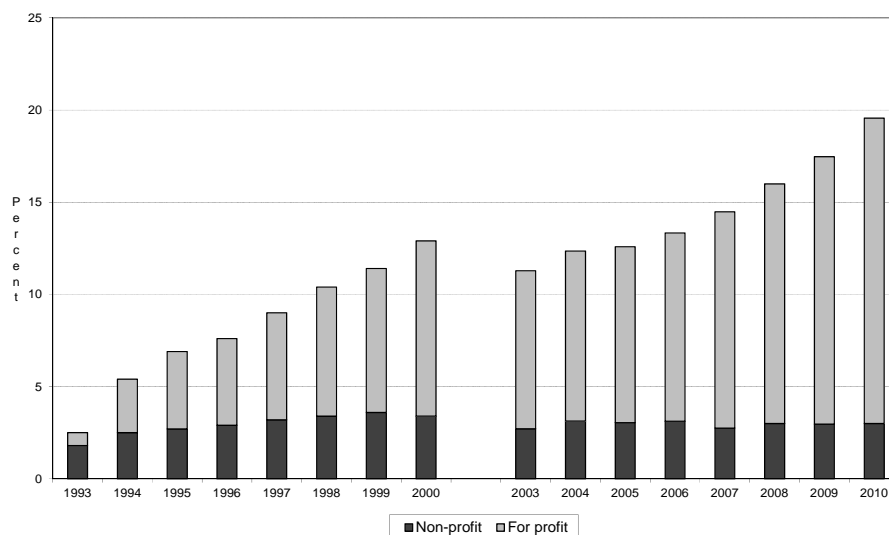
	1993	2000	2005	2012
Home care services (hours)	4	7	10	23
Residential care (residents)	5	12	14	21

Source: Konkurrensverket 2007:45 (for years 1993-2005); Socialstyrelsen 2013f (for year 2012).

The statistics on services compiled by the National Board of Health and Welfare do not distinguish between for-profit and non-profit providers, but it is possible to do so in the industrial statistics. Figure 1 shows the increase in the proportion of staff working in care services provided for *older people and people with disabilities*, who were employed by for-profit and non-profit employers between 1993 and 2010 (note that the graph does not show the majority of care workers who are public sector employees).

During the entire period, 2-3% of the workforce was employed by non-profit organisations, while the proportion employed by for-profit companies increased from virtually zero to close to 17%. As mentioned above, one explanation for the comparatively strong position of for-profit players in Swedish eldercare is that, until recently, outsourcing to private providers took place after a process of competitive tendering. Especially during the recession of the 1990s, competition was about price rather than quality. As noted in Section 2.2, this has favoured larger companies, since they have a greater capacity to handle the paperwork related to tendering procedures than small companies or non-profit organisations, and they can also underbid, if necessary, to enter the market (SOU 2007:37). Further, the fact that, under competitive tendering according to the Act on Public Procurement (LOU), companies took over both the customer base and the original staff meant that the risks to companies were significantly reduced (see Section 2.2) and enabled them to get a foothold in the market and a good position for increasing their rate of growth when free choice under the Act on System of Choice in the Public Sector (LOV) came into force.

Figure 1. Staff in publicly funded care of senior citizens and people with disabilities in Sweden. The proportion of employees employed by for-profit and non-profit enterprises respectively, 1993 and 2010.



Source: 1993-2000: Trydegård 2001, p 116; 2003-2010: Szebehely 2011, p 225. For both time periods the data source is Statistics Sweden's Business Register. The two time periods are not fully comparable due to a shift in the codes in the industrial statistics which most probably explains the decline between 2000 and 2003.

Another way of showing the extent of the marketisation of eldercare is to explore how much public funding goes to privately provided eldercare (see

Table 2). According to the most recent statistics, the Swedish municipalities purchased eldercare services to the value of SEK 15 billion, corresponding to 15% of the total cost of eldercare in 2011. The vast majority (87%) was purchased from private for-profit enterprises (SCB 2012a).

Table 2. Purchases of care activities by local authorities from various providers of eldercare, 2011, SEK millions and proportion of the user population (%)

	Private for-profit enterprises	Non-profit associations and foundations	Other public providers (local authorities, regions etc.)	Total
SEK millions	13,091	1,557	443	15,091
(per cent of all purchased care)	(87 %)	(10 %)	(3 %)	(100%)

Source: SCB 2012a, Table 5.

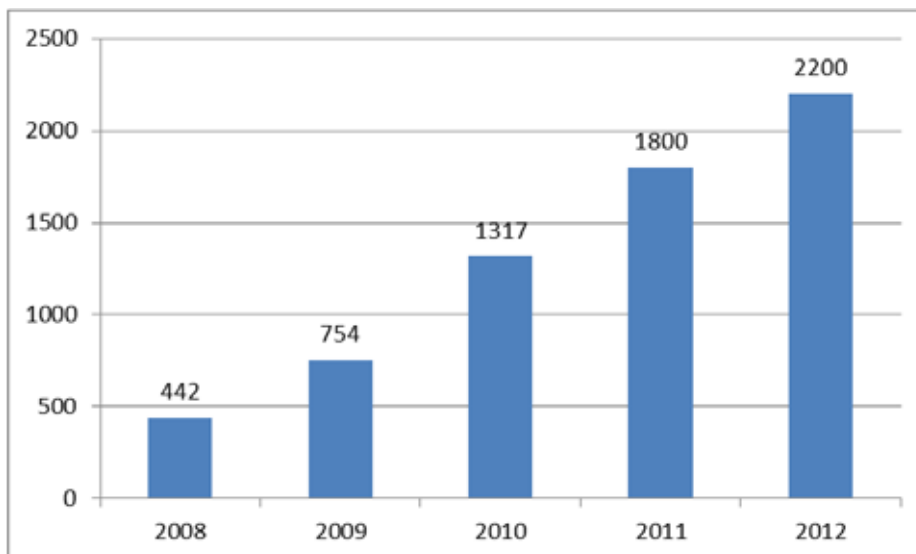
The coverage of needs assessed eldercare services has not kept pace with the ageing population. As a result there has been an increase of care provided by older people's family members as well as an increase of privately purchased care. There is a class-related pattern in these two trends: family care is used significantly more among older people with lower levels of education, while older people with higher levels of education use privately paid services to a significantly greater extent (Szebehely & Trydegård 2012; Szebehely & Ulmanen 2012).

While there is no legal support for the increase of family care, the use of privately purchased services has been encouraged by the introduction of the tax deduction on household services and personal care (RUT), mentioned in Section 2.4. The tax deduction interacts with the publicly funded home care services, as older people can use the RUT services as a substitute for, or a supplement to, home care services (Szebehely & Trydegård 2012).

The use of tax deductions has increased fivefold in five years, from SEK 450 million in 2008 to SEK 2.2 billion in 2012, see Figure 2.

There is evidence of a clear income gradient when it comes to the use of the tax deduction: it is most often used by households with the highest income. In 2011, 13% of people with an annual income of over SEK 400 000 had used the RUT credit compared to 4% among people with lower incomes (SCB 2013a).

Figure 2. Tax deductions on domestic services and personal care, million SEK

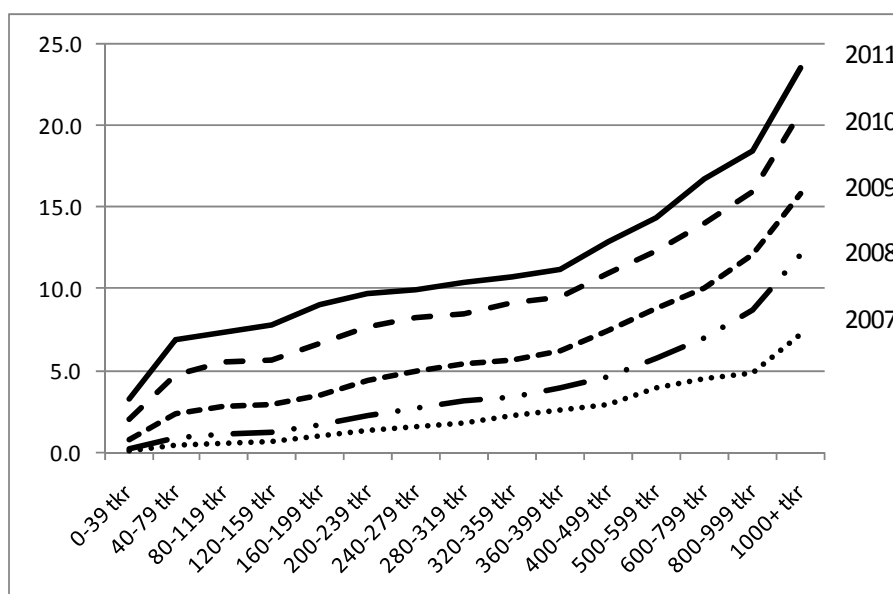


Source: Håkansson 2012, p 6 and Skatteverket (The Swedish Tax Agency) 2013.

RUT is most used by elderly persons – 8% in the age group 65 and older compared to 4.6% in the age group 20 to 64 years old (SCB 2013b). The uptake of the tax deduction has increased in all income groups, however, there is a clear income gradient also among older people, see Figure 3.

In 2011, the average amount deducted among older people was SEK 3000 (around €350); this corresponds to an average of approximately 20 hours of help per year (SCB 2013b). In comparison to the needs assessed home care services used by 9% of the population 65 years+, the privately purchased services are far less intensive: an average home care client receives 7 hours of help per week, corresponding to around 350 hours per year (Socialstyrelsen 2013a). Thus, even if the two sets of services are used by similar proportions of older people, the privately purchased household services are still marginal compared to publicly funded home-care services.

Figure 3. Older persons obtaining the RUT tax deductions by annual income (SEK thousands; tkr), 2008 – 2011. Per cent of the population 65 years+



Source: SCB (2013b), the authors' own compilation.

4.2 Regional and local variation in privately run eldercare

The high degree of autonomy of Swedish local authorities in relation to the state has led to major regional and local differences also when it comes to the prevalence of privately run eldercare. In 2012, all home care services were under public management in 60% of the 290 Swedish municipalities, while more than half of the home care services in the county of Stockholm and in a few municipalities in Scania (Skåne) were privately provided. As regards residential care, 65% of the municipalities used no private providers, while in around twenty municipalities half or more of their residential care was under private management (Socialstyrelsen 2013f). As a rule, bigger cities and regional centres have outsourced a large part of their eldercare to private providers, especially when it comes to home care services. In contrast, in the sparsely populated northern part of Sweden, far fewer municipalities have decided to hand over parts of their eldercare to the market (Socialstyrelsen 2013f). This is probably at least partly because densely populated urban areas are more attractive for private enterprises since the distance between users is shorter, compared to the sparsely populated rural areas (Stolt & Winblad 2009).

Studies on the evolution of marketisation of eldercare in the 1990s (Trydegård 2001), as well as in more recent years (Stolt & Winblad 2009;

Hartman 2011), have shown that both level of urbanisation and political colour matter: more populated municipalities and municipalities with a right-wing political majority and a larger proportion of highly educated inhabitants have a higher proportion of privately provided eldercare services.

However, municipalities with a social democratic majority have also outsourced eldercare services to private providers. In a detailed study of the process of privatisation of Swedish eldercare, Stolt and Winblad (2009) demonstrate that the trend to privatisation originated in the metropolitan areas and larger cities, and subsequently spread to neighbouring suburbs and smaller municipalities. The authors found that it was not only population density and a strained economy which proved to be of importance for the left-wing governed municipalities to introduce private providers, but neighbourhood influence was also a factor. If neighbouring municipalities – independent of their governing majority – had already introduced private providers in eldercare, left-wing municipalities also tended to choose private alternatives. There seems to be ‘a seducing power in the neo-liberal process of privatization’ (Stolt & Winblad 2009, p. 910).

When the consumer choice models were first introduced in Sweden in the 1990s, for a number of years the models were only used in a few municipalities, mainly in the capital city area and mainly with a right-wing political majority. The implementation of the *Act on System of Choice in the Public Sector, LOV*, in 2009 and the state subsidies that followed the Act led to a much wider use of choice models. In December 2012, 133 out of the 290 Swedish municipalities had implemented LOV, primarily in home care services corresponding to 45% of the municipalities, but 60% of the elderly home care users. Another 42 municipalities had decided to implement LOV (Socialstyrelsen 2013b). As with competitive tendering, there seems to be both a political and geographical pattern in the uptake of the model. Consumer choice has primarily been introduced in urban municipalities with many residents and right-wing majorities in local government (Socialstyrelsen 2010a). In 2012, 87% of the suburban municipalities and 74% of the larger towns had introduced LOV for home help services or had decided to do so, compared to 15% of the sparsely populated municipalities, most of which are situated in the northern part of Sweden (Konkurrensverket 2013, p 43).

However, the three biggest cities in Sweden have chosen different routes. Göteborg and Malmö, the second and third largest cities in Sweden, both governed by Social-Democratic led coalitions, have not implemented LOV, while the biggest city, Stockholm, governed by a coalition led by the conservative party (the Moderates), had already introduced a choice model in home care services in 2002, long before the introduction of LOV. Today two thirds of the home care hours in Stockholm are privately provided, while all home care is provided by publicly employed care workers in Malmö and Göteborg (Socialstyrelsen 2013f). A comparison between Stockholm and Göteborg shows that the local politicians in the two cities have taken a very

different stance on providing choice to home care recipients. In Stockholm, the politicians have placed high priority on the opportunity for elderly people to choose between *providers* of home care services. Through a centralised framework agreement, the local authority has listed as many as 148 different companies and, in April 2013, a home care user in the various areas of Stockholm could choose from between 84 to 106 different companies (Stockholms stad 2013a).¹⁷ In Göteborg, the local authority is the sole provider and older people are instead entitled to choose *the services to be performed* within a needs assessed allocation of hours (Karlsson 2012).

4.3 The private market in eldercare – structure and players

In the early 1990s, when competition entered the Swedish eldercare sector, local authorities started to outsource parts of their eldercare, initially mainly residential care for older people. Municipalities exposed their own eldercare units to competition and invited private organisations to take part in competitive tendering. As noted above, this process favoured major companies, which has affected the ownership structure of the eldercare market in Sweden. The larger companies have been more successful in bidding for contracts, and they have also grown as a result of merging and taking over smaller companies. As a result, the private sector, especially in residential care, has become dominated by large corporations (Szebehely 2011; Grant Thornton 2012). In 2012, 86% of all private residential care facilities were run by for-profit companies and close to half of them (46%) were run by two large actors, Attendo Care and Carema Care.¹⁸ A third large actor is Aleris. In 2005 all three corporations were bought up by private equity companies (Arfwidsson & Westerberg 2012).

Today Attendo Care is owned by the European private equity firm IK Investment Partners which bought the company from the private equity company Bridgepoint in 2006. In 2011, about 14,400 (full-time equivalents) were employed by the company in the Nordic countries, the majority in Sweden, but Attendo also provides publicly funded care on behalf of municipalities in Finland and to a minor extent in Norway and Denmark (Attendo 2012). In Sweden, Attendo runs 172 eldercare units in the Swedish municipalities (98 in residential care and 74 in home care services). The company also provides support to people with disabilities (for instance in 80

¹⁷ It is important to note that according to LOV the local authority cannot restrict the number of companies in the choice system – all companies that apply and meet the standards set by the municipality must be accepted as providers (Government Bill 2008/09:29).

¹⁸ In August 2013, Ambea, Carema's parent company, announced that the name of its eldercare subdivision, Carema, would be changed to Vardaga (see <http://news.cision.com/en/ambea>).

housing units) and social care for families and children including 17 units of housing for recently arrived refugee children (Attendo 2013).

The other very large company, Carema Care, is owned by private equity companies Triton and KKR, which bought the company from the private equity firm 3i in 2010. In Sweden, Carema provides care services for older people at 129 workplaces (81 nursing homes and 48 home care groups) and in more than 200 facilities providing care for people with psychiatric disorders or learning disabilities (Carema 2013). Carema's mother company, Ambea, has a total of 15,000 employees in health and social care services in Sweden and Finland (Carema 2012). The third large corporation in eldercare, Aleris, was established in 2005 by a merger between CarePartner and ISS Health Care. The same year the company was bought by the private equity company EQT, which in 2010 sold Aleris to Investor AB, a Swedish financial holding company. In 2011, the company employed a total of 7,000 persons and provided health care services, eldercare and psychiatric care in Sweden, Norway and Denmark; (4,700 employees in Sweden, 1,400 in Norway and 900 in Denmark). In all three countries, eldercare makes up a smaller part of the turnover (between 17% and 22%) (Aleris 2011). In Sweden, the company runs 19 residential care facilities and 18 home care units (Aleris 2013).

These large private actors have typically been awarded a contract to run a residential care facility after competitive tendering, and in these cases the buildings are owned by the local authority. However, increasingly private companies are building their own facilities and entering a framework agreement with one or several municipalities. For instance, 30 of the 98 eldercare facilities run by Attendo are owned by the company (Attendo 2013). The users pay the same fee for their care as in other publicly or privately run facilities, but some private facilities are advertised as being 'hotel like' offering topping up services to users who can pay more to get better services (Entreprenör 2012).

In a study of the Swedish care companies and their evolution in the first decade of the 2000s, the Swedish Agency for Economic and Regional Growth (Tillväxtverket 2012) concludes that the competitiveness of the entire industry is good. The value added to the companies amounted to an increase of 71% in four years. The growth was most extensive in home care services for older people: the companies saw their value increase by 268%, the number of employees rose by 163% and the number of companies increased by 98% between 2005 and 2009. The corresponding figures for residential care for older people were 93%, 98% and 26% respectively.

According to Statistics Sweden (SCB 2012b), companies with operations in the care sector show better financial results than other Swedish companies. In 2010, their return on total assets was 13% compared to 8% for all privately owned companies. Also their liquidity and solvency were above the average for all companies. However, Statistic Sweden's way of reporting the

financial results has been contested by (among others) the Association of Private Care Providers (Vårdföretagarna 2012a), with the argument that a more accurate way of reporting corporate profit is by looking at the operating margin.¹⁹ According to this measure, care companies have an operating margin of 7.5% compared to 7.3% for the industry as a whole. Grant Thornton (2012, p. 15), a major financial consulting firm, also finds similar profitability figures in their analysis of the care market and argues that the sector became slightly less profitable in 2011.

Nevertheless, in a research overview, Szebehely (2011, p 234) concluded that: ‘publicly financed eldercare and services for disabled persons have become an attractive market for international investors. The fact that international private equity companies have entered the arena on a big scale since 2005 is a sign of this’. The steady growth of the for-profit providers’ share of Swedish eldercare services suggests that both Swedish and international companies still find the market attractive, even if there are signs of a reduction in profitability (Grant Thornton 2012). The Swedish Tax Agency states that a partial explanation of private equity interest in the taxpayer-funded activities is certainly the fact that Sweden has one of the world’s most unregulated welfare sectors (Skatteverket 2012).

4.3.1 Small enterprises in the home care sector

The Act on System of Choice in the Public Sector (LOV) was introduced in 2009 partly as a way of breaking up the oligopoly described above. Experience from the evolution of the private market in Stockholm, where consumer choice was introduced in 2002, showed that the free choice model had stimulated many small enterprises to enter the market and compete for eldercare users.

In 2011, there were about 500 private providers of home care in the free choice systems of Swedish municipalities. Alongside the large corporations such as Attendo and Carema, most providers were small or medium size, and more than half of the companies had fewer than ten employees. Almost two thirds of these small enterprises were owned or run by a woman (Konkurrensverket 2013). There were few providers with that targeted specific groups of users (for example, aimed at particular ethnic or language groups), even though the development of a more diverse range of services was an aim of the free choice reform (Konkurrensverket 2012).

Small companies are fragile and more vulnerable to a loss of clients, for instance through hospitalisation or death, or absence for other reasons

¹⁹ One reason given is that companies in eldercare do not require a lot of own capital in the shape of buildings, machinery or equipment, since the municipalities, as a rule, own the buildings in residential care, and home care services operate in the homes of older people themselves. Therefore, profit measured as a percentage of invested capital is misleading, according to the Association of Private Care Providers (Vårdföretagarna 2012a).

(Sundin & Tillmar 2010). In Stockholm in February 2013, 148 companies were providing needs assessed home care services; an increase from 58 companies in 2006. One quarter of the companies in 2013 had fewer than 15 users, corresponding to not more than three full-time equivalent care workers (Hjalmarson & Wånell 2013 and Stockholms stad 2013b). There are no national or local statistics on company turnover but in one city district of Stockholm (Östermalm), in February 2011, there were 81 providers of home care services. Two years later, in February 2013, 27 of these providers (1/3) had disappeared and 40 new providers had been set up. All the providers were private organisations (the vast majority for-profit) apart from one public home care provider on both occasions (Östermalms stadsdelsförvaltning 2011; Stockholms stad 2013b).

In Swedish welfare research, there are few studies about the small care enterprises. One is a local study on the implementation of the choice model in Linköping, one of the bigger cities in Sweden. Sundin and Tillmar (2010) describe the pros and cons for smaller companies in the care market. Despite the wishes of local politicians, the smaller care companies had difficulties in obtaining a foothold in the market. They did not have the same resources for marketing and advertising their business as the major companies. Their administrative capacity was often not sufficient to meet the city's requirements in the tender documents, while the major companies had special departments to handle administrative paperwork. 'There is too much paperwork' as one of the smaller providers put it. A competitive advantage for small businesses was that the owners themselves could step in and perform the services, if needed, and also choose the 'right person' to perform the service for an individual user and ensure the continuity of staff.

4.3.2 A limited role of the non-profit sector

There are some non-profit providers in private eldercare, but as shown in Figure 1, the non-profit sector is small as regards the provision of eldercare services in Sweden, especially in home care services (Konkurrensverket 2013). Of all staff working in eldercare, about 11,000 persons are employed by the non-profit sector, corresponding to 3% of the work force (Johansson, O. 2011, pp. 18, 19). Major players in the non-profit sector are humanitarian organisations like the Red Cross and Ersta diakoni, and foundations like 'Borgerskapets enkehus' and to a smaller extent, staff or user cooperatives (Hjukström & Perkiö 2011).

The reason why the non-profit sector remains relatively small in eldercare provision in Sweden compared to other European countries has attracted some attention. The Swedish Competition Authority suggests that differences in tradition and history might be one explanation; Sweden has a strong public sector and activities from non-profit organisations have been performed and organised in other ways, for example through volunteering

(Konkurrensverket 2013). In an anthology about civil society and its involvement in the social contract, the authors argue that the market-inspired rules and regulations that municipalities have introduced through NPM reforms align better with the logic of for-profit businesses than with non-profit organisations, which operate based on certain political or social values or with the aim of promoting the welfare of their members or of vulnerable groups, and not of developing a business (Lundström & Wijkström 2012).

5. Consequences of marketisation

5.1 Consequences for the local authorities

5.1.1 New roles and new activities

As shown in previous sections, Swedish local authorities have the ultimate responsibility for eldercare, even when they do not provide these services under their own management. More than one-fifth of all eldercare is now provided by private organisations, and the private share of eldercare is increasing rapidly. To handle this new situation, local authorities must adjust their *organisation and activities*, and develop new skills in their new role as purchaser, while continuing as one of the providers of eldercare services (SKL 2011b). Many local authorities have established special procurement units with the expertise to develop clearly worded tender documents and to manage the procurement process with regard to the laws, regulations and principles involved. Local governments also spend a lot of time developing a basis for calculating the remuneration to care providers and finding reliable and simple time accounting systems for the care interventions (Statskontoret 2012) and the government has given various authorities the task of supporting the local authorities in this respect (see Section 3). The decision to outsource care, or to introduce free choice, requires *monitoring and quality control* and tender documents from local authorities must lay out required quality standards for the services to be purchased and determine how those services will be monitored and evaluated. Local authorities need to create processes and systems to regularly examine any external providers as well as their own businesses, leading to a need for extensive documentation in daily care work. They must also specify the consequences of non-compliance and state any relevant sanctions (SKL 2011b; Socialstyrelsen 2013d). Further, they also need to develop a system for documenting complaints and neglect in eldercare, and ensure transparency; a recent report has found that Swedish local authorities are at different stages of development in this respect (Konkurrensverket 2012).

Policy documents on the choice model stress that, for consumers to be able to make an active choice, municipalities have an important role to play in providing objective, comparable and accessible *information* about the various providers and their practices. This might take the form of brochures, information on a website or oral presentations. Here the needs assessments officers/care managers have a key role to play, both with regard to providing neutral information about the options available and also in supporting users to make a choice. They should also provide information to users about the possibility of switching to another provider if they are not satisfied and explain to users how they should go about changing providers if they so choose (Konkurrensverket 2012).

Empirical studies show that the introduction of choice models has rendered the role of the needs assessment officers more complex and time-consuming (Winblad et al. 2009). A qualitative study, conducted shortly after the introduction of the choice model in Stockholm, shows that the officers had to spend more time on administrative tasks and also more time together with the clients in managing the actual choice. They also found it difficult to handle the frustration of clients asking for help in making their choice as the managers are not allowed to give any advice (Hjalmarson 2003).

This study was conducted when there were far fewer providers in the Stockholm choice model, and a more recent study based on 'dialogue seminars' with 103 needs assessors in Stockholm shows that these difficulties have increased with the increasing number of providers. The needs assessors were positive to choice *per se*, but they found the large number of home care providers (on average 79 at the time of the study) problematic – it was virtually impossible for them to be up to date about each provider and the available written information about the providers was vague and of poor standard. Further, they reported that the older people were often worried that they would fail to make a good choice when they often felt vulnerable and were in a stressful situation (Norman 2010). In a recent report commissioned by the Competition Authority, Lundvall (2012) comes to a similar conclusion and argues that the situation may be even more stressful for the older people as the needs assessors tend to be too cautious when supporting them to make a choice, to avoid being accused of favouring a particular provider. There is an obvious dilemma between the professional role of the needs assessor to make sure that each person in need receives appropriate care and the demands of competitive neutrality, but there seems to be very little empirical research on the issue (Kastberg 2010; Hjalmarson & Wånell 2013).

5.1.2 Costs

At first, it was hoped that competition and private alternatives in eldercare would reduce costs and improve quality. Studies from the early 1990s indicate that *costs* decreased, but at the expense of quality. At the beginning of

the 2000s the National Board of Health and Welfare concluded that competition in eldercare had not lowered the costs. Currently, there is limited information about the consequences of privatisation on municipal expenditure for eldercare. This is partly because many local authorities do not follow up the financial consequences of competition (Szebehely 2011).

The Swedish Agency for Public Management (Statskontoret 2012) has investigated the consequences of the Act on System of Choice in the Public Sector (LOV) on costs and productivity in eldercare. They found no evidence of reduced costs in local authorities which had implemented the Act, but instead weak evidence of a higher growth rate in costs in those which had introduced free choice at an early stage. LOV requires more work on the administration of contracts, compilation of information, the enhancement of quality assurance and more invoice processing and controls of providers – undertakings which increase the costs.

In local authorities that have introduced choice models in home care, several care providers compete in the same (larger) geographical area, rather than being assigned a specific sub-district, which most probably increases the time spent on travel. There are no national studies that have assessed the possible increase in costs caused by competition in choice models, but based on simulations, the Swedish Transport Administration (Trafikverket 2011) has calculated the time used for travel by care workers in a municipality with only public home care services compared to one with also one private provider. The simulations show that, compared to municipalities with only public home care, the introduction of one private provider increases the distances travelled by 30%, and the care workers' hours worked by between 20% and 85%.

5.2 Quality differences between public and private providers

5.2.1 Comparisons based on Open Comparisons

As mentioned in Section 3.4, the National Board of Health and Welfare collects different types of information from providers within the framework of *Open Comparisons* (Öppna jämförelser) published at the level of specific operations in the web-based Elderly Guide (Äldreguiden). This makes it possible to compare eldercare provided in the public and private spheres. To date, this material has been used to make comparisons in a scientific article based on data from 2007 (Stolt et al. 2011), for an inquiry conducted by the National Board of Health and Welfare commissioned by the government (Socialstyrelsen 2012a), based on data from 2011, and for a masters thesis in Economics, based on data from 2010 (Arfwidsson & Westerberg 2012). The three studies differ in the way they distinguish between various private providers. Stolt and colleagues differentiate only between public and private

providers, the National Board of Health and Welfare makes a further distinction between non-profit and for-profit providers, and the most disaggregated comparison is conducted by Arfwidsson and Westerberg, who compare private equity owned corporations with other for-profit companies as well as with non-profit organisations and publicly provided care. The three studies also differ in the services compared: Stolt and colleagues and Arfwidsson and Westerberg only analyse residential care, while the National Board of Health and Welfare analyses both residential care and home care services.

Quality of care is often discussed in terms of Donabedian's distinction between structure, process and outcome aspects of quality (Donabedian 1966). The structure related aspects of quality consists of 'what you have' (factors which can be defined as the preconditions to achieve good quality in your operations), process quality is about 'what you do' (how the care is actually provided), while outcome quality is the actual result. The Elderly Guide primarily include indicators of process related quality aspects (how users are treated, risk assessments etc.) and to some extent structure related quality aspects (staff skills, staff continuity). Outcome quality is hardly covered.

Comparisons between public and private residential care

The study by Stolt and colleagues (2011), using data from 2007, indicated that residential care under private management has a 9% lower staffing level and a smaller share of full-time employees (-11%). The analysis by the National Board of Health and Welfare shows a similar trend. The lowest staffing ratio was found in for-profit residential care, with 0.8 full-time equivalent employees per resident as compared to 0.9 in both public and non-profit residential care. Further, public residential care had fewer workers employed by the hour (13%) than both for-profit and non-profit providers (17%) (Socialstyrelsen 2012a, pp. 20, 24). This comparison shows that the lower staffing levels in nursing homes only apply to for-profit providers. International studies have also found this difference (Comondore et al. 2009).

The more disaggregated analysis by Arfwidsson and Westerberg (2012) shows that private equity owned residential care providers report lower staffing ratios, higher proportions of hourly employment and lower levels of formal training when compared not only to public residential care, but also to other for-profit residential care providers, see Table 3. The study also found that staffing ratios declined after an operational takeover by a private equity firm. The authors' conclusion is that this indicates that 'the differences in Employees per Resident, observed in the cross sectional comparison, is not a co-varying phenomenon, but a causal consequence from private equity ownership' (Arfwidsson & Westerberg 2012, p. 31). These findings are in line with a recent US study on nursing home quality that found the lowest staffing levels in the ten largest nursing home chains, several of

which were owned by private equity companies (Harrington et al. 2011; see also Chapter 8 in this report).

Table 3. Comparison of quality in residential care between private equity owned companies and other providers, Sweden, 2010

	Public	Non-profit	For-profit (not private equity)	For-profit (private equity)
<i>Structure aspects of quality:</i>				
Employees (full-time equivalent) per resident	0.88 **	0.84	0.83	0.79
Hourly employment (%)	12.8 **	16.9	14.6 *	18.7
Formal training (% of care workers with permanent employment)	81.9 **	82.5 *	81.9 **	76.2
Employees per manager	32.6 **	28.5	26.2	28.9
<i>Process aspects of quality:</i>				
Participation in setting up care plan (%)	85.4 **	90.4	90.1	93.2
Having an updated care plan (%)	65.1 **	73.8 *	79.6	85.8
Nightly fasts of under 11 hours (%)	74.7 **	82.9 *	95.8	93.7
Risk assessment for falls (%)	51.2 **	76.9	69.5 *	78.2
Risk assessment for pressure ulcers (%)	42.0 **	67.2	64.1	69.6
Risk assessment for malnutrition (%)	50.8 **	76.1	68.2	75.7
Medication review (%)	65.9 **	89.7 *	80.1	77.6

* p<0.05; ** p<0.01

Source: Arfwidsson & Westerberg 2012, p. 27.

In contrast to the consistent finding regarding staffing ratios and training levels, the Swedish studies found that there were a larger number of care workers per manager in public residential care than in the other forms of ownership (Table 3). Further, when it comes to process quality management, the highest quality is found in private equity owned residential care. This applies to participation in setting up a care plan, the up-dating of care plans, nightly fasts less than eleven hours, and risk assessments for falls, pressure ulcers and malnutrition as well as the number of medication reviews, see the lower part of Table 3 (similar results are shown in Socialstyrelsen 2012a, p. 27 and Stolt et al. 2011, p. 565).

Comparisons between public and private home care services

The study provided by the National Board of Health and Welfare (Socialstyrelsen 2012a) shows a similar pattern in home care services – in general, higher levels of structure quality and lower levels of process quality in public home care when compared to private home care, see Table 4.

Table 4. Differences between public and private providers of home care services, Sweden, 2011

	Public	Non-profit	For-profit
Structure aspects of quality:			
Hourly employment (%)	15	26	33
Formal training (% of care workers with permanent employment)	75	74	66
Employees per manager	30	21	16
Process aspects of quality:			
Participation in setting up care plan (%)	70	88	92
Having an updated care plan (%)	40	49	63

Source: Socialstyrelsen 2012a, pp. 22, 25.

Employment by the hour was clearly more common among for-profit providers of home care where every third care worker was employed on an hourly basis compared to one out of four in the (small) non-profit sector and less than one out of six in the public sector. The lowest level of formal training was found in the for-profit sector and the difference is larger than it appears as training levels are only reported for permanent employees, and considerably fewer care workers employed by the hour have formal training (Socialstyrelsen 2013g, p. 148). Between 2011 and 2012, the difference in formal training between publicly and privately employed home care workers increased, most probably reflecting the increased impact of choice models in home care favouring small companies offering both private domestic help and needs assessed home care; companies that probably have fewer formally trained care workers (Socialstyrelsen 2013g, p. 148).

As in residential care, there were fewer employees per manager in for-profit than in public home care and more home care users in for-profit home care were reported to have participated in setting up their care plan and care plans were more often up-dated.

Users' perceptions of the quality of eldercare

Only a small number of studies have been compared users' perceptions of the quality of eldercare services provided by the private and public sector

respectively, and the results point in different directions. The results of the user satisfaction survey conducted by the National Board of Health and Welfare as part of Open Comparisons are normally presented at the municipal rather than the unit level (see Socialstyrelsen 2012e; Socialstyrelsen & SKL 2013). It is, however, possible to make comparisons between the public and the private sector by comparing the 17 local authorities that, in 2011, distributed the national survey to all users in the municipality, not only to a sample of users as was the case in the rest of the country.²⁰ The National Board of Health and Welfare analysed this data in their report on quality in public and private eldercare and did not find any significant differences in user satisfaction between public and private providers, neither in home care nor in residential care (Socialstyrelsen 2012a).

5.2.2 Relevance and reliability of the measures in Open Comparisons

There is no clear definition of what good quality of care actually is. However, if measuring quality is to be a meaningful exercise, the indicators need to reflect what is important to those receiving care and the measures of quality need to capture the actual conditions. Thus the measures need to be relevant and reliable (Socialstyrelsen 2012e). The indicators included in Open Comparisons have been criticised for being too medical in nature and for focusing too much on the external conditions of eldercare and for not being able to capture the relational aspects of care, for example, the relationship between the care recipient and the staff which is crucial according to care research (Johansson, S. 2011). At the same time certain external conditions must be fulfilled to make this relationship possible, which is why there should be some focus on structural measures. Comprehensive Swedish and Nordic eldercare research has shown that time, continuity and flexibility are vital if a care recipient is going to feel that he or she is receiving good care. Thus, staffing levels and the number of employees employed on an hourly basis are important parts of structure quality which affect both continuity of care as well as the time given to encounters between care workers and the elderly users (Szebehely 2011). International research has also highlighted staffing levels as one of the most important measures of the quality of care (Harrington et al. 2000; 2011).

Therefore it is important to note that information on staffing levels and staff employed by the hour are no longer collected and reported. According

²⁰ In May-June 2013, the National Board of Health and Welfare conducted the very first survey of all eldercare users in Sweden (245,000 individuals). In November, the results will be presented 'at such a detailed level as the statistics allow', that is, if possible at the level of specific operations, but the data can certainly be used to compare various forms of providers (Socialstyrelsen 2013g).

to the National Board of Health and Welfare, this is because providers have found it difficult to submit this information. The plan is that new measures of staffing levels will be included for 2013 (Socialstyrelsen 2012d). However, the government has recently asked the National Board of Health and Welfare to develop new quality indicators focusing care processes rather than structural aspects of quality of care (Government Bill 2012/13:1, p. 199). Thus the structure aspects of quality might become even more downplayed.

Another problem with quality measures is that the quality indicators that research has shown are important to most people, for example, choice, influence and feeling safe and secure, may mean different things to different people (Slagsvold 1995, Norman 1999). An example of this is that 'being involved in the drawing up of the care plan', which is an influence indicator in the Elderly Guide, has been shown to lack correlation with the care recipient's perception of being able to have a say in how the service is provided (Socialstyrelsen 2011c). Nor is it known whether the care plans are actually followed or whether those with a risk assessment actually have fewer fall injuries or pressure ulcers.

Two major surveys (part of Open Comparisons) aimed at local authorities/provider units and eldercare users respectively form the basis for the comparison of quality differences presented in the previous section. The value of these surveys depends on the validity of the measures and representativeness of the sample, which in turn is affected by the response rate of the survey. In the latter respect, the survey to local authorities and care providers comes out very well: in the 2011 survey, 5 200 provider units participated, corresponding to 97% of residential care facilities, 91% of home care services units and 96% of adult day centres (Socialstyrelsen 2012e). However, the information is submitted by providers themselves, and in a competitive environment, there is a temptation for providers to adapt their responses in order to be seen in an as positive light as possible (Lindgren et al. 2012; Szebehely 2011). Furthermore, providers often find the questions complicated to answer, and the questions may be interpreted in various ways by different providers (Lindgren et al. 2012; Socialstyrelsen 2012e)

The user survey has a much lower response rate which makes it difficult to draw firm conclusions from the results: in 2011 the response rate was 54% for residential care and 67% for home care services, which together with the fact that a large majority of the questionnaires, in particular in residential care, are answered by relatives (61% of the respondents in residential care and 19% of the home care respondents), gives rise to questions about the survey's representativeness (Socialstyrelsen 2011c). Other issues centre around what the user survey actually measures; is there, for instance, a risk that answers are based on events close in time rather than giving a more holistic impression? Further, older people are dependent on the care they need and their answers may express gratitude (Lindgren et al. 2012).

5.2.3 Other studies on quality of care and quality of work in public and private eldercare

Besides the studies reported above based on Open Comparisons, there are a few other larger studies comparing private and public eldercare. Regarding users' perspectives on service quality, these studies point in different directions. The City of Stockholm carries out an annual survey that seeks to cover all eldercare recipients. The overall assessment of care made by users in 2012 showed a slightly more positive assessment of private providers in both home care and in residential care (Stockholms stad 2012; Socialstyrelsen 2012a).

In contrast, according to a national survey conducted by Svenskt Kvalitetsindex (Swedish Quality Index), in both 2011 and 2012, users were less satisfied with private residential care than with municipal residential care (Svenskt Kvalitetsindex 2012). As we saw earlier, the National Board of Health and Welfare did not find any difference in user satisfaction between public and private eldercare. To summarise, there do not seem to be any major or clear differences between private or public eldercare with regard to perceived quality.

The care workers' situation is to some extent indirectly covered by the data in Open Comparisons, in that the structural preconditions of care services also have an impact on the work situation of the staff. Lower staffing levels probably lead to an increased burden of work, and a higher proportion with respect to employment by the hour is likely to be a signal of more precarious employment conditions. According to several studies, the work situation in eldercare is, generally speaking, difficult and there are signs that the situation has deteriorated in recent years (Gustafsson & Szebehely 2005; Trydegård 2012). There is limited information about the working conditions among privately and publicly employed care workers, but a survey carried out on care workers in eight local authorities in 2003 showed that there were no systematic differences in how the staff perceived their working environment in the two management forms (Gustafsson & Szebehely 2009). However, there was a significant difference between publicly and privately employed care workers in that the latter group found the local politicians' role substantially more diffuse and of less importance for their work environment and the quality of care, which in turn may generate an internal erosion of the legitimacy of democratic steering of Swedish eldercare services (Gustafsson & Szebehely 2009).

In 2012, Kommunal, the Swedish Municipal Workers' Union, which organises the majority of both private and public sector care workers in Sweden²¹, carried out a telephone interview survey on the working conditions in eldercare among its members (the response rate was 75% and the

²¹ The unionisation rate, however, is significantly lower among private employees (Kommunal 2012, p. 41).

study included 4,654 care workers in residential and home based eldercare). This study also found few differences between publicly and privately employed care workers. One third of the home care workers and one fourth of the residential care workers reported that at least once every week they had difficulties in taking a short break (no difference between management forms). Neither was there any significant difference between management forms in the matter of working with insufficient staffing levels at least once a week; this was reported by as many as six out of ten residential care workers. The only significant difference in working conditions between management forms was found in home care: 54% of municipal home care workers reported insufficient staffing levels as compared to 48% of the privately employed workers (Kommunal 2012). Thus the limited research on working conditions in public and private eldercare does not suggest any consistent or large scale differences between the two sectors.²²

The survey also asked those who had worked in both the private and the public care sectors which they preferred. Of the 548 respondents who had worked in both sectors, almost half said that the local authorities offered the best conditions. The reason for this was said to be that the local authorities offered better security and higher wages. Of those who said they preferred private employers (a fifth of the respondents), the most common reason given was that they had a greater sense of influence and control over their working tasks (Kommunal 2012).

As noted in Section 4.3, the number of small home care companies has increased significantly in the last few years as a consequence of LOV. A survey of 61 of the 70 local authorities that had implemented LOV in 2010, conducted by *Kommunalarbetaren* (the Municipal Workers' Union's magazine for members), shows that 272 of the 688 home care companies in question, in other words 40%, lacked collective agreements (Kommunalarbetaren 2011). Of 140 home care companies in the customer choice system in Stockholm, half did not have a collective agreement in 2012 (Kommunalarbetaren 2013a). There is no national data on whether and how working conditions differ between companies with or without a collective agreement. According to the Municipal Workers' Union, it is more common for people without a collective agreement to fail to receive overtime pay or compensation for working unsociable hours or for travel time between different users. Further, companies without a collective agreement may not pay the supplementary pension stipulated in the collective agreement, which corresponds to

²² One exception is a study that reports much better working conditions among employees in privately provided health and social care compared to those employed by municipalities and county councils, in particular regarding workload and relations between staff and management. Unfortunately, the report does not differentiate between different sectors and professional groups within the wide category 'health and social care', so it is not clear to what extent it compares like with like (Vårdföretagarna 2012b).

about SEK 1000 (around €15) per month for a full-time worker (Kommunalarbetaren 2013b).

5.3 The consequences of choice models

There is no clear answer to the question of whether or not the introduction of choice models has had an impact on the quality of eldercare since no *ex ante* or *ex post* studies have been conducted. One way of trying to understand whether quality has been enhanced is to study how customer satisfaction has changed over time. In the City of Stockholm, which introduced customer choice in home care in 2002, regular user surveys have been carried out since the mid-nineties. The proportion of users who are satisfied with their home care has remained unchanged over this time, but the proportion who is *very* satisfied decreased from 45% to 36% between 1995 and 2008 (USK 2009). Thus it does not seem as if the quality of eldercare has been enhanced, even if we cannot be certain that users have not become more demanding in relation to the quality of eldercare services over time, which, if true, could explain falling levels of ‘very satisfied’ responses (Szebehely 2011). The City of Stockholm changed the way it measured overall satisfaction with home care services in 2009, and according to the new measures, between 2011 and 2012, the number of users who were satisfied with various aspects of home care services increased (Stockholms stad 2012).

The Swedish Agency for Public Management has compared user satisfaction (as reported by the user surveys conducted by the National Board of Health and Welfare as part of Open Comparisons) over time in municipalities that have implemented choice models in home care according to LOV and those that have not. This analysis shows that user satisfaction increased between 2008 and 2011 in the municipalities that had implemented the Act, while it remained unchanged in the municipalities that had not. It must be stressed, however, that user satisfaction in municipalities with LOV was lower in 2008 and the level of satisfaction did not differ between the two groups in 2011 (Statskontoret 2012). In 2012, the questions in the user satisfaction survey were changed quite significantly and it is no longer possible to compare responses over time. However, in 2012, the level of general satisfaction was similar in municipalities with and without LOV: 88% of the home care users in both type of municipalities were very or rather satisfied with the home care services they received (Socialstyrelsen 2012e).

A few smaller surveys have been conducted on how the choice system works in practice and how older users who have chosen a provider of eldercare have perceived their choice. They show that most older people view the opportunity to make a choice positively, but also that they often have to make a choice in a demanding situation. Most older people, who have had the option of choosing their home care service provider in the Stockholm

area, were positive to the choice option. This also applied to those that had not made that choice (Hjalmarson 2003, 2006). However, it was more important for the elderly persons to have a say about what the service actually entails and who carries it out than to be able to choose the organisation that provides it (Hjalmarson 2003, 2006; USK 2009). Also, in practice, many older users had problems actually making the choice, since they were often ill or found it hard to absorb information (Hjalmarson & Norman 2004; see also Meinow et al. 2011). The decision was also often made under time pressure, in many cases during, or immediately after, the appointment with the needs assessor, which exacerbates an already stressful situation for users (Winblad et al. 2009; Socialstyrelsen 2012f; Lundvall 2012).

Several surveys have shown that it is difficult for senior citizens and their relatives to understand what differentiates providers, particularly if there are many to choose from (see, for example, Edebalk & Svensson 2005; Norman 2010; Socialstyrelsen 2012f). There is a lack of comprehensive information about the results of quality monitoring, any complaints made or observations from authorities (Hjalmarson 2006; Hjalmarson & Norman 2004).

When choosing a nursing home, senior citizens and their relatives want information giving them facts about the various facilities in ways that enable them to compare the facilities. They want information about the staff (for example, about staffing levels and skills, about staff turnover and about access to nurses, doctors and specialists) and about the premises and activities, as well as information about the provider organisations (for instance, operational goals, HR policy, finances) (Socialstyrelsen 2011e; Socialstyrelsen 2012f).

Only a few local authorities provide the information that users and their relatives demand (Winblad et al. 2009). Many local authorities conduct user surveys, but very few present the results by provider on their websites (SKL 2010c). A great deal has been expected of the system of choice as regards increasing the influence of users and enhancing the quality of the care. The theory was that users would gain greater influence because they can switch provider if they are not satisfied, and that, as a consequence, poor performing companies would be weeded out because dissatisfied customers would go to another provider. In practice, however, few users switch provider, and it is impossible to know the exact number since many local authorities do not compile statistics on the switches. One larger study of local authorities with systems of choice in home care showed, however, that 4% of users had switched provider in 2009. In the cases where the reason for the change was known, a fifth was due to the fact that the operations of the provider were ceased (Svensson & Edebalk 2010). According the representatives for local authorities interviewed in another study, users may not be asked why they switched providers because the question may be perceived as doubting the judgment of the older person. The risk here is, however, that deficiencies in a provider's operations will not be made known to the local authorities

(Winblad et al. 2009). In a smaller study of people who had switched home care provider, dissatisfaction with staff continuity, above all, led to the change (Hjalmarson & Norman 2004).

There may be several reasons why older users do not avail themselves of the opportunity to switch provider. One obvious reason could be that they are satisfied with the provider chosen. But there are indications that also those less satisfied are reluctant to use their exit option (Szebehely 2011). Continuity of care is a crucial aspect of care quality and, for a frail older person who is dependent on the help and the relationship with the staff, a change of provider might be too a big step (Eika 2006; Möller 1996). For users of residential care a change of provider also means moving house and in addition there is a shortage of places in many local authorities (Socialstyrelsen 2012f).

There are also possible distributional effects of choice models in that there is a risk that individuals with more resources benefit more from a choice system than those with fewer resources. The National Board of Health and Welfare has highlighted that people who are very ill, people who are hard of hearing or have visual impairments, and people with cognitive difficulties may all be at a disadvantage due to the difficulties with making a well-founded choice or requesting a switch. Other groups which may be at a disadvantage are people who do not speak Swedish and those with lower levels of education (Socialstyrelsen 2011g; Statskontoret 2007; Socialstyrelsen 2012g).

Whether or not different social groups of older people handle choice in different ways, or choose public or private providers to the same extent, is currently unknown, but as discussed in Section 3.2, there is an incentive for wealthier groups of older people to choose a private provider of their needs assessed home care services. Many of the private providers in the systems of choice offer extra services paid for by the user, and those who choose a private provider for their home care can top up services from the same staff (Szebehely & Trydegård 2012). It is, however, currently not known who, in practice, makes use of these services. That said, because the tax deductions for household services (RUT) is used a great deal more by older people in higher income brackets than in lower ones (see Section 4.1), it is probable that there is a similar socioeconomic pattern of uptake of additional services. If so, this would suggest that groups of older people who are well off may choose private rather than public providers for their needs assessed home care, because of the competitive advantage that LOV has given private providers. As a result, those who are less well-off may come to dominate publicly provided services, which in turn may lead to a reduction in the quality of public home care and to an increase in inequalities (Szebehely & Trydegård 2012). There are no statistics available to enable assessment of whether or not choice systems increase inequalities (Socialstyrelsen 2011d), but a research review of patients' choice of caregiver in medical care shows

that well-educated patients make more active choices than patients with low levels of education. International studies also indicate that people in low and high income brackets respectively evaluate information about quality in different ways (Rehnberg & Goude 2011).

A couple of qualitative studies indicate that the ability to make demands, either by oneself or through one's relatives, may have an impact on the scope of the care and its quality. A study conducted in Stockholm, where the competition over users is strong, shows that users who make demands or who have relatives who do so tend to receive more time and more services without extra cost in order to keep them satisfied and to prevent them from leaving a particular provider, with the extra time reallocated to them from less resourceful users (Gavanas 2011). A Norwegian thesis on choice in nursing homes also highlights the role played by relatives. According to the author, relatives often monitor quality in the nursing homes, and nursing homes where residents have less resources risk becoming poor performers compared to nursing homes which are constantly monitored by more resourceful relatives (Eika 2006).

6. Concluding discussion

Private actors have a long history in Swedish eldercare. In particular, religious and other non-profit organisations have provided residential care for many years. By contrast, for-profit companies only entered the field in the early 1990s, encouraged by the changes in the Local Government Act and the Social Service Act in 1992. An even newer phenomenon (since 2005) is that an increasing proportion of private eldercare providers is owned by private equity companies. This type of ownership is more common in welfare services than in the rest of the Swedish economy (Skatteverket 2012).

Today more than every fifth bed in residential care and every fifth publicly funded home care hour are provided by a private organisation. Every fifth employee in care services for older or disabled people is employed by a private provider – 17% by a for-profit company and 3% by a non-profit organisation. Of all private residential care facilities in 2010, 86% were run by for-profit companies and close to half of the private facilities were run by the two largest private equity owned corporations Attendo and Carema (Arfwidsson & Westerberg 2012). In 2012, 93% of all private providers of home care services were run by for-profit companies; the majority with less than 10 employees (Konkurrensverket 2013). Thus the private eldercare sector in Sweden is strongly dominated by for-profit actors, but with different profiles in residential care and in the homecare sector. The role of non-profit providers is smaller in Sweden than in Norway and Finland countries (see Chapters 3 and 5), and has not increased since the early 1990s.

When competition entered the Swedish welfare service sector in the early 1990s, residential care facilities and, to a minor extent, home care districts were outsourced after competitive tendering according to the Act on Public Procurement (LOU), often focusing on price rather than quality. This form of marketisation favoured larger corporations, whose economies of scale made it easier for them to make competitive bids. In 2009, the Act on System of Choice in the Public Sector (LOV) was implemented with the aim of facilitating the introduction of choice models of home care services. In 2012, more than half (60%) of the Swedish municipalities had introduced, or had decided to introduce, choice models of home care following LOV. In these municipalities, all companies that apply and meet the standards set by the municipality must be accepted as providers in the choice system, and the standards are not permitted to be unduly high in order to facilitate the entrance of smaller companies. The interplay between the choice legislation (LOV) and the tax deduction on household services and care (RUT) is crucial for the profitability of these smaller companies: besides providing needs assessed home care (personal care as well as practical help), the majority of private home care providers in the LOV system also offers domestic services to both the general public and to their home care clients.

The different forms of marketisation in residential care and in home based care – competitive tendering and choice models combined with the tax deduction for household services – have led to the combination of oligopoly and fragmentation that now characterises the Swedish private eldercare sector. We can also conclude that neither of the two forms of marketisation has favoured non-profit providers.

While choice models were initially mainly used in home care services, more recently some municipalities are introducing choice models in residential care as well. This trend is related to another recent trend: for-profit companies are increasingly building their own residential care facilities and are ‘selling beds’ to one or more local authorities instead of bidding in a competitive tendering process. In such cases, the private companies, as well as the private providers of home care services, can offer extra services beyond the needs assessed care to users who pay out of pocket (but can use the tax rebate to halve their spending). Whether these providers attract more resourceful groups of older people is not known. But if this is the case, it may lead to a dualisation of care where publicly provided services might become increasingly dominated by those with fewer resources, which in turn may lead to reduced quality in public services.

Characteristic of marketisation in Swedish eldercare is that various state authorities have become increasingly active in the regulation and oversight of the eldercare sector. In 2009, the government commissioned *Kammarkollegiet* to develop procurement instructions for municipalities. The *Swedish Competition Authority*, Konkurrensverket, is commissioned to supervise compliance with LOU and LOV and has responsibility for evalu-

ating the competitive situation related to LOV. In 2010, the government commissioned the *Swedish Agency for Economic and Regional Growth*, Tillväxtverket, and the *Swedish Agency for Growth Policy Analysis*, Tillväxtanalys, to support private providers in eldercare and health care. In 2011, the *National Board of Health and Welfare*, Socialstyrelsen, was commissioned to develop guiding principles for the municipalities outlining how to outsource and monitor quality of care. The Board has also been given responsibility for evaluating possible differences in quality between private and public providers of eldercare, and for assessing the consequences of LOV from a citizen perspective. Finally the *Swedish Agency for Public Management* – Statskontoret was commissioned in 2011 to evaluate the consequences of LOV on costs and efficiency, and in 2011 the *Swedish Tax Authority* – Skatteverket was commissioned to investigate tax avoidance schemes by internal loans among private equity firms in the welfare service sector (Skatteverket 2012). Altogether these authorities have published more than 50 reports on competition and choice in eldercare in the last 2-3 years, and we refer to many of them in this report. While these reports contain a lot of useful information, there is surprisingly little focus on the possible effects of marketisation in relation to the universal ambitions that characterises Swedish eldercare – the focus of the reports is clearly more on regulating and promoting competition than on the possible risks for less resourceful groups of users, or to social cohesion.

The extent of recent state activity in this area is remarkable compared to previous years and in comparison to the other Nordic countries. In addition, several government commissions have recently been appointed to investigate various aspects of marketisation: one commission was appointed in September 2012 to evaluate the consequences of LOV in eldercare for costs, quality and efficiency. Based on that evaluation, the commissioner is to consider whether it should become mandatory for municipalities to introduce the LOV system in home care and possibly also in residential care (Dir. 2012:91). Another commission was appointed in December 2012 (Dir. 2012:131). The task for this commission is to analyse whether there is a need for stricter requirements on those who own or run private companies in the welfare service sector.

Responsibility for controlling the quality of services rests with the municipalities, even when a private company provides the services. Issues of quality have increasingly come under scrutiny, partly as a reaction to the increasing number of private providers. Not only is there an increased focus on how to regulate and measure quality in eldercare, there is also an increased focus on the role of profits and profit making in eldercare and other welfare services. When Swedish eldercare and other welfare services were opened up for competition in the early 1990s, public provision was usually contrasted to ‘alternative providers’, and the expectations were that innovative small companies and non-profit organisations would enter the field and

stimulate innovation in the public sector. The distinction between for-profit and non-profit in the public debate is a very new phenomenon in Sweden, and there are still limited national statistics that differentiate service providers according to whether they are for-profit or non-profit; statistics still only distinguish between public and private.

Despite this lack of statistics, the National Board of Health and Welfare (Socialstyrelsen 2012a) as well as some scholars have made efforts to compare the quality of eldercare services run by the municipality and by non-profit and for-profit actors, utilising the quality measures collected by the Board as part of Open Comparisons (see section 5.1.1). The Board's main conclusion was that there is a need for more studies and that there is not enough information to draw any clear conclusions whether there are any quality differences between public, for-profit and non-profit providers, or between municipalities with and without choice models. The Board, as well as Arfwidsson and Westerberg (2012), found, however, that local authority residential care had higher staffing ratios and fewer employees paid by the hour than residential care run by for-profit providers and especially those owned by private equity firms. In contrast to these structure related aspects of quality, process related aspects of quality, such as the resident's participation in formulating the care plan, or various risk assessment (risk of falling, pressure ulcers and malnutrition), were generally higher in the private sector and, in particular, in facilities run by private equity owners. The lack of outcome data on, for instance, pressure ulcers or fall injuries makes it difficult to assess the importance of these process quality measures. Finally when it comes to user satisfaction, there is no difference at a national level between public and private providers.

These findings can be interpreted in two ways. One standpoint is that for-profit providers are more efficient as they can provide better care (measured by process quality indicators) or equally good care (measured by user satisfaction indicators) with less staff. Another standpoint is that, based on research that has found that older people would much prefer to have sufficient time with the care provider and to have high staff continuity, staffing levels and lower proportions of workers employed by the hour are more relevant quality measures than process related quality measures and user satisfaction. There is obviously a need for more research in this field. In any case it should be noted that after 2011 the Board does not collect measures on staffing ratio and hourly employed care workers, and the government has recently assigned the Board to develop new indicators for the Open Comparisons focusing on indicators that describe care processes (Government Bill 2012/13:1, p. 199). Thus there is political will to collect data on the process aspects rather than the structure aspects of quality of care. Moreover, quality requirements made by local authorities that outsource eldercare services tend to focus on process quality: an analysis of 70 cases of competitive tendering of nursing homes in 2011 and 2012 showed that 2/3 of the on average 215

requirements in the tender documents were about the process of care and 1/3 were about structure. Altogether half of the requirements were deemed possible to monitor. Of specific interest in this context is that, over the period under study, only 5% of the tender documents included specific requirements on staffing ratios. However, after an intense media debate on allegedly very poor quality of care in a nursing home run by one of the largest corporations in autumn 2011 (see Lloyd et al. 2013), this share increased to 16% (Almega et al. 2013, p. 31).

It is an open question whether or not the last two decades of increasing for-profit provision of eldercare will continue. It has been argued that the welfare service sector in Sweden has been more unregulated than in other countries (Skatteverket 2012). The media debate on 'care scandals' prompted calls for stricter regulatory control, and today demands for stricter regulation and more quality control are heard from many corners – from the government, the political opposition and from organisations representing private providers as well as users and older people in general. The Swedish LO (the Swedish Trade Union Confederation) and the Social Democratic party have recently presented their programs for eldercare services (LO 2012; SAP 2012). Both programs are pro-choice and both argue for stricter regulation of quality and are thus do not differ from the right-centre government in these respects. But, in contrast to the government, both programs propose binding national guidelines on staffing ratios, both are against the free establishment for private companies stipulated in LOV and both propose restrictions for profit-seeking companies in welfare services – the LO program is more far reaching in this respect. In April 2013, the Social Democratic Party Congress reached a compromise between these two programs but did not follow the demands from several congress participants that sought to forbid profit making entirely.

Several recent opinion polls show that public opinion in Sweden is more sceptical regarding profits in welfare services than is the political elite. According to one large study, 62% of the Swedish population agrees to the statement 'Profit-making should not be allowed in tax-funded health care, schools and social care'. Only 17% disagreed (19% were neutral and 2% had no opinion). There were some differences between income groups and by party identification, but in all groups the balance of opinion was clearly in favour of the statement (Nilsson 2013). Another study shows similar results: 64% of the respondents argued that profits in eldercare and other welfare services would either be reinvested or entirely stopped. In that survey, the respondents were also asked whether they thought that a halt to profit making in health care, schools and social care would change the quality of the services for the better or the worse – 41% answered that they thought quality would improve and 20% that it would deteriorate (the rest did not know or answered that it would not change). There were clear differences by party group: 55% of Social Democratic voters answered that they thought

quality would improve and 13% that it would get worse compared to non-socialist voters where the corresponding figures were 29% and 26% respectively (NOWA 2013). Whether marketisation of welfare services and the role of for-profit companies providing these services will be an important issue in the 2014 elections is, however, still to be seen.

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Chapter 3

Marketisation of eldercare in Finland: legal frames, outsourcing practices and the rapid growth of for-profit services

Olli Karsio and Anneli Anttonen

1. Introduction

Since the early 1990s, marketisation has increasingly framed and shaped social service delivery in Finland. In this report we provide an overview of the increased presence of both internal and external markets in the field of public policy on eldercare. We pay attention to changes in social service legislation promoting market shift, instruments for creating managed markets at the local level in local authorities and the extent of market provision in eldercare as well as the main consequences of the overall marketisation process that has taken place during the last two decades in Finland.

Marketisation refers to slightly different but intersecting phenomena. One should speak about ‘marketisations’ instead of a single process of marketisation. Firstly, marketisation refers to a process of change: the governance and organisation of publicly-funded eldercare services is redefined through the creation of internal and external markets (Meklin et al. 2009). Secondly, marketisation designates the increasing presence of market-like mechanisms in the organisation of public services. With the implementation of outsourcing, competitive tendering, voucher systems and tax credits, market-like mechanisms are brought into effect in the local authorities. These instruments can be implemented without any major market shift in service delivery, but they seem to be integral to the overall marketisation process. In this report marketisation is used in a fairly broad sense, as a general frame for understanding some major changes in the organisation of publicly-funded eldercare services.

Anttonen and Häikiö (2011) have shown that marketisation processes are a crucial element both in policy discourse around, and actual practices of, social care for older people. It is however important to note that, in Finland, the market-related turn has taken place later than, for instance, in Sweden. It

is only very recently that marketisation has become a major driver of change in Finnish social service policies. From this it follows that there has been little empirical research conducted on the different aspects of marketisation (see, for example, Kovalainen & Österberg 2006; Lith 2012a; Rahkola 2011). For instance, too little is known about how market mechanisms are implemented in the local authorities and about the distribution between provider types (public, for-profit, non-profit) in different service categories. In addition, there is a lack of statistical data, most particularly data which would help to understand changes over time. Thus, there are extensive gaps in knowledge.

Our intention is to evaluate the role of marketisation processes, firstly, through legislative frames and changes; secondly, by describing the main instruments that promote market-based service provision in Finland; and, thirdly, by estimating the extent and intensiveness of the market turn. Finally, we look at the main consequences of marketisation and some future trends. Before moving on to the legislation and instruments section of the report, an overview of the general traits of the eldercare services system is given.

2. Finnish eldercare services: general traits

Marketisation means different things at different times and in different countries. It is a contextual and normative concept and phenomenon. To understand the national characteristics of marketisation, we start our analysis with a section looking at the general traits and structures of eldercare services. This is important because there are more than 300 municipalities in Finland, and they are fairly autonomous social service providers. The state sets the legal frames for welfare service provision, but the *Social Welfare Act* obliges local authorities to provide services according to the needs of residents. However, local authorities also have some freedom to decide how these needs should be met, although this freedom has been limited by state financial and austerity priorities since the early 1990s. All this means that there is a large number of slightly different marketisation policies and models to be found in the Finnish municipalities (Junnila et al. 2012). Taking into account this variation and the lack of access to proper data, we aim to construct a fairly general view of marketisation.

The public system of eldercare in Finland consists of different kinds of services and different financial allowances that are specified in social legislation. The system is tax-funded and locally implemented, and access to services is nearly always based on professional needs assessment. There are very few subjective rights to eldercare compared to health or childcare. There is also a fairly long tradition in municipalities of outsourcing part of eldercare services to non-profit welfare associations. This partnership was

facilitated by the legally defined role of Finland's Slot Machine Association that assisted associations and foundations to run residential and service housing units for older people by granting subsidies. Against this background, we can argue that a welfare mix in eldercare has always existed. However, a turn towards marketisation, in the sense of active promotion of both internal and external care markets, has taken place during the last 20 years, during which eldercare services have become increasingly outsourced to for-profit providers and the non-profit sector has increasingly given way to the for-profit providers. The former close partnership of local authorities and welfare associations is withering away due to changes in legislation and in the overall ethos of public provision, which increasingly emphasises effectiveness, efficiency and competitive neutrality. Between 1990 and 2009, the share of social service personnel working in public services fell from 88% to 68%. Between 2000 and 2009 the number of for-profit service units more than doubled while the number of non-profit units slightly diminished.²³ The most intensive growth of for-profit provision is seen in service housing.

Eldercare, like all social services, is governed at three levels in Finland. The *central* government and ministries set the legal frames through legislative power and funding mechanisms, as well as by policy declarations. The state also executes supervision through a number of bodies (see section 5). The regional level consists of regional state administrative agencies (AVI). At the local level, local authorities are responsible for actual service provision, which is not only funded by municipal taxes, but also subsidised by the state in combination with user fees. Of all social and health services, the state funds roughly one third, users under one tenth and local authorities the remainder. In eldercare, the share of user fees is bigger, roughly one sixth. In practice, individuals' access to eldercare services is based on needs assessments carried out most typically by a municipal care manager or social worker. These officials follow legislated, professional and other standards as well as financial constraints, including those set by municipal decision-makers.

In this report, it is only possible to pay attention to some aspects of marketisation. We are not able to study how internal and external markets are created, constructed and governed by the state and local authorities. The same applies to the variety of municipal practices and policies. We cannot take into consideration the vast differences between local authorities when it comes to the adoption and implementation of market principles and instruments. Another major challenge is to explain the relationship between the market shift and political decision-making. There is no easy way to show which political parties or coalitions have given support to the overall market shift. The same applies to different instruments used and adopted in the local authorities. It is, however, evident – as Kovalainen and Österberg-Högstedt (2008) argue –

²³ Source: Statistical Yearbook on Social Welfare and Health Care 2011, THL.

that marketisation is a highly political process. This political process takes place both at the level of national and of municipal decision-making.

In addition, we can assume that marketisation processes, as well as the development of eldercare policy in Finland, has been shaped by the nature of Finnish politics. In Finland, the Social Democrats have never been as dominant as, for instance, in Sweden. The nature of coalition formation often leads to complex compromises, as can be shown in the instance of childcare policies (Anttonen & Sipilä 2000). In eldercare policies, we have not seen similar historical compromises between very different and opposing policy alternatives as has characterised the domain of childcare. However, left-wing parties have most typically given strong support to public service provision, while right-wing parties have campaigned for tax rebates and vouchers. Parties in the middle have favoured more cash-for-care schemes than others. Final policy decisions tend to be compromises between different policy options and practical instruments.

3. Eldercare service provision in Finland

Although the focus of our report is on marketisation, we also have to pay attention to the overall structure of service provision. Eldercare is often provided through a mix of formal and informal help, and publicly financed contributions may be offered as services in kind and/or as cash. There are some preconditions shaping the process of marketisation: it does not happen in vacuum. Our intention is to clarify some of these conditions and traditions. In Finland, public eldercare consists of: 1) home care services and support services, 2) residential care services, and 3) informal care allowances. Home care services are a combination of home help and home nursing that are integrated administratively and at the level of care-giving in most Finnish municipalities (Kröger & Leinonen 2011). A wide range of support services is also provided, although, in some municipalities, older people themselves are left to obtain cleaning and grocery services, for instance. Support services include meals-on-wheels, washing and bathing, help with shopping and other errands, transportation and services that aim to support independent living and provide help in daily activities. Support services can be provided in the client's home, in service and day centres, and in long-term residential care units (SOTKANet 2013). Living at home is also supported by an informal care allowance (in Finnish: *omaishoidon tuki*) paid by local authorities and a care allowance for pensioners (in Finnish: *eläkeläisten hoitotuki*) paid by the Social Insurance Institution (Kela).

Municipal home care and support services have to be specified in a service and care plan, the same applies to the informal care allowance (ICA) that is granted to a person who needs care but is paid to the care-giver. The

ICA is defined as one social service in the *Social Welfare Act*. There is no subjective right to ICA, but by the late 1980s all local authorities had begun to use this instrument. The ICA consists of a monetary benefit for the carer and home care and support services for the person being cared for. Home care and support services are specified in a service and care plan and there has to be a written contract between the client and the local authority. Since 1993, there has been specific legislation on the ICA and, the *Act on Informal Care Allowance* came into force in 2006. The minimum allowance is €374.51 and the minimum for those assessed as having high care needs is €749.01 per month (2013).

Residential care consists of long-term care given in nursing homes for older people, long-term care wards in municipal health care centres and, increasingly, in intensive service housing units that are service housing units with 24-hour assistance. In addition, there are service housing units for older people without 24-hour assistance. According to the national policy guidelines, in the future most long-term care should be given in intensive service housing units instead of nursing homes and long-term care wards (STM 2008, p. 2; *Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons 2012*²⁴).

There is a major policy change currently taking place in Finland. The national government, the Ministry of Social Affairs and Health and the local authorities all strongly favour the delivery of care in the home or in intensive service housing units as opposed to care delivered in traditional nursing homes. Against this background, it is interesting to note that coverage of home care service provision has declined in the last 20 years as we see from Table 1. During the same time period the number of ICA recipients has slightly grown.

²⁴ <http://www.finlex.fi>.

Table 1: Coverage of publicly-funded services supporting care at home among clients aged 65 and over, as % of total population of same age, 1990-2011.

Type of service	1990	1995	2000	2005	2008	2010	2011
Regular home care ⁽ⁱ⁾	-	7.1	6.8	6.3	6.2	6.4	6.5
Home help services ⁽ⁱⁱ⁾	18.7	11.8	10.7	10.2	10.9	11.2	11.0
Support services ⁽ⁱⁱⁱ⁾	15.3	13.4	13.5	12.9	13.1	12.3	12.1
Informal care allowance ^(iv)	2.0	1.5	1.8	2.4	2.6	2.6	2.7

⁽ⁱ⁾ Recipients of home-help, home nursing or day hospital care at least once a week, clients living at home. See Appendix 1 for more detailed explanation of service types.

⁽ⁱⁱ⁾ Households receiving home help during the year (year-end data).

⁽ⁱⁱⁱ⁾ Recipients of meals-on-wheels, washing and bathing, help with shopping and other errands, transportation and other services during the year, all housing arrangements.

^(iv) Recipients of ICA during the year (year-end data).

Source: SOTKANet 2013; Statistical Yearbook on Social Welfare and Health Care 2012.

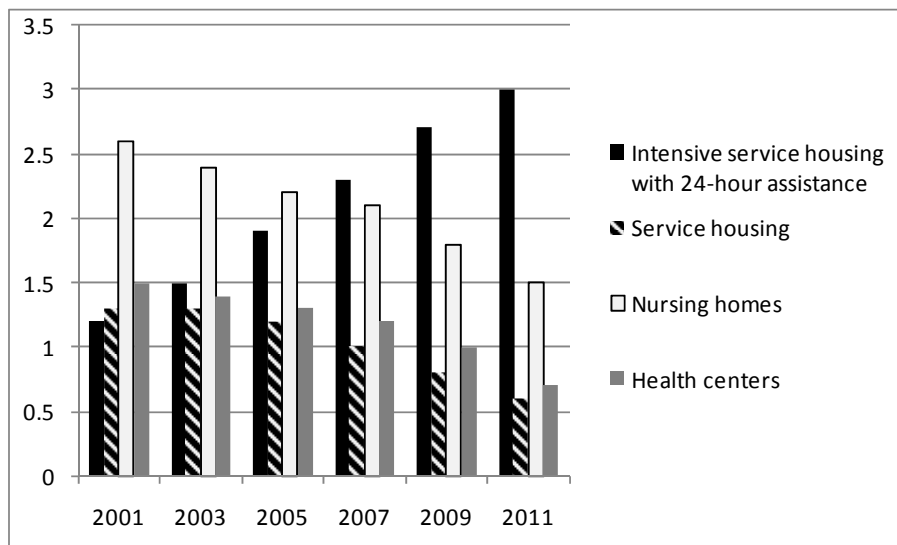
Table 1 shows that the coverage of municipal home care services, including regular home care, has declined in the last 20 years. The recession of the 1990s had some effect on this, but there are also other reasons. At the national level, the ICA has been promoted as an option for expanding care at home. The usage of the ICA has slightly increased, and it now covers 2.7% of the population aged 65 and over. The decline in regular home care and the corresponding rise in use of the ICA suggest that some elderly people with extensive care needs who might have received municipal home care had they entered the system in the 1990s may now be cared for instead by their relatives receiving ICA. Figures also indicate that elderly with smaller care needs are less supported with home help than they were 20 years ago.

Yet, even today, home care service is the most important mechanism to support older people's living at home. Home care service consists typically of home help and home nursing services. In national statistics, home care is divided into *regular home care* and *home help* services. The category of *regular home care* includes all clients who have a valid service and care plan and/or receive home-help services, home nursing or day hospital care at least once a week. The category of *home help service* covers all households who have received the respective services during the year. Home help service is also provided to families with children and to disabled and chronically ill persons under age 65. In Finland, data is collected only on care services that the local authority provides itself or purchases from other municipalities, joint municipal boards, the state, or private service providers (see also

Appendix 1). To sum up, the figures presented in Table 1 refer to publicly-funded service provision.

Figures on coverage do not indicate anything about the content or quality of the services. Regular home care might include anything from personal care and home nursing to cleaning and taking care of banking if needed. The general trend is to concentrate on the personal bodily and medical care (Kröger & Leinonen 2011, p. 117).²⁵ Increasingly, food preparation and cleaning are being dropped from regular home care, but not in all municipalities and not in all individual cases. There is a lot regional variation, as well as case-specific flexibility, in the arrangement of home care services to meet the needs of older people.

Figure 1: Clients 65+ in residential care units as a percentage of the total number of people of the age group (year-end data).



See Appendix 1 for more detailed clarifications.

Source: SOTKAnet 2013.

If an elderly person needs residential care, four types of service are provided: 1) service housing, 2) intensive service housing with 24-hour assistance, 3) nursing homes for older people, and 4) long-term care in health care centres or in hospitals. Figure 1 shows that profound changes have taken place in long-term residential care for older people. The number of intensive service

²⁵ There is no easy way to define the range of services provided through home care. The idea of the service is to make it possible for elderly people to live in their own homes. Since care needs vary a lot from day to day and from one client to another, it follows that the nature of home care provision will also vary between different municipalities.

housing units has grown steadily over the last decade, while the number of nursing homes has respectively gone down due to policies favouring home help and home-like housing arrangements such as intensive service housing. Local authorities also use other incentives to reform the residential care system towards more home-based housing. In nursing homes, clients pay a fixed monthly fee that is income-tested, and which includes housing, personal care, medication, meals – in principle everything. In the new type of intensive service housing units with 24-hour assistance, clients pay separately for housing, care and support services and for medication. The state reimburses the costs of medical care through the Social Insurance Institution of Finland (Kela) and subsidises housing through the pensioners' housing allowance (also administered by Kela). In this way local authorities have managed to move part of the long-term care costs to the state (EVA 2011, p. 14). Interestingly, service housing with 24-hour assistance is the service that has become most extensively outsourced to for-profit providers in Finland.

4. Legislation and other instruments of marketisation

4.1 Legislation

In Finland, citizens' right to social security and care is written into the constitution. Section 15 of the Finnish constitution of 17 July 1919, as amended on 1 August 1995, states that anyone unable to obtain the security needed for a decent life has a right to essential assistance and 'care'. At the level of ordinary law, the *Social Welfare Act of 1982* (which came into force in 1984) remains the major framework law for eldercare service provision. According to the *Social Welfare Act*, local authorities are obliged to organise social services, provide social assistance and pay social allowances for their residents. The act permits the use of state subsidies for purchasing social services provided not only by the municipal authorities but also by voluntary (or non-for-profit) and for-profit service providers, as well as for making payments for informal care (implemented in the form of the ICA).

In practice, the state and ministries (most importantly the Ministry of Social Affairs and Health) had nearly unlimited power over the policy of outsourcing until 1992 when the *Planning and Government Grants for Social Welfare and Health Care Act (733/1992)* was legislated. This law dismantled the earlier system of earmarked state subsidies for social welfare and strengthened the idea that local authorities are both in charge of arranging services and free to decide how these services are arranged. Before 1993, outsourcing was strictly regulated, but since then local authorities have, in practice, been able to outsource nearly all services.

Municipal service provision and outsourcing of services are also regulated by more recent legislation, including *the Act on Central Government Transfers to Local Government for Basic Public Services* (1704/2009) and the *Act on Restructuring Local Government and Services* (169/2007). Following these various reforms, only a very few functions, such as decisions over involuntary placements in child protection and mental health care, are left exclusively to public authorities (Huhtanen 2012).

As already mentioned, the early years of outsourcing favoured social service provision by non-profit welfare associations and foundations. This was made possible through the special status of Finland's Slot Machine Association (RAY) that had a monopoly on running slot machines and was obliged to use the profit for the public good. Financial support from RAY funded the building of about 50 old age homes during the 1960s, and around 14,000 service housing flats for older people between the mid-1980s and the mid-1990s (Pasanen 2010, p. 22). Subsidies could not be paid to local authorities or to for-profit service providers. The associations had to have a purchase contract with a local authority to receive the financial aid.

This type of partnership between local authorities and associations came into end in 2001, when the former 676/1976 regulation concerning slot machine profits was replaced by regulations written in the *Lotteries Act* of 2001. This legislative change represents a clear turn towards a policy of competitive neutrality.²⁶ The overall emphasis on competitive neutrality in public procurements is one of the most important factors behind the growth of for-profit provision and the *incorporation* of welfare associations that has taken place since the 2001 legal reform.²⁷ Incorporation of non-profit associations usually means separation of service provision from other activities of the association or foundation (Kananoja, Niiranen & Jokiranta 2008, p. 32). Non-profits have been forced to incorporate service provision due a number of factors. Among them are the role of EU-legislation over competition and public procurement, national as well as local service system reforms, the change in Finland's Slot Machine Association's funding policy, and changes in national taxation practices concerning social and health services (Kettunen 2009; 2010).

²⁶ For more on competitive neutrality see Valkama (2004) and Kähkönen (2007).

²⁷ In Finland non-profit organisations and associations have provided welfare service as registered associations (registration is required for these organisations to sign contracts with local authorities to provide services). In recent years, some of these non-profit registered organisations have separated the service provision part of their operations from other activities, and changed the registered organisation into a for-profit firm by establishing a new firm which is owned by the registered organisation/association. Some for-profit firms have also been establishing non-profit firms/associations, but only for the purpose of building service houses, as discussed in section 6.3.

Non-profit service providers have started to resemble the for-profit firms to be successful in competitive bids. This means for instance that non-profits have to be successful in price competition to win the bid because the system of direct award (see section 4.2.1, procurement procedure number 4) is not common in Finland. Thus, there is no room for developing innovative but costly services (Lith 2013, p. 41). Often pilot services are expensive because of the novel and experimental nature of new practices. There is not much room any longer for special arrangements for non-profit service provision that were earlier justified on communitarian principles. Communitarian principles have been increasingly replaced by principles of market competition. This means that traditional non-profit service provision and competitive neutrality do not easily fit together. It is also worth remembering that the principles of public good and the non-profit service ideology might be endangered if welfare associations are forced to give up the communitarian logic that their earlier performance was based on.

Further steps toward the creation of an external market in social care were taken when the *tax credit for domestic help*²⁸ came into force in 2001. The main political forces behind tax credit reform are right-wing parties and employers' associations (including the Confederation of Finnish Industries) which have been most outspoken in their demands for free choice policies and tax rebates to enable people to purchase services with their own money and/or to employ service or domestic workers in private households. This measure provides a tax rebate on the purchase of domestic or care services or on employing personnel to assist an old person in their home. The tax rebate for domestic help clearly represents a market-friendly policy alternative to publicly-funded service provision. In principle, this reform allows people to purchase cleaning and also care services direct from private providers or to employ domestic or care workers.

Through a number of legal reforms and changes in political preferences, more space for market provision within social welfare has been opened up. It is, however, important to stress that Finnish local authorities are not *obliged* by any law to outsource any of their social and health services. They can outsource services if they prefer to do so, but they can also provide all the services themselves or in collaboration with other local authorities. In addition, outsourcing in itself does not automatically lead to an increase of market provision, as stated earlier. In Finland, local authorities have a fairly strong tradition of using outsourcing to purchase social care services from associations and foundations.

Next we take a look at the legislation that applies to situations when local authorities have decided to outsource services. The decision over outsourcing, whether political or practical, always precedes the outsourcing process

²⁸ Tax credit based on the Act on Income Tax (2001), which is not translated in English.

(Fredriksson et al. 2009). Between 1992 and 2007, the *Public Procurement Act 1505/1992* regulated public procurements. This law was not as comprehensive when compared to the *Act on Public Contracts 348/2007* which replaced it, and which is based on EU Directive 2004/18 on public procurements. Significantly, the Finnish legislation for public procurement is, in some parts, even stricter than the EU directive. The legislated threshold for the procurements is lower in Finland than the directive requires, and the Finnish legislation includes welfare services, although EU directive does not require them to be included.

Problems related to the low threshold for public procurements in social and health services have been noticed and reported in Finland. A working group appointed by the Ministry of Social Affairs and Health published a report entitled 'The functionality of competitive tendering in social and health services' in 2012 (STM 2012). The working group was partly set up to consider the need to create a specific procurement law for social and health services. In particular, some 'special group services' (for example, eldercare, childcare, mental health) were regarded to be especially vulnerable or in risk under the existing procurement legislation. The working group uncovered many problems with, for example, the quality of services, customer participation, and inflexibility of procurements. The report suggests that the public procurement law should be re-evaluated, because of the specific nature of social and health care services. The Finnish procurement law offers, in principle, several options for the procurement process. Yet, as discussed below, in most cases competitive bidding has been used, instead of, for example, the negotiation method.

Outsourcing and marketisation of services are closely linked to the voucher systems that have been implemented in many countries as a way to promote individual choice and the creation of managed care markets for private providers. In Finland, a voucher system was first piloted in the 1990s with respect to some of the functions of child care and home care for older people in some municipalities, and it became integrated into social legislation in 2004 (Heikkilä et al. 1997; Vaarama et al. 1999). Legislation for the voucher system comprised amendments to the *Social Welfare Act 1982* (710/1982 29 a § 30.12.2003/1310). Finally, in 2009, a specific law, *the Act on Health and Social Service Vouchers 24.7.2009/569*, was passed. Introduction of the voucher system to cover all social and health care services, except for emergency services and involuntary services, was justified with arguments that it will enhance customer choice and improve the effectiveness of services through competition. We do not yet know to what extent the voucher system reinforces marketisation in social care provision. It might lead to a much wider use of for-profit services, but it is also possible that, by using service vouchers, service users actually make choices that favour non-profit providers instead of for-profits. The main difference between outsourcing and service voucher system is that in the former case it is the local

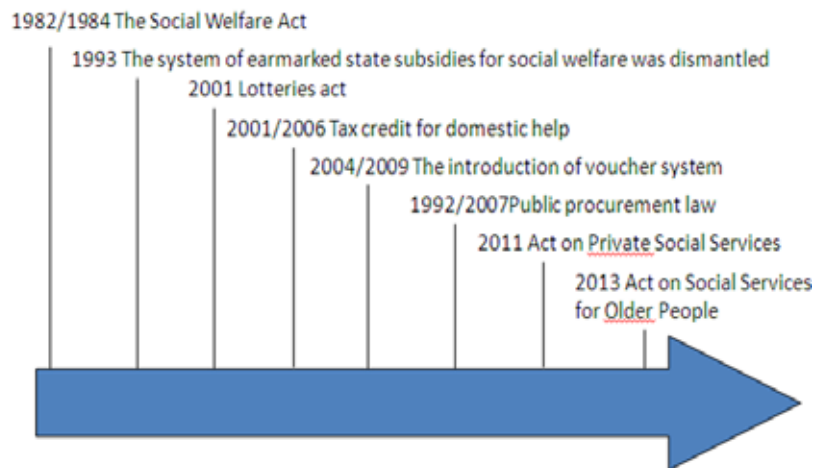
authority that arranges the competition between different providers, and in the latter case it is the individual service user who makes the decision between different service providers.

In 2011, *the Act on Private Social Services* (922/2011) was passed to ensure customers have access to high quality services, when using private social services. It covers outsourced services, services acquired with a voucher and services purchased out of pocket. This law also regulates the definition of social service, taxing and the regulation and oversight of private social services (Lith 2012b). The law was required as a result of the growing use of private services by individuals and local authorities.

At the end of 2012, a new *Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons* was passed (Stm.fi²⁹). It came into force on 1st July 2013. According to the policy documents, the Act aims: 1) to advance welfare and to decrease welfare inequalities between older citizens; 2) to support the participation of older people and ensure they have adequate resources; 3) to advance independent management of life; and, 4) to secure access to the needs assessment process and to services which are provided in sufficient quantity and of sufficient quality. The law was discussed extensively. The most heated topic in public debate and in the parliament was the issue of setting a binding level for the staff-to-client ratio, especially in residential care services with 24-hour assistance. In the end, the final draft did not include a fixed staff ratio, but it advises service providers to have a 0.5 full time equivalent staffing ratio per client. Even before it was implemented, the law was heavily criticised as unlikely to impact positively on the quality and quantity of eldercare services. It remains to be seen, though, how it will actually affect elderly citizens' access and right to services.

²⁹ Retrieved from: <http://www.finlex.fi/fi/laki/ajantasa/2012/20120980> [in Finnish].

Figure 2. Marketisation timeline



4.2 Instruments of marketisation

Although the Finnish welfare system includes almost as many different kinds of service systems as there are municipalities, some instruments are widely adopted and used. We also want to stress that Finnish legislation tends to provide framing guidelines rather than detailed prescriptions. As a consequence of these factors, the outcomes of marketisation vary between municipalities. In this section we describe more precisely the purchaser-provider model, the system of social service vouchers and the tax credit for domestic help, all of which are important public policy measures that promote social care markets.

4.2.1 Models for outsourcing services

Local authorities are not required by any law to outsource services that they arrange to meet the social and health care needs of residents. The decision to outsource is always locally made. Finnish procurement legislation, based on the EU-directive, regulates outsourcing (Directive 2004/18; *Act on Public Contracts* 348/2007) where it takes place, so that outsourcing local authorities must act according to this law. Nevertheless, local authorities interpret the law in different ways, thus producing even greater variation in practices. All public procurements which exceed the threshold regulated in the EU-directive or *the Act on Public Contracts* must be announced in an internet database, HILMA.³⁰ This database contains all currently open public procurements and gives some indication of the variety of different tendering

³⁰ <http://www.hankintailmoitukset.fi/fi/>.

practices carried out in Finland. What actually is carried out in municipalities has neither been widely researched nor evaluated by the state or other actors (Kokko et al. 2009; Lith 2013). Existing research, however, shows that eldercare services have been at the core of outsourcing, including the use of vouchers (Kokko et al. 2009; Sinervo & Taimio 2011; Lith 2012a, 2013).

The options for outsourcing public services include six procurement procedures.

1. *Open procedure* is a procedure in which the contracting authority publishes a contract notice and all interested suppliers may submit a tender; in addition to the contract notice, the contracting authority may send invitations of tender to suppliers which it deems appropriate.
2. *Restricted procedure* is a procedure in which the contracting authority publishes a contract notice and any supplier may make a request to participate, but only those suppliers invited by the contracting authority may submit a tender.
3. *Negotiated procedure* is a procedure in which the contracting authority publishes a contract notice and any supplier may make a request to participate; the contracting authority negotiates the terms of the contract with selected suppliers.
4. *Direct award* is a procedure in which the contracting authority admits one or more suppliers to the procedure without publication of a contract notice and then negotiates the terms of contract with these.
5. *Competitive dialogue* is a procedure in which the contracting authority publishes a contract notice and any supplier may make a request to participate; the contracting authority then conducts a dialogue with the candidates admitted to that procedure with the aim of developing one or more suitable alternatives capable of meeting its requirements, and then, on the basis of these dialogues, the selected candidates are invited to tender.
6. *Framework agreement* is a contract between one or more contracting authorities and one or more suppliers, the purpose of which is to establish the terms (for example, price and envisaged quantity) of the contracts to be awarded during a given period.

Despite varying outsourcing practices and rapid changes at the municipal level, we can observe that the law offers six different options for how to execute outsourcing. Two of them are favoured according the law: those of *open procedure* and *restricted procedure*. These procedures favour open competition over negotiation. In 2011, 98% of publicly-funded housing services that were open to tender were outsourced by using the open procedure (Lith 2013, p. 41). The law sets certain prerequisites for the use of procedures other than the two favoured procedures (*Act on Public Contracts* 348/2007). There are other laws involved in outsourcing process, but it is impossible to

cover all the legislation related to the use of private providers in social services in this context. At any rate, procurement law is the most important. Next we will cover some of the most common practical marketisation measures used in eldercare.

4.2.2 Purchaser-provider model

The purchaser-provider model refers to two separate, but related, processes. Firstly it can refer to a local authority's 'internal' administrative split between purchasing and providing units. Purchaser and providers are divided inside a local authority thus creating quasi-markets (Le Grand & Bartlett 1994; Kallio et al. 2006; Valkama et al. 2008). Thus, the purchaser-provider model does not necessarily mean that services are outsourced; the model can function solely inside a local authority.

Secondly, the purchaser-provider model can refer to outsourcing of services based on an 'external' split between a municipal purchaser and private provider(s), which are considered as external providers in this case. The local authority can decide whether or not to outsource services to private providers. If they do outsource, procurement law is more relevant than in the case of the 'internal' purchaser-provider split. Thus, in the Finnish context, the term 'purchaser-provider split' can refer to an internal or external purchaser-provider model. In practice, both splits usually coexist. Thus, by means of a purchaser-provider model, the creation of both internal and external markets can be promoted.

Purchaser-provider splits are implemented in various ways in Finnish local authorities. This means that it is not possible to describe only one purchaser-provider model. Nevertheless, purchaser-provider splits can involve many different instruments of marketisation. One important instrument that can operate in either 'internal' or 'external' purchaser-provider models is the use of contracts to manage and govern service provision. Further, in purchaser-provider split models, municipal providers usually have to change their services into 'products' or 'commodities', which must be specified in more or less detail, and which can then be written into contracts more easily. Contracts and commoditization are both regarded to be market mechanisms (Stenvall & Airaksinen 2009; Miettinen & Junnila 2012.)

There are limited statistics on the usage of purchaser-provider models in social and health services. According to Kokko et al. (2009, p. 82), roughly one third of Finnish local authorities reported using a purchaser-provider model in 2009. The smaller the municipalities the more likely they were to use a purchaser-provider split. The early enthusiasm for the purchaser-provider model seems to be fading in Finland. The biggest think tanks and research centres have become more critical towards the model and increasingly acknowledge its weaknesses as well its strengths (see, for example, Mielityinen 2011; Junnila et al. 2012).

4.2.3 The voucher system

The official aim of the voucher system is to promote both the citizens' freedom of choice and their opportunity to acquire social and health services from the private sector. The voucher system can be seen as the only form of free choice in social and health services in Finland. A voucher is to be used to acquire services that local authorities are obliged to arrange for citizens. A voucher is, therefore, an alternative to publicly provided services and can only be used to choose and use privately provided services. The ministry prohibits the use of vouchers for urgent or involuntary treatment.³¹

Local authorities can decide whether or not they use vouchers and in what services. A service voucher is given to individual service users following a needs assessment, which sometimes also includes means-testing. If a citizen or client does not want to receive a voucher, municipal authorities must arrange service for the person in other ways. In that case, the local authority arranges provision through the regular service delivery system so that the client uses publicly-funded municipal services provided either by the local authority or some other type of provider (where services are outsourced). Where vouchers are used, they are generally available to any service user in need of social or health services (for example, a voucher for dental treatment), but they require needs assessment by municipal officials in the same way as in any access to publicly-funded services. The value of the voucher can be the same for everybody at a given level of need, or it can be income-related. This variation is due to the political compromises and different practices adopted in different municipalities.

For some services, local authorities favour a flat-rate and, for others, income-related vouchers benefit services users whose income is low. For instance, for regular home care, a voucher is always income-related. The other side of the coin is the opportunity to top up. Clients can purchase extra or more services by paying for them themselves. The value of a voucher has to cover all expenses in those services that are free for customers according to the Act on Customer Fees (Laki sosiaali- ja terveydenhuollon asiakasmaksusta 1992/734). Eldercare services are usually not free for customers according to the law. In the cases where the voucher is income-tested the value of it has to be raised if a customer's, or his/her family's, livelihood is in danger because of paying for services that are not required to be free according to the act.³²

The potential user of a voucher acquires the services from a service provider that is included on a list of providers approved by the local authority. Information about the providers, services and costs must be publicly available. Private service providers must deliver at least the same level and quality

³¹ See http://www.stm.fi/sosiaali_ja_terveyspalvelut/asiakasmaksut/palveluseteli (in Finnish).

³² See http://www.stm.fi/sosiaali_ja_terveyspalvelut/asiakasmaksut/palveluseteli (in Finnish).

of services as the local authority offers. Users of vouchers have the same rights as users of other public social and health services. In addition, legislation concerning consumers also applies to users of private services (*Act on Voucher System in Social and Health Care System 569/2009*). The actual voucher is usually an official decision document which is given to the client. The client or service user hands over the decision document to a private provider when receiving the service. The private provider is then entitled to charge the amount of the voucher to the local authority. All costs exceeding the value of the voucher are paid by the client. In practice, a voucher system is nearly always implemented on the local level and municipalities have very different voucher practices. This causes a lot of confusion among service users. In addition, the system of service voucher use is still being developed, and there are many practical and other issues to be sorted out. In principle, a service voucher is like any other voucher to be used to purchase services.

The Law on Health and Social Service Vouchers might be of great importance from the point of view of marketisation process. This reform certainly accelerates the process by which care becomes marketised more extensively than before. There are no statistics covering all voucher users. However, since 2006, there have been figures available on service voucher use in home care. In 2006, municipal authorities granted service vouchers to roughly 3,000 service users in home help; by 2011 the number had risen to nearly 9,000 users. Thus, in five years the number of clients receiving voucher in home care services has basically tripled. Compared to the total number of clients in home care, 9,000 service voucher users corresponds to approximately 9%.

In 2009, when the law was introduced, local authorities reported that they most commonly used vouchers for cleaning services, home care for older people, and for an informal carers' right to have three days off per month. All of these situations are closely or directly related to eldercare. Whereas purchaser-provider models were used more often in the smaller municipalities, vouchers were used in the bigger municipalities (Kokko et al. 2009³³, pp. 88–89). A recent report on the use of vouchers in Finnish municipalities reveals that half of them reported using vouchers in 2012 (Nemlander & Sjöholm 2012³⁴). According to this study, vouchers were mostly used in social services and the voucher system was used mainly in services closely or directly related to eldercare.

In summary, by using tax-funded service vouchers, citizens become consumers with consumer rights, they use care services according to consumer rules and legislation (Huhtanen 2012). According to the Ministry of Social Affairs and Health, the same legislation that applies to customers using

³³ The response rate was 90%.

³⁴ The response rate was close to 70%.

public services also applies to customers using vouchers. In addition, as mentioned already, voucher users are protected by consumer laws.³⁵ The local authority retains legal responsibility for meeting the care needs of older citizens and carries the responsibility for quality control of private services, but in practice new market mechanisms shift at least part of these responsibilities to individuals. Since 2009, the system of service vouchers has been extended to cover practically all social and health care services, but the real voucher boom is probably yet to come.

4.2.4 The tax rebate

According to the tax credit for domestic services, all Finnish residents with taxable income are entitled to deduct expenses caused by the purchase of household services. The maximum yearly amount of deduction was €3,000 in 2011. In 2012, the deduction was lowered to €2,000. Because the deduction is granted on an individual rather than a household basis, it favours households with two adults; in other words, households with two adults can deduct €2000 twice.

Household services for which the credit can be claimed include repairs, construction or building work, taking care of older family members or small children, and cleaning. When a household arranges for someone else to provide such services, the service provider will fall into one of the three following categories, each having an important impact on the tax responsibilities of the household: 1) prepayment-tax-registered independent contractor (business company or self-employed professional); 2) independent contractor with no valid registration; and, 3) individual worker, who starts working for the household as its employee. When the contract is made between the household and the service provider, it is important to ascertain whether the worker or workers will be working as employees or as independent contractors. If they are workers, it is an employment contract, and payment for services will be taxed as wages. If they are independent contractors, the household will simply pay for the services provided by the company/individual, according to the amounts showing on their invoices, with almost no other obligations. Thus, the main principles are that households may either pay a business company or a worker on their own payroll to have this work done. If paid to a worker, the householder/taxpayer can deduct from his or her taxable income a total of 15% of the salaries plus secondary expenses. If the services are purchased from a prepayment-tax-registered independent contractor, the householder can deduct a total of 45% of the invoice concerning work compensation (wages and the employer component of social insurance

³⁵ See: http://www.stm.fi/sosiaali_ja_terveyspalvelut/asiakasmaksut/palveluseteli (in Finnish).

taxes) for the provision of domestic services. Only expenses related to work can be deducted. Travel and equipment expenses are excluded.

The system has existed since 1997 and has expanded rapidly, particularly after 2001, when the corresponding legislation came into force. Yet even today the system is used very little for purchasing care services for older or disabled persons, although adult children have a right to deduct expenses of care and cleaning services purchased for their parents. In 1998, roughly 20,000 users availed themselves of the tax credit for household services, in 2004 the corresponding figure was nearly 180,000 users that is 6.6% of all households in Finland. In 2011, over 400,000 users availed themselves of the tax credit for home repairs or domestic help, which is approximately 10% of all household.³⁶ In 2009, roughly one fifth of the total amount was used for domestic (16%) and care (3%) services, and the rest went to home repairs (81%) (Anttonen & Häikiö 2011; Häkkinen Skans 2011; Veronmaksajien keskusliitto³⁷). The tax credit is clearly used more often by people with medium or high income, and people aged 75 and older use the tax rebate most often (Häkkinen Skans 2011.) We do not know if the tax rebate system compensates for declining coverage of public home care services, but we do know that one fourth of tax rebate users are pensioners (that is, over 100,000 users). Cleaning services are increasingly left out of the municipal home help and care managers actively encourage older people to turn to private providers due to the availability of the tax rebate (Tynkkynen et al. 2012). Therefore it seems reasonable to infer that the tax rebate compensates for the decline of publicly-funded home care provision, probably for older people with more financial resources in particular.

4.2.5 Client fees and distribution of cost

Client fees are higher in Finland compared to other Nordic countries. Higher client fees in publicly-funded services mean more responsibility for the client. As mentioned in Section 2, client fees correspond to less than 10% of the total costs for social and health services. However, in eldercare services client fees are higher than in other social and health services, as shown in table 2.

³⁶ Retrieved from: Eurofound:
www.eurofound.europa.eu/areas/labourmarket/tackling/cases/fi004.htm

³⁷ Retrieved in Finnish from:
<http://www.veronmaksajat.fi/tutkimukset/jatilastot/tuloverotus/kotitalousvahennys>

Table 2. Client fees in municipal social and health services, share of expenditure %

Year	Residential care for older people	Home help services	All other social services
1997	19.8	13.7	8.9
2000	18.9	13.9	8.6
2005	17.8	14.4	7.4
2010	21.7	15.1	7.5

Source: Kuntien ja kuntayhtymien asiakasmaksutulot 1997–2010.³⁸

5. Regulation and oversight

Private social and health services are regulated and controlled by public authorities. Partly because of the growing number of private providers and rationalisation of the public sector, private providers' self-monitoring has been increasingly required and relied upon. A self-monitoring plan is required for every private unit. Further, a person who is in charge of the legal prerequisites has to be appointed in the private unit (*Act on private social services* 922/2011; Valvira.fi³⁹.)

The highest actor in the regulatory system is the Ministry of Social Affairs and Health. The National Supervisory Authority for Welfare and Health (Valvira) is responsible for national coordination of supervision of social and health care. The Regional State Administrative Agencies (AVIs) have primary responsibility for supervision in their own regions. In local authorities, the departments of health care and social services also have a responsibility for supervision.

By law, local authorities are also in charge of monitoring the private providers from whom they purchase services. The manner and extent of monitoring differs between municipalities. Monitoring practices are usually concentrated on *ex-ante* factors like education of personnel and sufficiency of space rather than on *ex-post* factors like how well are patients recovering from their illnesses (Syrjä 2010⁴⁰; Syrjä 2011, p. 97).

³⁸ Retrieved in Finnish from:

<http://www.kunnat.net/fi/asiantuntijapalvelut/soster/asiakasmaksut-talous-rahoitus/asiakasmaksut/Sivut/default.aspx>.

³⁹ Retrieved in Finnish from: http://www.valvira.fi/ohjaus_ja_valvonta/sosiaalihuolto.

⁴⁰ Syrjä (2010) used municipal procurement documents and interviews as research data in his research.

Private health care service providers and social care service providers that offer 24-hour assistance⁴¹ are obliged to apply for a permit from public authorities to provide services. If services are provided only within one Regional State Administrative Agency (AVI), a permit is applied for from the AVI in question. There are six AVI's in Finland. If services are provided within two or more AVIs, the provider must apply for a permit from the National Supervisory Authority for Welfare and Health (Valvira). Providers providing services other than those involving 24-hour assistance, mainly home care providers in eldercare services, must notify the local authorities in which they are operating. Local authorities evaluate if legal preconditions are met and inform the AVI, which registers providers. Exceptions are support services in home care, which are not registered anymore. Providers also have to give notification if they stop providing services. AVI and Valvira maintain a register of private health and social care providers and individual practitioners. The legal preconditions that local authorities are obliged to evaluate include, for example, certain kinds of facilities, staff education, staff ratio and the existence of a self-monitoring plan. Legal preconditions are always set in relation to the type of service and needs of the client⁴². AVI recommends that private providers have a minimum of 0.5-0.6 staff ratio in service housing with 24-hour assistance and in nursing homes depending on how intensive care clients need. AVI also states that a good standard for staff ratio in service housing with 24-hour assistance and in nursing homes is 0.7-0.8. (AVI 2008.) Recommendations apply to both public and private service providers. AVI and Valvira offer instructions and information for private providers to help them meet their legal and formal obligations.

⁴¹ Including residential care, long-term care in health centres and service housing with 24-hour assistance.

⁴² More specifically see Stm.fi; *Act on private social services* 922/2011.

Table 3 *Supervisory system in 24-hour assistance eldercare services*

Task		Action/responsibility	
Private service provider	Starting operation, changing operation	- Permit application	
	Service provision	- Self supervision - Annual report	
Municipality	Service provision	- Self supervision	
	Supervision of private providers	- Statement of private providers starting operation - Supervision of visits and inspection reports - Competitive tendering, contract negotiation, service purchasing	
Regional State Administrative Agency (AVI)	Regional permit administration	- Permits to private providers	
	Other preliminary supervision	- Supervision of private providers' inspection reports and annual reports. - Supervision of inspection reports delivered by local authorities - Planning-based and initiative supervision	
	Steering, guidance	- Education, negotiations, information-steering and municipal letters	
	Retrospective supervision	- Supervision based on complaints from citizens, clients and relatives	
	Information production	- Register of private providers - Self-monitoring - Reports	
National Supervisory Authority for Welfare and Health (Valvira)	Informing	- Announcements - Reports and publications	
	National permits	- National permits to national providers	
	Other preliminary supervision	- Monitoring of providers' annual reports	
	Steering, guidance	- Supervision plan and implementation program - Valvira and AVI co-operation groups - Education - Information steering, guidance and consultation - Joint data network for Valvira and AVIs	
	Retrospective supervision	- Supervision based on complaints - Register of private providers - Questionnaires for service providers and local authorities - Gathering and reporting of statistics	
National Institute for Health and Welfare (THL)	Information-based supervision	- Register of private providers - Questionnaires for service providers and local authorities - Gathering and reporting of statistics	
	Information	- Announcements - Reports and publications	
National Institute for Health and Welfare (THL)	Data and information production	- Statistics - Research - Development	
	Ministry of Health and social Affairs (STM)	National steering and guidance	- General planning, steering and supervision - Legislation - Quality recommendations, national programs, publications - General letters - Development

Source: (Valvira 2010).

6. Extent of marketisation

6.1 Distribution of provision between public, for-profit and non-profit care organisations

6.1.1 Distribution of employment

Finnish public authorities and research centres produce statistics on social services and eldercare services mainly on annual basis. Statistics used in this report are gathered from different databases and reports produced and maintained mainly by the National Institute for Health and Welfare (THL, up until 2008 STAKES). The available statistics do not give very detailed information about different services. Accordingly, we include figures on all social services, although we try to pay attention most particularly to eldercare services. We start with more general data and then provide some more detailed information on service provision and different providers. This is done, firstly, by looking at the distribution of personnel across public, non-profit and for-profit social services (Table 4).

Table 4: The share of personnel working in public, non-profit and for-profit social services in Finland

Provider type	% of total number of personnel					
	1990	1995	2000	2002	2006	2009
Public	87.9	86.6	79.3	76.0	71.4	68.3
Private (non-profit and for-profit)	12.1	13.4	20.7	24.0	28.6	31.7
Non-profit	11.6	11.9	16.2	18.1	17.8	17.2
For-profit	0.5	1.6	4.5	5.9	10.8	14.5

Source: Ailasmaa 2012; Arajärvi & Väyrynen 2011; Statistical Yearbook on Social Welfare and Health Care 2011, THL.

Table 3 shows the general trend that has taken place during the last 20 years or so. The share of personnel working in the public sector has decreased, while the most intensive growth has taken place in the for-profit sector. Some of the growth in the for-profit sector can be explained by the incorporation of non-profit service provision, discussed in more detail in Section 4. There are no statistics on that, but the trend has been obvious. The same trend is confirmed in Table 5. It shows that, in eldercare services, the share of personnel working in the private for-profit sector grew from 6.7% in

2000⁴³ to 17.0% in 2010. During the same period, the share of personnel working in public sector decreased from 74.1% to 66.0%. These changes are remarkable given the long history of the Finnish social services state.

Table 5: The share of personnel working in public, non-profit and for-profit eldercare services in 2000 and 2010

Year	Institutional care ⁽ⁱ⁾		Service housing ⁽ⁱⁱ⁾		Home care services ⁽ⁱⁱⁱ⁾		Total ^(iv)	
	2000	2010	2000	2010	2000	2010	2000	2010
Public	84.7	83.0	41	37.0	90.5	85.0	74.1	66.0
Private total	15.3	17.0	59.0	63.0	9.5	15.0	25.9	34.0
Non-profit	14.1	12.0	42.6	34.0	4.6	2.0	19.2	17.0
For-profit	1.2	5.0	16.4	29.0	4.9	13.0	6.7	17.0

⁽ⁱ⁾ Includes nursing homes (old age homes) and long-term care in health centres.

⁽ⁱⁱ⁾ Service housing and service housing with 24-hour assistance.

⁽ⁱⁱⁱ⁾ Regular home care and home help services.

^(iv) Institutional care, service housing and home care services combined.

Source: Ailasmaa (2012; 2013).

6.1.2 Distribution of clients

Home care

There was very little publicly-funded for-profit provision of home care services in Finland before the 1990s, but it has increased since then. By contrast, the role of non-profit associations in home help services was more important in the the 1990s and the beginning of 2000s than it is today. According to Peltosalmi and Särkelä (2011, pp. 108–114), non-profits had approximately 15,000 eldercare clients in home help services in the beginning of 2000s, the corresponding figure was as low as 9,000 in 2010. There are no corresponding longitudinal figures from the for-profit sector, but in 2010 for-profits had 20,000 clients in home help services.⁴⁴ Statistics that report home care clients divided between non-profit and for-profit providers are no longer maintained. THL maintained statistics⁴⁵ on clients divided between the non-profit and for-profit service houses until 2012, but has given up on this

⁴³ Statistics not available before year 2000.

⁴⁴ Note that figures reported by Peltosalmi and Särkelä concern clients whereas the figures in table 5 are for employees.

⁴⁵ Source: Yksityinen palvelutuotanto sosiaali- ja terveydenhuollossa. SVT, Sosiaaliturva. Helsinki: THL. www.thl.fi/yksityinenpalvelutuotanto [in Finnish].

division. One reason behind this change is the increasing incorporation of non-profit associations. This development is blurring the distinction between the non-profit and for-profit sectors.

After 2005, it is possible for us to track how many people have used a voucher for home help services. As noted earlier, in 2007, approximately 3,000 people used a voucher to purchase home help and, by 2011, this figure had increased to 9,000 people. Since 2004, it has been possible to use vouchers for home care. This has opened up some of the market to private providers. Also, growing use of tax rebate to purchase cleaning and to some extent also home care services indicates that private service use is increasing. Vouchers can only be used to purchase private services and the same applies to the tax credit. The difference between the voucher system and the tax credit is that the tax credit can be used by anyone, whereas vouchers are granted following public needs assessment. Fully private use of home care and household services is not registered, so we do not have information about the private purchases of domestic and home help. We can conclude that more and more people are receiving their home help services from the private for-profit sector due to the tax credit and voucher systems.

Residential care

In eldercare policies, home care has a priority over residential care, but residential care has also been redefined. Firstly, there is a policy that limits the number of older people living in long-term care wards, in health care centres and in nursing homes. Secondly, nursing homes are increasingly being transformed into intensive service housing units. The Ministry of Social Affairs and Health has suggested that all aged people needing 24-hour care should be living in service houses instead of nursing homes and health care centres (Working Group Ikähoiva, 2011). The policy goal of caring for people in their own homes and in service houses is stated in the new *Act on Social Services for Older People*. This is an apparent trend according to some research projects in this area (CaSO-group).⁴⁶ The strong emphasis given to intensive service housing is interesting from a marketisation point of view, because housing services for older people have historically been social services provided by the non-profit providers and to some extent also by for-profit providers (see Table 5) rather than by the public sector.

Service housing is defined as an outpatient service. This means that people are officially considered to be living in their own homes when living in service houses and are, therefore, in a different position compared to people living in residential care institutions. In nursing homes, clients pay a fixed fee that covers all services including medication. The fee is income related and there is no ceiling, meaning that people with a high income

⁴⁶ See: <http://www.uta.fi/yky/research/caso/index.html>.

might pay as high a fee as if they were purchasing the same service directly from a private, market-priced provider. This type of fee policy means that local authorities can shift costs to service users but not to the state. In turn, in service housing units, clients pay separately for all the services they need and use.⁴⁷ Thus, housing, care and health care services, medication and cleaning are priced and paid for separately⁴⁸ and the costs can be shifted to the state, through the social insurance system, and to the service user. Overall, the old system of institutional care was more progressive and ensured that older people with low incomes were not disadvantaged, because everything was included. The new system in service housing favours more choice and people who can afford to choose. However, it is difficult to get a national overview on the extent and impact of user fees, because each local authority has its own policy and there is no systematic information regarding the client fee system in intensive service housing. For this reason, we will simply use examples.

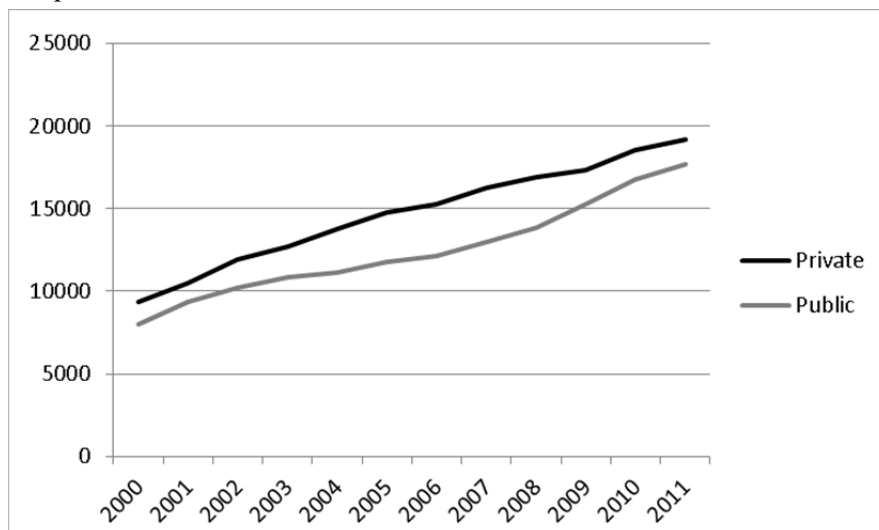
Transition from care given in nursing homes towards care in intensive service housing units is an important avenue for moving part of the financial responsibility from the local authority to the state (and clients), since Kela subsidises expenses caused by medical care and rehabilitation through the universal sickness insurance and housing through the system of pensioners' housing allowance that is an income-tested benefit. In 2009, two thirds of the total costs of social services were covered by municipal taxes. Thus, local authorities have the main financial responsibility for social service costs. In health care, the corresponding share of local authorities is 35%. There really is a strong incentive to move part of the expenses to the state, and also to users themselves, by developing service concepts that lower the financial

⁴⁷ In the city of Tampere (3rd biggest city in Finland), client fee in intensive service housing, arranged by the local authority, is determined as follows. A client pays to the local authority a housing fee (gross income - €528 * 0.35), a security service fee (€17-40/month) and a meal fee (€70). These three fees paid to local authority form a (total) client fee. If client's gross monthly income is, for example, €250, the fee would be €546.70. In the next step, the client's net income is counted, including other public subsidies (e.g., the pensioner's housing allowance and care allowance). Rent (in addition to water, electricity and home insurance) and medicine costs are deducted from net income. If the total is less than €243.40, the local authority reduces the client fee so that €243.40 is left for the use of the client for so-called other expenses. With the disposable income, the service housing client is responsible for the acquisition of everything except geriatric health services; that is, personal expenses like hairdressers, telephone, clothes, travelling and also some medical and care equipment. In addition, living in the outsourced service housing units, older people have the possibility to buy extra services from a private provider (www.Tampere.fi). This is not the case in service housing units run by municipal providers.

⁴⁸ In the beginning of 2013 the Minister of Health and Social Services has set up a working group to redefine the client fee system in service housing (Retrieved in Finnish from: <http://www.stm.fi/tiedotteet/tiedote/-/view/1848582#fi>).

burden on local authorities. Finally, and most importantly, for private companies, intensive service housing seems to be an attractive business as can be seen from the growth trends in Table 5 and Figure 3.

Figure 3: Service housing and service housing with 24-hour assistance clients at the end of the year; services provided by public and private sectors



Source: SOTKANet.

In 2000, there were approximately 8,000 clients living in service housing units provided by the public sector and 9,500 living in privately provided units. By 2011, the corresponding figures had risen to 17,500 and 19,000 clients, respectively. The private sector includes both non-profit and for-profit providers. Within SOTKANet, the Statistics and Indicator Bank maintained by the National Institute for Health and Welfare (THL), the non-profit and for-profit sectors have been combined as one category, namely, the private sector. Yet, Peltosalmi and Särkelä (2011, pp. 109, 115) report that non-profit services providers had approximately 12,000 clients in service and intensive service housing at the end of 2010, whereas for-profit providers had roughly 10,000 clients. In the beginning of the 2000s, the non-profit sector in service housing was about the same size, but the for-profit sector has increased its client base significantly. It is apparent that the growth in the 2000s has been strongest in for-profit service housing. It can be stated that the move towards replacing residential care in nursing homes with service housing has benefitted for-profit providers the most and thus accelerated the marketisation process in Finland.

6.2 Structure of the private sector

The distinction between non-profit and for-profit services is widely used in Finland. There are good reasons for this type of categorisation, since in Finland the role of the non-profit sector has historically been important, most particularly within eldercare services. As noted previously, incorporation of non-profit services is a current trend and the trend seems to be expanding (Kettunen 2009 and 2010). Non-profits incorporate services in order to hold on to their established service provision. Non-profits have been forced to incorporate service provision for a number of reasons. Among them are the role of EU-legislation over competition and public procurement; national as well as local service system reforms; the change in Finland's Slot Machine Association's funding policy; and changes in national taxation practices concerning social and health services (Kettunen 2009, 2010). The new incorporated non-profits are included in the category of for-profit firms in all national statistics (Karsio 2011); nevertheless, most for-profit firms operating in social and eldercare services do not have their origins in a non-profit organisation. In this section we concentrate mainly on the for-profit sector but also present some figures for the non-profit sector. In this section, we aim to show how many firms are operating in Finland, what size they are and who owns them.

First, it is important to note that approximately 80% of all private social services are funded by local authorities, that is, they are outsourced services (Hartman 2012). Thus, 20% of private services are privately funded and acquired. There are no statistics on how vouchers, tax rebate and other market mechanisms are considered in these figures. In general, we don't have data on these fully privately purchased services. The following statistics are derived from the social service sector report published by the Ministry of Employment and Economy from 2010 (Hartman 2012).

The private for-profit sector's share of all social care was approximately 15% in 2010, whether measured by personnel, output or turnover. Almost half of that 15% consists of for-profits operating in eldercare. Measured in money, total social service output/value/turnover was close to 9 billion euros. Private firms providing social services had a combined turnover of 1.4 billion euros (residential and housing services 1 billion and outpatient services 0.4 billion). There were 3,300 firms operating in social services and approximately 1,300 of them were operating in eldercare services. Service housing for older people was the biggest business within private social services, whether measured in money or by personnel. Thus eldercare is a big business within private social services.

Table 6: The number of private social service units in 2002-2010

	2002	2004	2005	2009	2010	% change 2002-2010
Private social service units	3,018	3,275	3,550	4,272	4,350	63.,3%
Non-profit	1,632		1,726		1,509	-7.5%
For-profit	1,365		1,803		2,824 ⁴⁹	106.7%

Source: Väyrynen 2011.

Private services are also measured in service units. A social service unit is one place providing a service in question. This means that one firm could have many units in one local authority. Table 6 shows the number of private social service units between 2002 and 2010. It is interesting to note that the number of non-profit units has slightly decreased during the first decade of the 21st century while the number of for-profit units has increased. From Table 5, we see that the number of private social service units increased between 2002 and 2010 by more than 60%. All growth happened within the for-profit service sector, where the increase was more than 100% in eight years. Only a small part of this increase can be explained by the incorporation of non-profits.

6.3 Extent of concentration

In Finland, social care markets are not yet concentrated significantly, but there is evidence of a rapid increase in concentration (Lith 2013, p. 59). Growth in the number of for-profit firms has slowed down. For example, in service housing, the number of firms started declining in 2008, but the number of staff and turnover continues to grow (Lith 2012a; Lith 2013). These trends suggest that service provision is starting to concentrate within large for-profit firms, at least in service housing. The latest statistics are from

⁴⁹ Hartman (2012, 9) reports different numbers of private social service units in 2010. According to Hartman, there were 4104 for-profit social service units in 2010. The difference concerns out-patient services only. The Ministry of Employment and the Economy, National Institute for Health and Welfare (THL), Statistics Finland and Regional State Administrative Agency (AVI) have all been consulted in this matter. According the consultations (OK), there is no one explanation for this. Firstly, out-patient services don't have to apply for a permit to operate, although they should inform the local authority they are operating in their region. Secondly, the definitions of home care, home help and support services are unclear. Some firms might register themselves as cleaning firms whereas others as home care service firms, though they operate in the same field. Thirdly, most of the for-profit firms operating in out-patient services are small, that is, from 1 to 5 workers. These smaller firms don't necessarily operate as formally as larger firms do within the domain of private social service provision.

2010 and 2011 (Lith 2013; Hartman 2012), but the trend seems to continue. Once more it should be emphasised that even today the non-profits have a strong foothold in some service sectors. It is also worth mentioning that when the marketisation process started to become more intensified in the 1990s, there were lots of small and local companies entering the care business (Kovalainen & Österberg 2006). This was also an important reason for local authorities to support outsourcing to these small enterprises often run by people who were working earlier in the municipal sector. This created trust and confidence toward the new business of eldercare services.

In 2008, the ten biggest private firms in social services combined had personnel numbering 4,400, which amounted to a 20% share of personnel in all private for-profit firms in social services. Their combined turnover was 210 million euros. In 2011, the figures were 7,800 personnel and 410 million euros turnover. The ten biggest firms had increased their share of all social services to 30% of the private sector.⁵⁰ The group of ten biggest firms changes from year to year because of ownership changes. Among the ten firms, five provide service housing for older people. The five firms are, from biggest to smallest, Attendo, Mainio Vire, Mikeva, Esperri Care and Carema. Of these five firms, four have an international background and only one is Finland-based. Only one firm out of the top ten is an incorporated non-profit association and this firm has already been operating as a private for-profit firm for a number of years. Attendo Oy, the biggest private actor in eldercare in Finland, has continued to grow its business in eldercare services. Its development has been rapid given that its first housing service unit was founded only nine years ago in Finland (Lith 2013). In 2011, it acquired 10 new eldercare units in Finland, all of which were small Finnish firms.⁵¹ In total, Attendo Oy now has over 80 care units operating in 50 different municipalities across Finland (Lith 2013).

Most of the firms providing social services are small. There is a clear distinction between services provided in people's own homes and services that include housing. Private home care services are mainly provided by small local firms, often employing only one person, whereas firms that provide housing services are almost always large ones. In 2010, of all private for-profit social service firms, 11 employed over 250 employees. Sixty percent of firms providing residential care services employed fewer than ten employees.⁵² In outpatient services, including mainly home care services for

⁵⁰ The ten biggest firms' share of all social services in 2011 is compared to that for 2010, because statistics on all social services are available only until 2010.

⁵¹ See: http://www.attendo.com/PageFiles/696/Annual-report_Attendo%20AB_2011_Final.pdf

⁵² Note that 'residential care services' also includes services other than eldercare that are likely to have a small staff, such as rehabilitation services for people with substance abuse problems. The average in residential eldercare is likely to be larger.

older people and disabled people and for child day care, the share of firms with fewer than ten employees was as high as 94%.

The small firms have not been the focus of public debate in Finland, but large international companies have been in the spotlight on a few occasions. The most widely discussed case relates to public funding for the building of service houses. Service housing consists of two separate fields of business, property owning/constructing and social service provision. The Housing Finance and Development Centre of Finland (ARA, part of the Ministry of the Environment) finances construction, but only for non-profit firms.⁵³ Bigger firms providing service housing services for older people have set up non-profit firms to receive subsidies to construct (intensive) service housing units. Subsidies of at least 60 million euros and interest free loans of 250 million have been granted to private companies.⁵⁴ The Ministry of the Environment ordered an investigation into whether ARA has acted according to the law when deciding on the subsidies in question. Eskola's report (2012) found that ARA was acting lawfully when granting subsidies for non-profit firms owned by private firms.

7. Some consequences

There are only some empirical studies of how marketisation has affected local authorities, users and staff of eldercare services. There are some reports concerning individual municipalities, but national level evaluations are rare. The most researched area in the field of eldercare services, in the context of marketisation, is (service) housing. Kähkönen and Volk (2008) researched services for older people in 18 Finnish municipalities, including 66 tender processes, in the first half of the 2000s. Their main result is that costs were lowered in eight of the municipalities, raised in five, and unchanged in the remaining five municipalities. However, it is difficult to draw conclusions about public and private provision, their costs and quality. Kangasharju and colleagues (2010) researched productivity and effectiveness in eldercare services in 21 Finnish municipalities during a two-year period. They found that, irrespective of who provides the services, the effectiveness of services is better when more money is spent and vice versa. In general, in the public sector, services were provided with higher costs and, in the private sector, with lower costs.

The most recent, fairly comprehensive research on service housing for older people compared costs, older people's ability to function, quality of

⁵³ The concept of non-profit firm is defined in the *Act on Interest Subsidy for Rental Housing Loans and Right of Occupancy Housing Loans*.

⁵⁴ See: <http://www.rakennuslehti.fi/uutiset/talous/27816.html> (in Finnish).

services, staff and tendering practices from the perspective of different providers (Sinervo & Taimio 2011). The data comprised 134 service housing units with 24-hour assistance and 45 nursing home units (2007-2008). Public, for-profit and non-profit providers were all included in the research. A couple of caveats are, however, required. Firstly, according to this research, it is apparent that a comparative study of the different sectors is extremely challenging. Secondly, the data was gathered roughly five years ago and there have been a number of changes since. These shortcomings notwithstanding, the research still provides a relevant overview of some of the consequences of marketisation.

The report concludes that the type of service provider does not affect the costs of services (Pirttilä & Taimio 2011). Further, Finne-Soveri (2011) claims that provider type is not directly related to any changes in older people's ability to function. The quality of services was researched using an even larger dataset that included nursing homes and long-term care in health centres (Noro 2011). One of the main findings is that the quality of services was not correlated with the type of the provider, but the staffing ratio was higher in the private sector. This could partly be explained by the fact that the public sector seemed to favour customers with lighter care needs (Pirttilä & Taimio 2011; Noro 2011). These results suggest that it is more relevant to examine how older people with different levels of needs are cared for in different services than it is to just compare public and private providers (Noro 2011).

Also, well-being at work and the functionality of the work community (the social relations and organisation of work) have been examined in some studies in relation to marketisation in eldercare. These studies suggest that differences in well-being at work are larger than differences in service quality, older people's ability to function, costs and tendering by the type of the provider. Thus, whether people are working in public, for-profit or non-profit services affects their well-being at work. Stress and time pressure at work were typical in public sector service housing, while unjust leadership and management was found in for-profit service housing. Stress at work was explained mainly by low staff-to-client ratios in public service housing and in non-profit nursing homes. (Sinervo et al. 2011; Finne-Soveri et al. 2011.)

It is important to stress that the results reported here are only suggestive of the effects of marketisation on eldercare service provision, since they neither cover all eldercare services nor all outsourcing and tendering processes. As such, it is very difficult to make any generalisations about marketisation in eldercare based on these findings. Rather, as we see, the results are partly conflicting. To conclude, in the Finnish system of autonomous local authorities, eldercare services and legislation allow many different outsourcing strategies and, probably, nearly as many different outcomes. Thus, it is not an easy task to study the consequences of marketisation. This might be the main reason for the overall results that suggest that type of provider

(public, for-profit or non-profit) has no significant effect on costs, quality of care or staff wellbeing in long-term eldercare services.

8. Conclusion

Marketisation has influenced public service redesign in most post-industrial countries, although the pace and timing of the market reforms that have been adopted vary. We can talk about a more or less global market shift in the provision of public goods that is paving the way for the commercialisation of social and health services, which, along with education, are among the most important public goods in providing welfare for citizens (Crouch 2004). Against this background, marketisation in Finland is a fairly late phenomenon compared to many other post-industrial countries. It is only during the last 15 years or so that the marketisation process has intensified, although some important doors were already opened for marketisation in the early 1980s.

In this report, we have assessed the processes of marketisation in Finland. Marketisation is a complex phenomenon that refers to a number of changes in the organisation of publicly-funded eldercare services. Firstly, we have evaluated marketisation by paying attention to the most important legislative changes. These changes have made it possible for both internal and external markets to be created and expanded. At the core of these changes is outsourcing, which does not, in and of itself, automatically lead to the growth of for-profit service provision. In fact, non-profit service provision could, under certain arrangements, be strengthened by outsourcing. Yet, the implementation of outsourcing practices together with the purchaser-provider model has, in fact, strengthened market practices in social service governance. In the Finnish case, outsourcing has a long tradition, but the status, operation, and outcomes of outsourcing changed fairly radically in the 1990s, due to a policy of competitive neutrality and the EU regulations concerning public procurements. The former close partnership between local authorities and welfare associations dissolved and the role of these associations as service providers changed.

Secondly, we have briefly described the mechanisms and instruments that have strengthened the market turn in Finland. Besides outsourcing and the purchaser-provider model, the voucher system and the tax credit for domestic services have also been important, because these systems relate to the benefits that users or consumers receive. Compared to Sweden and Denmark, Finland lacks a comprehensive customer choice system. It is possible that the service voucher system can be understood as a substitute for a customer choice system, although the system is very complex and varies across municipalities. At least by receiving service vouchers, clients or

service users have a chance to make choices between different service providers (although they cannot choose a public provider).

Thirdly, we have estimated the extent and intensiveness of market shift by presenting available data showing how the proportions between public, for-profit and non-profit service provision have changed over time. For-profit eldercare service provision is clearly increasing at the expense of public and non-profit provision. We can conclude that, before the early 1990s, both internal and external markets in eldercare were poorly developed in Finland. Nearly all service provision falling into the category of private, as opposed to public, was non-profit in the 1980s.

Finally, we have looked at some consequences of marketisation. We have, however, had considerable difficulty finding adequate data and coming to grips with the large variety of municipal practices. As far as we can discern, it seems as though marketisation is taking place in an unsystematic and somewhat chaotic fashion, and that there is significant variation between municipalities and between different services.

Marketisation has been most profound in the field of eldercare in Finland. Most particularly, intensive service housing, now the dominant form of residential care, has become a target for rapid privatisation in the sense that there are more and more for-profit providers in the field. In particular, large international private equity firms are strengthening their share of service provision. We have presented data that show that the share of private for-profit service providers is rising year by year and that market mechanisms like vouchers, tendering and the tax rebate are more and more widely used in the municipalities. Compared to education, childcare services and health care, eldercare represents one of the social policy fields where marketisation has advanced relatively rapidly in Finland. This might be due to the fact that the marketisation process has been most intensive in those services that integrate housing with care. Marketisation has also strongly affected other areas of social services, for instance child protection, in which roughly 60% of institutional out-of-home care is provided by for-profit firms.

It be premature to argue that marketisation has been most influential in services where clients are most vulnerable. While at first glance it seems as if marketisation affects the most vulnerable, on a second look it appears that *residential care* seems attractive to for-profit firms. We assume that the attractiveness of residential care relates to the fact that local authorities prefer to avoid investing in new service housing facilities and, therefore, for-profits can own the facilities and sell beds on a framework agreement.

Marketisation is a process that has changed the earlier welfare mix typical in Finnish social service provision. In Finland, the third sector has historically played a crucial role in the provision of housing and residential services for older and disabled persons due to the special status of Finland's Slot Machine Association (RAY). Non-profit service provision has, however, given way to for-profit provision. As noted above, it is residential care,

including intensive service housing, which has become privatised on a much wider scale than home care and other out-patient services.

There are also changes taking place in home care where many previously publicly defined responsibilities have been shifted to individuals and their families. The coverage of home help has decreased, and services are increasingly targeted to those who need greater assistance. In addition, responsibility for some elements of the earlier home help service has been off-loaded to individuals themselves, for instance, cleaning and shopping. All this means that minor care needs are less likely than previously to be met by municipally organised home help. Marketisation and privatisation tend to advance also this way. In many municipalities older people are asked to purchase cleaning from private providers, due to the availability of the tax credit for domestic services. A shift in responsibilities has also occurred through changes in policy on service fees. There is much debate and little systematic evidence on rising service fees, most particularly in intensive service housing where clients themselves pay separately for all the services they need, and even where a service voucher is used, the voucher may only cover part of the total expenses.

Marketisation of eldercare has occurred in Finland, and its consequences are multifaceted and mostly understudied. Thus, evaluating and studying marketisation would require more local level research along with nationwide evaluations. There is also a lack of systematic and reliable statistical data. For instance, there are different figures counted by different ministries and research centres concerning the amount of private social service units. It is very difficult to know which of these figures are correct or nearly correct. Without statistical data, it is not easy to show the exact number of private providers or the share of market provision in different service domains. Even more difficult is the evaluation of marketisation processes, for instance competitive tendering, are carried out in more than 300 municipalities – not to mention the difficulties of evaluating the outcomes of marketisation. One example of these difficulties is the fees in intensive service housing; there is no systematic national information on service fee policies – how much a client pays and what the value of a voucher is when it is used.

The changes in the municipalities have been so deep and rapid that there really are extensive knowledge gaps to be filled in. Outsourcing, vouchers, purchaser-provider models and competitive tendering have altered how local authorities organise and govern eldercare service provision (Junnila et al. 2012). In this report we have not been able to touch upon issues such as how local authorities have adopted new policy ideas and how they regulate the new welfare mix in which for-profit providers play a much more central role than ever before in Finland's history. In Finland, marketisation is a field of research that needs to be given much greater prominence if we are to understand it more deeply and broadly.

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Appendix 1

Regular home care. Clients who receive regular home care have a valid service and care plan or who receive home-help services, home nursing or day hospital care at least once a week.

Home help. Home help refers to the performance of, and assistance with, functions and activities related to personal care and support, child care and other activities of daily life, and supporting the everyday life of families.

Support services. Support services include meals-on-wheels, washing and bathing, help with shopping and other affairs, transportation and other services that aim to support independent living and provide help in activities of daily living. Support services can be provided in the client's home, service and day centres, institutions or other units.

Support for informal care. Informal care refers to care or other support for an older, disabled or ill person in his/her own home by a family member or other person close to the person to be cared for. Support for informal care refers to a package formed by services provided for the person to be cared for according to his/her needs, and a care allowance paid and a leave granted to the carer and services that support informal care. The local authority and the carer make a commission agreement on the provision of informal care.

Ordinary sheltered housing = Service housing for older people, clients. Sheltered housing always includes both accommodation and related services, such as home help, hygiene services, etc. The actual content of sheltered housing may thus vary. The type of housing also varies: the units include group homes as well as sheltered accommodation where residents have their own apartments. Sheltered housing does not include ordinary rental flats of older people under the Tenancy Act, or sheltered housing including no daily or regular home-help services. The difference between sheltered housing and institutional care is that sheltered housing is always based on a rental relationship, owner-occupancy or other type of tenure.

Service housing with 24-hour assistance = Intensive service housing for older people. Sheltered housing with 24-hour assistance has staff available day and night.

Residential homes = Nursing homes for older people. Institutional care for older people in social care is care in a unit that has been defined as an institution by the Social Insurance Institution.

Health centres, long-term clients. Institutional care in health-centres includes care provided in GP-led health-centre wards. Long-term care refers to care given to a client with a decision on long-term care or when the client has received care for more than 90 days.

Source: SOTKANet. <http://uusi.sotkanet.fi/portal/page/portal/etusivu>.

Chapter 4

Marketisation in eldercare in Denmark: free choice and the quest for quality and efficiency

Tilde Marie Bertelsen and Tine Rostgaard

1. Introduction

In Denmark, outsourcing the provision of eldercare to a for-profit provider has occurred primarily within the domain of home care (hjemmehjælp), but is also gaining ground in nursing home care (plejehjem/plejeboliger), although to a far lesser degree. While the marketisation of home care is a direct result of right wing political policies, the introduction of the market in residential care has been more piecemeal and incremental.

Marketisation principles were originally introduced with the implementation of the purchaser-provider model in 1996. In Denmark, this model was intended to be a steering and control instrument in the pursuit of horizontal and vertical efficiency within the public sector, but later it became important in the emergence of for-profit providers in eldercare. Another key element in the shift of activities to the private sector was the introduction, in 1998, of a standardised needs assessment tool, 'Fælles sprog', to be used across municipalities.

Outsourcing of home care to for-profit providers began in earnest in 2003, with the introduction of the 'Frit valg' ('Free Choice of Provider') scheme, which requires local authorities to encourage alternative service provision from for-profit providers. Today, most, but not all, local authorities offer a choice of home care providers, and private for-profit providers have a market share of approximately one third of all home care users. Private for-profit provision is used mainly for practical assistance, including domestic chores such as cleaning, and is used much less often with personal care. Marketisation in residential care facilities either takes place as private service delivery of some of the main services, such as administration or the provision of cleaning services, or as private provision in independent nursing homes, under the Fripheje nursing home scheme. The latter arrangement, however,

also includes a number of non-profit providers. Only a small number of older people reside in nursing homes organised as Frippeje nursing homes, and just a few local authorities use private for-profit providers in the delivery of services to nursing homes; in short, the degree of marketisation in nursing home services is rather limited.

Still, having a choice of provider as an alternative to municipal providers has gained ground and, especially within home care, it is generally considered as uncontroversial; moreover, it is also popular among older adults. Further, at least under the previous right-wing government, there was substantial political support for the extension of marketisation, particularly in home care. Under the present centre-left government (consisting of Socialdemokraterne (the Social Democratic Party), de Radikale (the Danish Social-Liberal Party) and SF (the Socialist People's Party)), there is perhaps less ideological support for marketisation, but the instruments of marketisation have by no means been overturned or rolled back and, in fact, new rules have been introduced which simplify the process of outsourcing home care for local authorities.

For Denmark, only a handful of studies have been conducted that examine whether there is any difference in the eldercare services that are being provided by alternative providers, whether providers apply the required care principles according to the Act on Social Services, or whether the working conditions for employees differ in the municipal and the private provider sectors. This report documents the legislation underpinning marketisation in eldercare and the rules that delimit its scope. Using secondary data and official statistics, the report also examines the extent of marketisation in home care and residential care homes, as well as investigating the consequences for users and employees.

2. Eldercare in Denmark

In Denmark, the local authorities are responsible for the assessment of the need for eldercare and for the organisation and financing of care. The main care services consist of home care and nursing home care.

Home care services consist of practical care (help with domestic chores like cleaning and doing laundry etc.) and personal care (help with bathing, getting dressed, getting in and out of bed etc.). These services are free of charge for the user, and are provided by care staff, most of whom are trained. As will be described below, the Act of Social Services obliges local authorities to enable for-profit providers to provide home care services in competition with the public home care provider, namely the local authority itself.

Nursing home care consists of accommodation and personal care, as well as practical assistance and the offer of recreational activities and physical

training. In the modern version of nursing homes, the so-called nursing home facilities (plejeboliger), the residents pay for rent and services used, such as meals, laundry, and cleaning, with a maximum payment ceiling applied. In the more traditional, and now increasingly rare form of residential care, the nursing home (plejehjem), the resident receives full board and lodging as well as other services, and thus is not provided with the choice of services. Members of staff in both forms of care accommodation typically have training in care, physical therapy or occupational therapy.

2.1 Use of home care and nursing home services

Overall, home care reaches a considerable number of adults aged 65 and over. By 2012, 13.7% of this group received home care⁵⁵ (See Table 1). Most received practical assistance only: 47% of all users of home care, or 6.5% of the population aged 65+. A further 41.9% received both practical assistance and personal care, which is equivalent to 5.7% of this age group. Finally, a smaller group received personal care only: 11.1% of users aged 65+, or 1.5% of that age group as a whole.

Table 1 Users of home care 65+ with personal care and practical assistance, no. of users, as percentage of population 65+ and as percentage of users 65+, 2012

	Number of users 65+	% of population 65+	% of users
Personal care only	14,745	1.5	11.1
Practical assistance only	62,483	6.5	47.0
Both personal care and practical assistance	62,483	5.7	41.9
Total	132,810	13.7	100.0

Source: Statistics Denmark, StatBank Denmark: FOLK2; AED06.

As mentioned previously, with regard to the use of residential care, there are two types of nursing homes in Denmark, offering the same around the clock services, but differentiated according to the legal status of the resident and the choice of service provision: the traditional nursing homes (plejehjem) are set up as institutions with full service provision, while in the modern version, the nursing home facilities (plejebolig), residents are tenants who can choose whether or not to purchase services such as cleaning, food delivery etc. As of

⁵⁵ This refers only to the so-called 'permanent' home care; that is, provision of home care given as a long-term service.

2012, 4.1% of the population 65 and over were residing in a nursing home, of which most lived in the modern version (3.4%) (See Table 2).

Table 2 Residents in residential care facilities 65+, no. of users, as % of population 65+ and type of provision, 2012

	No of users 65+	% of population 65+
Nursing homes (traditional)	6,270	0.6
Nursing home facility (modern)	33,335	3.4
Total	39,605	4.1

Source: Statistics Denmark, StatBank Denmark: FOLK2; RESI01.

3. Legislation enabling and regulating marketisation

It is only since 2003, with the introduction of the requirement that local authorities outsource some of the home care service provision, that marketisation in eldercare has really gained ground in Denmark. However, the ‘Free Choice’ scheme was initially launched by the Conservative government in the health care sector in 1991, as part of a strategy of marketisation and privatisation. The notion of ‘free choice’ soon proved to be a constant theme in Danish political rhetoric, even for the Social-Democratic government that came to power in 1992. However, the backbenchers in the party demanded a stronger opposition to privatisation and out-sourcing. Regarding eldercare, the concern was that labour conditions for employees and quality of care would be negatively affected, and more generally, the party believed that marketisation would lead to user charges and increased inequality. It was therefore agreed that basic services, such as home care, were to remain within the public sphere, since market forces were believed to be detrimental to the very idea of providing care for social, rather than commercial, purposes. So, in contrast to the reforms that took place in Sweden, which had already introduced outsourcing of eldercare services in the early 1990s, Denmark persisted with collective provision of home care services into the new millennium. To resolve policy tensions, a compromise was reached: a ‘diluted’ form of free choice was created, consisting in a so-called ‘freer choice’ of welfare, without specifying further what this would mean in practice, along with strategies of democratisation through citizen participation (Greve 2004; Rostgaard 2006). The Act on Social Services included no binding requirements as to what provider-type should be used. Local authorities were thus welcome, but not obliged, to outsource services, but they remained reluctant to do so within the domain of eldercare. By March 2002,

only about 2.5% of home care for people older than 67 was provided by private for-profit providers (Strukturkommissionen 2004).

When a Liberal-Conservative government came into office in 2001, free choice was again on the agenda and was to become a central concept in their policy discourse, in line with their overall New Public Management approach. In 2002, the new government (in office 2001-2011) developed a reform program ('Welfare and Choice') aimed at introducing user choice into public services, arguing that it would improve quality and increase efficiency. As part of this, in 2002, the government proposed a new law, the so-called 'Free Choice' in home care services. A widely used slogan was 'place the user at the centre' ('Brugeren i centrum'). While the stated policy aim was to increase cost efficiency, the tacit aim was to introduce market forces in the provision of eldercare (Greve 2004; Rostgaard 2011).

In June 2002, the Parliament voted for the Law on Free Choice of Provider of Practical Assistance and Personal Care (Lov nr. 399 af 6. juni 2002 Frit valg af leverandør af personlig og praktisk hjælp.) to be part of an amendment of the Act of Social Services. Under this law, which came into effect from January 1 2003, every local authority is obliged to provide access to a choice of providers of home care; that is, they must encourage private for-profit providers to establish themselves and offer services alongside municipal providers. The service remains free of charge and the hours per week allocated to the individual care recipient remain the same, regardless of who is the provider.

Local authorities must, according to the law on free choice, set up procedures to endorse private actors as providers of home care if they are deemed qualified. The law thus requires local authorities to formulate local standards for the quality and price of home care. These standards constitute the terms of tender or endorsement that guide potential providers when they seek to deliver publicly funded services. The local authority maintains the responsibility for the assessment and allocation of services; that is, it decides on the various home care tasks which will be provided and the actual time set for such provision, and it also holds the responsibility of regulating the for-profit providers, by carrying out -announced, as well as unannounced, visits. For-profit providers are allowed to earn a profit from the delivery of home care services, and have the advantage of being allowed to offer so-called additional home care services (tillægssydelser) which can be purchased by older people (see Section 4.1.3).

The law on free choice does not apply to nursing homes, so local authorities are not obliged to contract out these services or to offer a choice of provider, but can opt to do so. Marketisation of nursing home services via user choice is, instead, facilitated by the *Law on Independent Nursing Homes (Lov om friplejeboliger)* which was enacted in January 2007. The aim of the legislation was to increase choice for users of nursing home care, and to introduce more variation in service delivery through competition between

various providers. This includes the possibility of buying additional services which nursing home providers are allowed to offer. The spectrum of nursing home providers includes values-based foundations, non-profit providers, for-profit providers and municipal providers.

In addition, Denmark implemented the EU directive on procurement in 2004 and is thus obliged to put out to tender any service contract exceeding the amount of 500,000 DKK. The regulation of contracts under this amount is found in the national procurement act, *Tilbudsloven (Lov om 1410 af 7. december 2007 om indhentning af tilbud på visse offentlige og offentligt støttede kontrakter)*.

4. Instruments and models of marketisation

There are various instruments set up to stimulate private provision and, until recently, a number of models to regulate tendering for services as well as for regulating the role of public agencies and public providers in the process of marketisation. These will be presented in the following section.

4.1 Instruments of marketisation

4.1.1 Purchaser-provider split

One of the instruments is the purchaser-provider model (Bestiller-Udfører model, BUM). Unlike other countries where the purchaser-provider split has been introduced as part of the introduction of marketisation of social services, in Denmark this step was originally part of a process that was intended to ensure that assessment of care took greater account of horizontal and vertical equity. In the attempt to better control assessment for care, the purchaser-provider split was introduced in 1996, six years before the introduction of private for-profit providers in home care. The argument was that individual 'purchasers', the case managers, paid too little attention to politically set goals and targets and were too involved in the daily management of home care. According to a report commissioned by the Ministry of Social Affairs, local authorities were not able to control costs, and assessment of need depended too much on the individual case manager's opinion. This was in conflict with principles of equal treatment of users and the recommendation was to introduce a purchaser-provider split (Schultz-Larsen et al. 2004). The purchaser-provider model has only been legally mandated for home care since 2003, but local authorities can also apply it to nursing homes.

4.1.2 Common Language

Another important instrument enabling comparison of private versus public offers is a codification system called the ‘Common Language’ (Fælles sprog). The Common Language was launched on a trial basis in the period 1994-1998, and was implemented from 1998 onwards, with further development of both Common Language II and the present version Common Language III. This instrument was not introduced only for the sake of marketisation, but is used in general when specifying needs and service provisions. It provides a standardised system of categorising service users’ functional capacity as well as the services provided to meet identified needs. In this way, it offers a codification of need and a general conceptual framework for the various actors, be it care assessors or care providers. It is also a tool for the creation of statistical indicators which can be used at the local political level, as well as for bench marking between local authorities (Dahl & Hansen 2005; Burau & Dahl 2013). In 2005, 82% of all local authorities made use of Common Language (Hansen & Vedung 2005, p. 193).

4.1.3 Purchase of additional services

Private for-profit providers of home care are allowed to offer so-called additional services (tilkøbsydelser) for which the older person pays a fee, based on the real costs; that is, these services are not subsidised. Services may include gardening, window cleaning and other services which are not part of home care provision, but can also include the purchase of additional time for cleaning and personal care on top of the needs assessed allocation, if the older person wishes. Even time for social contact can be purchased (Rostgaard 2007). Until recently, public providers of care have not been allowed to offer such extra services outside the needs assessment that the user pays for. However, since 2012, as part of the ‘Frikommuneforsøg’ (the ‘Free Municipal Experiments’),⁵⁶ three municipalities (Odsherred, Vejle and Fredensborg) have been allowed to offer additional services on the same terms as private for-profit providers. Individual municipalities and the association of municipalities in Denmark (Local Government Denmark; KL) have, for a number of years, argued for such a possibility, claiming that private for-profit providers had an unfair advantage in being the only ones able to provide such services (KL 2012b).

In the wake of the introduction of the ‘Frikommuneforsøg’, a High court order of 2012 has since made it possible for local authorities to adjust their level of services; that is, to make cuts in service, not only on the basis of

⁵⁶ Under the Frikommuneforsøg, nine municipalities have applied for an exemption to the national rules regarding documentation and processes in specific policy areas, in order to try out new ways of working and cooperating, both internally as well as externally.

assessed need, but also on the basis of lack of municipal resources. In 2010, Køge municipality reduced home care services to two home care recipients on these grounds and, in 2012, received the court's decision that this did not violate the law. Concerns have since been raised that this may provide an incentive for local authorities to reduce their needs-assessed free services and, instead, let private providers offer additional services for which users would be expected to pay the full price (for example, Danske Fysioterapeuter 2012).

4.1.4 Tax rebate

In order to create new jobs, a tax rebate scheme (*Hjemmeserviceordningen*) that was in force from January 1, 2009 until August 31, 2011 made it possible for older adults, among others, to purchase privately provided domestic services. The scheme entitled people aged 65 and over, along with recipients of early retirement benefits (*førtidspensionister*), to a 30% subsidy for the purchase of private assistance with domestic chores only, with a maximum subsidy ceiling of 3,200€ yearly per household.

From June 1, 2011-December 2012, the centre-right wing government introduced a new fiscal scheme, *Boligjobordningen*, replacing the old scheme. The new scheme was available for all households regardless of age. It allowed every individual to deduct one third of the cost up to DKK 15,000 (2,000 €) annually for privately purchased cleaning, child minding and renovation services.

Both schemes could be used to subsidise the cost of services provided by a private for-profit provider. As of January 2013, the centre-left government converted the *Boligjobordning* into a subsidy scheme for energy-saving renovations, removing the subsidy for the cost of purchasing domestic services. However, in April 2013, the previous scheme covering cleaning, child minding and renovation was reintroduced and extended until the end of 2014 (see www.bolig-job-ordning.dk).

4.2 Models for competition in home care

This section introduces the various models for competitive tendering in home care service delivery. At present (mid 2013), three models of competition under the free choice provision as well as a voucher system are in place. However, in November 2012, the government introduced a new bill in parliament concerning a revision of the present regulations relating to free choice and competitive tendering in eldercare. The new system is currently being implemented. Below, the existing three models and the voucher model will be presented, followed by a presentation of the new amendments.

As for free choice of provider in home care services, according to the present regulations in the Act on Social Services, the local authority is legally

bound to encourage for-profit providers to operate. To ensure that qualified for-profit providers have the opportunity to deliver care, the local authority is required to determine and promulgate the quality standards that providers must meet. According to current regulations, the local authority can enable free choice of providers and access for private for-profit providers under one of the following three models.

4.2.1 Models for tendering for service delivery within home care

Competition by tendering (Udbudsmodellen)

In the ‘competition by tendering’-model (udbudsmodellen) under the Free choice legislation, the local authority puts one or more services in one or more service districts or in the entire municipality out to tender. Following a competitive tender process, the Act on Social Services requires the local authority to contract with at least two qualified providers and with the providers who offer the best terms, based on price.⁵⁷ The municipal provider is able to participate in the tender process as well, however, it can only continue as a provider if the local authority submits one of the best bids. This means that the municipal provider may risk losing its role as a service provider to a private for-profit provider with a better tender submission. This ‘competition by tendering’ model allows for a competitive pricing environment; that is, the providers who tender for the services set the prices themselves. When the tendering process does not result in at least two providers, the following ‘competition by endorsement’-model must be chosen instead.⁵⁸

Competition by endorsement (Godkendelsesmodellen)

The competition by tendering model may not appeal to local authorities because they run the risk of being excluded from service provision. As an alternative the ‘competition by endorsement’ model (godkendelsesmodellen) is available as part of the Free Choice legislation. The competition by endorsement model is used in 97 of 98 municipalities (KL 2012c). If the local authority chooses to make use of the ‘endorsement’ model, the local authority determines and promulgates the price and quality requirements that private for-profit providers of personal care and practical assistance need to meet.⁵⁹ The price set by the local authority must reflect actual average long-term costs of delivery,⁶⁰ and must include costs for administration, rent,

⁵⁷ Act on Social Services, § 91, subsec. 2

⁵⁸ Act on Social Services, § 91, subsec. 3

⁵⁹ Act on Social Services, § 91, subsec. 4

⁶⁰ Act on Social Services, §91, subsec. 6

wages and so on. Under this model, the local authority is obligated to endorse and contract with every private for-profit provider that meets the requirements on price and quality.⁶¹ Private for-profit providers that meet the requirements and contract with the local authority then operate on equal terms as the municipal provider, although only private for-profit providers are, as mentioned in section 4.1.3, able to offer extra services for a fee.

It is up to the individual for-profit providers to decide whether they want to be endorsed for the delivery of both personal care and practical assistance. If a for-profit provider is endorsed to deliver one or both of these services, the provider must be willing to deliver services to all citizens in the municipality and cannot decide to provide services only to, for example, citizens with higher incomes.

A number of cases in which the municipal provider bid for service delivery at too low a price led, in May 2005, to an amendment of the Act of Social Services (Lov om Social Service) (*L 33 – Forslag til lov om ændring af lov om social service (Revision af reglerne om frit valg af leverandør i hjemmeplejen m.v.)*) and local authorities have since been obliged to compensate providers if the hourly price was set too low.⁶²

Combined tendering/endorsement-model (Kombineret udbuds- og godkendelsesmodel)

Under the Free Choice legislation, a local authority is also able to make use of a third model, the combined tendering/endorsement-model (den kombinerede udbuds- og godkendelsesmodel). In this model, the local authority is to put the provision of services out to tender and subsequently hand over the provision of services to *the* single provider who offers the best terms. This provider becomes the main service provider in the contractual period. The municipal provider is able, however, to remain the main provider of services if it offers the best terms and thus wins the bidding round. After signing the contract with the successful service provider, the specific quality requirements and the stipulated price are announced so that other for-profit providers can contact the local authority for endorsement under the same conditions and terms as the main, selected provider. By using this model, the price and quality of services are thus determined on the basis of competitive tendering, and the process is then completed through the endorsement-model. Using the combined tendering/endorsement model, the local authority is able to put price and quality out to tender and is then guaranteed a certain standard concerning price and quality from any further providers due to the criteria of endorsement.

⁶¹ Act on Social Services § 91, subsec. 5

⁶² Act on Social Services § 91, subsection 9.

Voucher model (Servicebevis)

In the voucher model,⁶³ the user her/himself finds a provider, whether a company or a private person. This is regulated in the Act on Social Services, but is not part of the Free Choice legislation. The voucher system was introduced in 14 April 2009 (L 113 Forslag til lov om ændring af lov om social service (Markedsføring af leverandører af samt servicebevis til personlig og praktisk hjælp)), and, as of July 1 2009,⁶⁴ permitted local authorities to offer a voucher to people who, according to the Act on Social Services § 83, were considered to need practical help and/or personal care.

Price is based on the provider (or the municipally set) cost per hour. Practical assistance, personal care as well as shopping are the main services included under this model, but the local municipal board decides on what precisely is to be included and whether the user can receive a voucher instead of a service benefit. The user acts as the employer with the responsibilities this implies, but can hand over this responsibility to their next of kin, an organisation, or a private company. The local authority is obliged to guide the user in the possible legal requirements of the model related to acting as an employer. The actual value of the voucher is based on the user's assessed need for services. An evaluation showed that, by autumn 2011, only three of 98 local authorities had introduced the voucher system (Frederiksberg, Halsnæs and Fredericia), and only one (Frederiksberg) had users who actually made use of the vouchers, with a total of 251 users in all as of March 2012 (Socialstyrelsen 2012). These municipalities had chosen to introduce the voucher to increase choice, and mainly offered the voucher in relation to the purchase of practical assistance (cleaning). In Frederiksberg, the voucher could be exchanged for shopping only. Relatives made up 20% of providers, while the other 80% were private companies (no mention is made of whether they were for- or non-profit).

4.2.2 Amendments to the Act on Social Services

Until recently, the three models of outsourcing home care under the Free Choice legislation and the voucher model represented all the instruments related to marketisation via consumer choice and competitive tendering. However, in November 2012, the centre-left government introduced a bill in parliament concerning a revision of current legislation relating to free choice and competitive tendering in eldercare. As of April 2013, this revised system is being implemented.

The new bill and the proposed legislative changes are expected to lead to municipal economic savings, to reduce administrative burdens of existing

⁶³ Act on Social Service § 94 b

⁶⁴ Act on Social Services § 94b

regulations and to create better opportunities for the private providers. Furthermore, as a result of the amendments, the local authorities are expected to put more and more contracts out to tender, which is expected to improve the market for private for-profit providers, both big companies and smaller providers (KL 2012a).⁶⁵ There has been some concern, however, that for-profit providers may not possess the required competences, and may not work according to principles of prevention and reablement, which are otherwise recommended. Concern over increased administrative costs has also been raised (KL 2012b).

The overall aim of this new bill is to improve the free choice of provider and at the same time to dissolve the special rules concerning competitive tendering. In addition, the aim is also to encourage private providers to offer personal care. According to Local Government Denmark (KL 2012a):

- Local authorities are no longer required to make use of specific competition by tendering-models.
- Instead, following a tendering process, the municipal provider is now able to continue as provider, as long as this is specified in the tender documents.
- The local authority is then able to decide which types of services are to be included in a tender, for example, by combining for-profit delivery of several services such as cleaning and care provision in nursing homes or both home care and reablement. In principle, a new potential is created for ensuring that for-profit providers provide services in accordance with a reablement orientation. Previously, for-profit providers had little incentive to offer reablement services, since doing so meant that they would be providing services intended to reduce dependence on the service provider itself. The local authorities can decide how many providers their older citizens have to choose among, with a choice between two set as a minimum.
- The local authority is still able to make use of the endorsement-model.
- Further, local authorities will have the opportunity to provide free choice by means of a Free choice voucher, by which citizens who are eligible for home care will have the opportunity to choose and contract care provision with a business registered company themselves (KL 2012a). The difference from the service voucher is that, with the Free Choice voucher, the local authorities do not need to include costs for overheads and users can only use a registered company (and not a family member, which had been possible under previous legislation).

⁶⁵ Social- og integrationsministeren (2012): Forslag til Lov om ændring af lov om social service (Kommunalbestyrelsens tilrettelæggelse af borgernes frie valg af leverandør af hjemmehjælp og fritvalgsbevis)

4.3 Models for competition in residential care

In contrast to traditional nursing homes (plejehjem) where residents have no tenant rights, all nursing homes built after 1987 are set up as nursing home facilities (plejebolig) according to the Law on General Housing (*Lov om almene boliger*). Residents in a nursing home facility are members of a housing association and pay rent and a deposit. The housing association is in charge of the physical maintenance of the building and the local authority is in charge of the delivery of care services and for the operation of other services, such as leisure and physical activities. In a traditional nursing home the local authority is responsible for the building as well as for service delivery.

In either case, the delivery of care and help within the nursing homes are not encompassed by the rules of free choice as outlined in the Act of Social Services. Nevertheless, various activities may be outsourced, including administration (overseeing payment of rent and electricity, water, etc.), maintenance (of buildings and green areas etc.), daily operation (emergency calls, café services etc.) and service delivery (delivery of care and meals). In recent years, local authorities have also set up partnerships with private for-profit providers in the building of nursing home; that is, taking part in planning and construction. There are various models available for outsourcing activities, as follows:

Competitive tendering

With competitive tendering (udbud), providers compete on price for service delivery. Providers are allowed to earn a profit from the delivery of services. The local authority maintains the responsibility for assessment of need and allocation of places in the nursing homes. By 2009, only six nursing homes were operated on such terms (Rambøll, 2009, p. 27).

Delivery contracts

So-called independent nursing homes (selvejende almene plejeboliger) run by non-profit providers can enter into a delivery contract with the local authority. The provider must be endorsed by the local authority, but there is no competition on price. The local authority maintains the responsibility for assessment of need and allocation of places in the nursing homes. This model is the most widespread (Rambøll, 2012).

Provision without delivery contracts

Nursing homes may operate without a delivery contract and then change their status to become a 'Fripleje' nursing home (Friplejebolig⁶⁶). In such

⁶⁶ Friplejeboliger (literally Free nursing homes) were introduced, by law, in 2009 (Lov om friplejeboliger, jf. lovbekendtgørelse nr. 786 af 18. august 2009)

cases, providers must first obtain certification, and then compete for a share of a national quota of Fripeljebolig places. Also here there is a municipal assessment and regulation, but not allocation; that is, this provision is not considered part of municipal service delivery. This means that a Fripelje nursing home has the opportunity to offer the services but also that the provider cannot set up an agreement with the local authority about delivery of places. Once need has been assessed and established, the older person can opt for a Fripelje nursing home, if so desired, even if this is located in another municipality.

Under this model, it is possible for providers to make a profit, but not all providers are working for profit. By 2011, 33 providers were certified to provide services under such conditions, 13 of these were non-profit providers (for example, Diakonissestiftelsen and Danske Diakonhjem) (Rambøll 2013).

5. Forms of regulation and oversight of providers

Providers of eldercare, whether non-profit, for-profit or public, are subject to the same forms of regulation. According to the law on supervision of nursing homes, as of 2001 (*L192 den 29. maj 2001*), municipal boards have been obliged to carry out at least one announced and one unannounced inspection visit of all nursing homes annually. This visit must be carried out by an independent body. Since 2005, the law on supervision of nursing homes (L52) has confirmed that the local authority bears overall responsibility for nursing homes (myndighedsansvar), but is free to outsource the actual inspections to a private for-profit provider. The inspection must, however, not be outsourced to any provider that is also providing nursing home services.

Private for-profit and public home care providers are also subject to inspection under the Act of Social Services, but the law does not specify that this inspection has to be independent. The municipal unit providing services may, therefore, also be the one carrying out the inspection. Some local authorities have chosen an external provider for inspection visits, for example, in Copenhagen, a private company carries out the inspection. This includes inspection of case journals for a number of users, observation of service delivery in the homes, and qualitative interviews carried out with users and staff (Københavns Kommune n.d.).

As part of more 'soft regulation', a number of institutions and organisations have been set up alongside the local authorities in order to assist them in outsourcing, and also in documenting, the use of private for-profit providers. The institutions and organisations also make available information on private for-profit providers which should assist users in making their choice.

These include *Udbudsrådet* (the Procurement Council) which is charged with facilitating public-private partnerships by making recommendations for

new initiatives and by analysing and documenting the effects of such partnerships. It consists of representatives from ministries and from labour market and employer organisations. In April 2013, the council was replaced by *Rådet for Offentlig-Privat Samarbejde.dk* (The Council for Public-Private Co-operation).⁶⁷

The *Konkurrence- og Forbrugerstyrelsen* (The Danish Competition and Consumer Authority) is responsible for the executive administration of the Competition Act. The Authority rules in major cases, including cases of fundamental importance, and sets a precedent in other cases. It is composed of a chairman and 17 members appointed by the Minister of Economic and Business Affairs.

The *Tilbudsportalen*, an online database set up in 2007, provides an overview of existing social service provisions. Through another online database, *Fritvalgsdatabasen* (The Free Choice Data Base), all local authorities are obliged to make public their quality and price requirements when they put services out to tender. This database also provides information about the private for-profit providers that have been endorsed. A further source of information comes from the user satisfaction surveys that have been carried out regularly in recent years, using standardised questionnaires. This not only allows comparison over time and across municipal borders, but also allows comparison between users of private and public home care services and nursing homes (see also section 6.2).

A report from Udbudsrådet (2012) concludes that public-private cooperation generally, including in eldercare, is more extensive in Denmark than in Sweden. The report concludes that use of private providers is greater in Danish than in Swedish municipalities, not least because Denmark had already implemented the EU directive on procurement in 2004 (Sweden only partly in 2008) and because Denmark has initiated more legislative and political initiatives to further public-private partnerships than Sweden. Local authorities in Denmark also work in a strategic and coordinated fashion with respect to the procurement arrangements (*indkøbsordninger*) for purchasing services from non-public providers. Many local authorities join together in voluntary networks with shared procurement arrangements which makes the purchase of services cheaper. According to this report, on average, 19% of municipal services in Denmark are provided by private providers, while in Sweden it is 14% (Udbudsrådet 2012, p. 39).

⁶⁷ See www.udbudsraadet.dk.

6. Extent of marketisation in eldercare

What is the current status and extent of marketisation in home care and residential care for older people in Denmark, and how has it developed in recent years? As mentioned, marketisation has occurred mainly within home care. Since the introduction of free choice of provider in 2003, the number of private for-profit providers of home care and the total number of people over 65 years of age using for-profit providers have been increasing, to the extent that more than one in three home care recipients in Denmark today makes use of for-profit provision for their needs-assessed support. The increase has primarily occurred in the area of practical assistance and, to a lesser extent, in personal care.

Within residential care homes, some marketisation has taken place in the provision of services. Local authorities may opt to let private for-profit companies provide services such as administration, but the extent of for-profit provision of care services remains limited. Since the introduction of the Law on Independent Nursing Homes (*Lov om friplejeboliger*) in 2007, it has also been possible for private for-profit providers to set up nursing homes.

In the following, we account for the extent of marketisation in home care and nursing home services, measured as the number of users receiving services from for-profit providers, the number of employees working in the for-profit sector, and the number of providers offering such services. While there is considerable data on for-profit provision of home care, there is little data on for-profit provision of residential care. There is also very limited information on private *non*-profit provision in general, both within the home care and residential care sectors.

6.1 The users

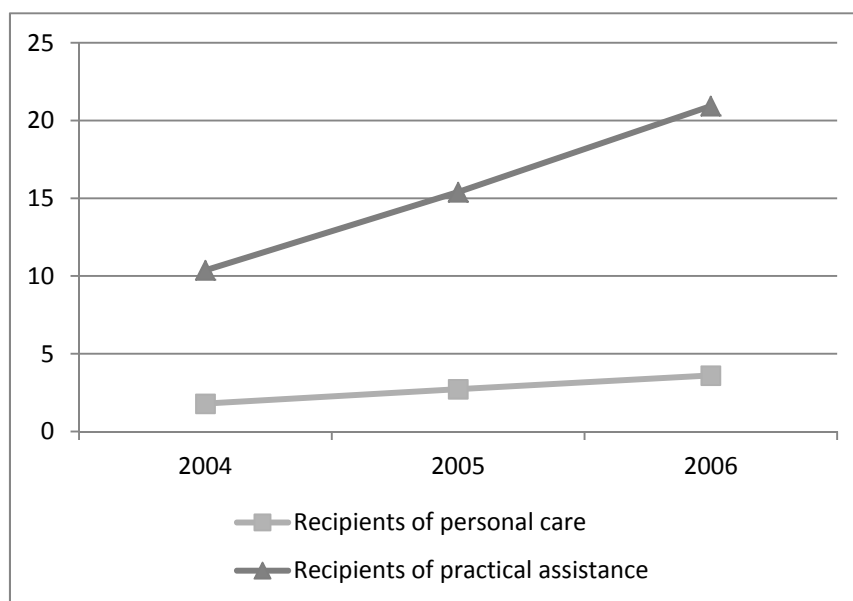
6.1.1 Use of private for-profit providers in home care: numbers of users

Within home care there is good statistical information on the number of home care users making use of private providers, and here private providers are all operating on a for-profit basis. Since the introduction of free choice in 2003, it is evident from the increase in the number of older people that make use of private for-profit providers of home care that these providers have increasingly gained a significant market share. By 2012, 37.2% of home care recipients over 65 years made use of a private for-profit provider (Statistics Denmark; StatBank Denmark, AED12). Before the introduction of free choice, in 2002, an estimated 2.5% of home care for older people aged over 67 was carried out by private for-profit providers (Strukturkommissionen 2004).

There are statistics available for take-up since the introduction of free choice in 2003. However, because of changes in the way statistics have been collected it is not possible to compare the take up rates from 2004 until the present. Therefore, trends are shown below in separate figures (see Figures 1 and 2). The figure for 2004-2006 (Figure 1) is based on data in which the number of persons who received both practical assistance and personal care were included in both categories of users receiving either personal care or practical assistance, and there is no information on the share of private provision of home care overall. However, in the figure covering the period 2008-2012 (Figure 2) this has been corrected. Data from 2007 is not available. The figures account only for those older people who, at the time, resided in municipalities that offered a choice of provider. As we account for later, this is not the case for all the municipalities, although today 97 out of 98 municipalities offer choice of provider.

All in all, as figures 1 and 2 illustrate, there is an upward trend in the proportion of home care users who make use of private for-profit providers, to the extent that, by 2012, one in three home care recipients were making use of private for-profit provision.

Figure 1. Percentage of users of home care 65+ included in the free choice scheme who used a private for-profit provider for personal care or practical assistance, 2004-2006

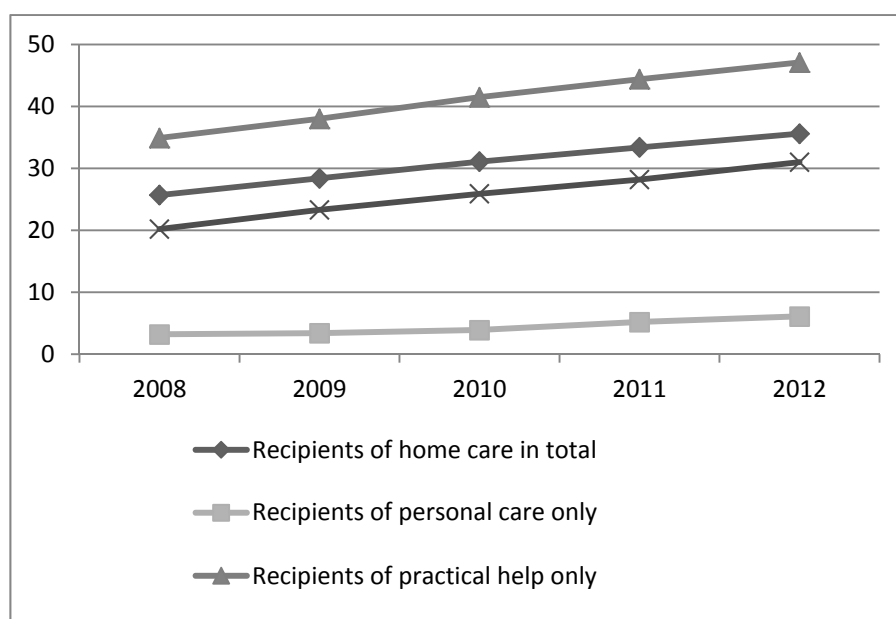


Source: Statistics Denmark, StatBank Denmark: VH4. www.statbank.dk⁶⁸

⁶⁸ For much of the statistical information provided StatBank Denmark, it is possible to explore the statistics according to, for instance, region, type of assistance, age and sex of service user.

However, as figure 1, indicates, in the period 2004-06, the increase in older people using a for-profit provider depended on the type of assistance needed and provided. As figure 2 illustrates, the increase in the use of for-profit providers continued over the 2008-2012 period, but once again, the share has increased primarily in the area of practical assistance. As is indicated in Figure 2, the greatest increase in the use of private for-profit providers has taken place among users of practical assistance only (from 35% to 47% of users) and among users of both personal care and practical assistance (from 20% to 31% of users). The use of private for-profit providers for users of personal care only is, by contrast, still at a very low level, increasing from 3% in 2008 to 6% in 2012.

Figure 2. Percentage of users of home care 65 and older included in the free choice scheme who use for-profit provider, in total and by type of assistance, 2008-2012



Source: Statistics Denmark, StatBank Denmark: AED12.

Among people being assessed for the first times, the same pattern is evident (see Table 3). Among first-time assessed users in 2012, more people used a for-profit provider for practical assistance than for personal care; almost half of the persons who are included by the free choice scheme and assessed for the first time received practical assistance from a for-profit provider. But as other statistics show, it is not only people who are entering the system who choose a private for-profit provider. The statistics show little difference

between persons who have to choose provider for the first time and persons receiving home care in general regarding the choice of public or private for-profit provider. However, reports from the early years of the free choice scheme by Ankestyrelsen (2004a; 2005) concluded that the first-time assessed showed a greater tendency to choose private for-profit providers than users of home care in general.

Table 3. Percentage share of first-time assessed individuals, all ages, who choose a for-profit provider, 2012

	2012
Recipients of home care in total	21.3
Recipients of personal care only	5.5
Recipients of practical assistance only	41.9
Recipients of both personal care and practical assistance	19.6

Source: Statistics Denmark, StatBank Denmark: AED13.

We find clear evidence of a steady increase in users of private for-profit providers, especially among users of practical assistance. However, statistics on the total number of home care hours show that personal care is much more time consuming; 80% of home care hours were used for personal care in 2011, while only 20% of home care hours were used for practical assistance (Statistics Denmark, StatBank Denmark, AED022). According to KL (Local Government Denmark), in 2011, 30.7 million hours of practical assistance and personal care were provided. Of these, 4 million hours were provided by private for-profit providers (KL 2012c), which means that approximately one in eight (13%) hours were privately provided. Thus, despite rapid growth in the use of privately provided practical assistance, the overall proportion of privately provided home care remains modest.

6.1.2 Use of private for-profit providers in home care: characteristics of users

What is known about the older adults who choose a private for-profit provider for home care? In the following, we examine a number of characteristics of people over 65 who choose private for-profit providers in home care, such as sex, age and location.

In general, studies find that women use for-profit home care providers more than men do, but there has been an increase in the proportion of both men and women who choose a private for-profit provider of home care. In 2012, 29% of men and 38% of women had chosen a private for-profit home care provider (see Table 4).

If one distinguishes between types of assistance provided, one finds that women use private for-profit providers for practical assistance to a considerably greater extent than men, see Table 4. However, no significant gender difference in the use of personal care is found.

Table 4. Percentage of users of home care aged 65 and over, included in the free choice scheme, who chose a private for-profit provider, by gender and type of assistance, 2012

	Recipients of home care in total	Recipients of personal care only	Recipients of practical assistance only
Women	38.6	6.5	49.2
Men	28.9	6.9	40.6

Source: Statistics Denmark, StatBank Denmark: AED12.

There are no significant relations between choice of provider and age found, both when we look at provision in general and when looking at type of provision (Statistics Denmark, StatBank Denmark, AED12; AED06).

In relation to geographical location, the use of private for-profit home care providers is primarily a big-city and urban area phenomenon (Statistics Denmark 2011; KORA n.d.). The use of private for-profit providers is primarily centred around the capital of Copenhagen and, in particular, in the affluent northern suburban municipalities in Zealand, as well as in an affluent municipality in Jutland. It is, however, not known whether it is the relatively high average incomes in these municipalities that increases the likelihood that services users will choose for-profit providers, or other factors, such as a political will to outsource services that increases the availability of private providers (or both).

6.1.3 Use of private providers in nursing homes: numbers of users

Compared to home care, very little statistical information on private provision is available within the area of residential care. Some information is, however, available on residents living in the 'Free nursing home facilities' (Fripeljeboliger), where providers may be for-profit or non-profit. Data giving the number of older people who reside in these facilities is available from 2009 onwards: in 2009, 242 older people lived in a Fripelje nursing home, while the number of residents increased to 436 in 2010, and then fell to 378 in 2011. By 2012, the number of older people living in such facilities increased once again to 403. As a share of the 40,008 people over 65 who live in nursing homes and assisted living facilities, only 1% lived in a Fripelje nursing home in 2012 (Statistics Denmark, StatBank Denmark,

RESI01). Not all residents are 65 and over; in 2011, 16% of residents were under 65 (Statistics Denmark, StatBank Denmark, RESI01)

6.1.4 Use of private providers in nursing homes: User characteristics

There is, as mentioned above, only limited information on the private provision of nursing care, as such, information on resident characteristics is also limited. Based on the existing data, we can say that most residents have chosen a Frippeje nursing home situated in their home municipality; that is, there is little mobility involved, and residents may have chosen the nursing home because of its proximity rather than its value orientation or ownership status. When surveyed, residents and relatives identified the main reason for choosing their particular nursing home was geographical locality and reputation (Rambøll, 2012). Two thirds of residents and relatives in a small survey (N=71) stated that geographical location was the main reason for their choice of a Frippeje nursing home (65%), followed by the value orientation of the home (23%). Contrary to expectations, the possibility of buying additional services was not a primary consideration for residents (only 13%). Additionally, 10% named the insufficiency of other nursing homes available in the municipality and another 10% expressed that they had no active choice in the matter, as the nursing home had been converted into a Frippeje nursing home. Another 6% pointed at the interior design of the dwelling (Rambøll 2012).

6.2 The employees

As a consequence of the increased number of users of private for-profit provision in home care in Denmark since 2004, it is reasonable to expect that an increasing number of employees are working in the private home care sector. It is estimated by Statistics Denmark that, by 2011, approximately 3,500 fulltime equivalent employees were employed by private for-profit providers of home care⁶⁹ (Statistics Denmark, 2012) (See Table 5).

⁶⁹ No information about the nature of the work and job function is available, but the personnel mainly work with practical and personal care.

Table 5. Employees working with elder and disability care, total number of employees and number of employees employed by a private for-profit provider, full-time equivalents, 2008-2011

	2008	2009	2010	2011
Employees of private for-profit providers of home care (FTE)	3,200	3,600	3,800	3,500
Employees in elder and disability care (residential care, home care, day centres, preventive visits, rehabilitation) (FTE)	106,390	108,947	111,195	108,297

Source: Statistics Denmark 2012: Den Sociale Ressourceopgørelse.

Of 108,297 full-time equivalent persons employed in the elder and disability care sector in Denmark in 2011, 3,500 employees were employed by private for-profit providers of home care services. There is no information on the number of employees working in for-profit nursing homes.

6.3 The private providers

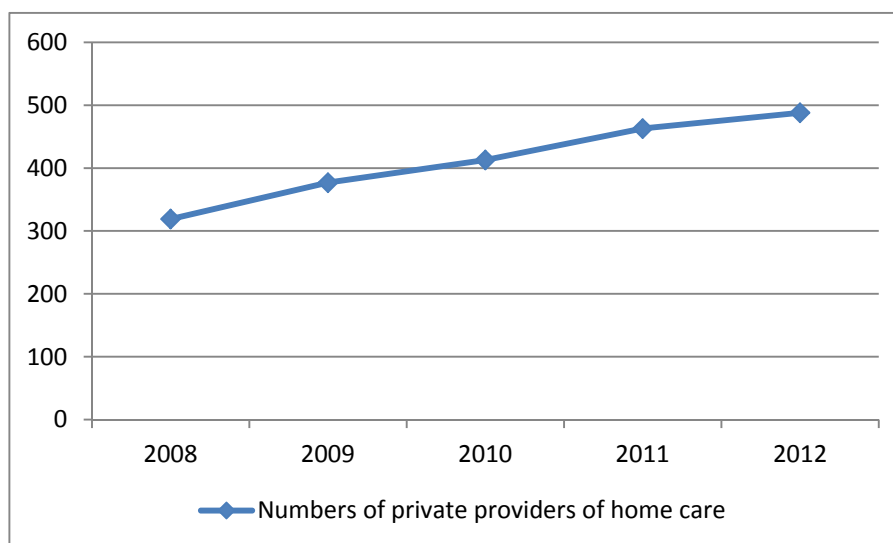
A third way to assess the extent and character of marketisation in eldercare in Denmark is to look at the number of private providers, both non-profit third sector and private for-profit, and to identify their characteristics.

6.3.1 Private for-profit providers of home care

Within home care, 488 private for-profit home care companies were operating in Denmark in 2012 (Statistics Denmark, StatBank Denmark, VH33). Since 2004, there has been an increase in the number of private for-profit providers of home care (KREVI 2011).

As illustrated in Figure 3, on a national basis there has been a growing trend for more private for-profit providers of home care. But as in the case of users, the increase has been much greater among private for-profit providers of practical assistance than private for-profit providers of personal care (KREVI 2011). Part of the explanation for lower usage of privately-provided personal care may be that: a) there are fewer providers who offer this kind of service, perhaps because many local authorities are reluctant to contract with private for-profit providers of personal care (discussed in more detail below); or b) the market for personal care, for various reasons, is not attractive to private for-profit providers; or c) users prefer public providers for personal care.

Figure 3. Total number of private for-profit providers of home care, 2008-2012



Source: Statistics Denmark, StatBank Denmark: VH33.

Although the local authorities are obliged to ensure that a number of private home care providers are available, along with the public home care provider, by approving and contracting with every provider, public or private, that meets the quality and price demands specified by the local authority, in reality not every local authority is able to provide choice for their citizens. According to Statistics Denmark, by 2012, five of the 98 Danish municipalities had no private for-profit provision of home care (Statistics Denmark, StatBank Denmark, VH33).

Excluding Copenhagen, which had 54 private for-profit companies in 2012, on average eight companies operated in each municipality, with urban areas having the highest concentration of for-profit providers. It is the smaller island municipalities (Ærø, Samsø, Læsø, Langeland) or more rural municipalities (Thisted) that do not provide their older adult citizens with a free choice in home care (Statistics Denmark, StatBank Denmark, VH33).

Generally, municipalities are less likely to have private for-profit providers of personal care than private for-profit providers of practical assistance: By 2010, 5% of the municipalities did not have any private for-profit providers of practical assistance while approximately one third of the municipalities did not have any private for-profit providers of personal care (KREVI 2011).

The reason why some local authorities do not endorse any private for-profit providers of practical assistance or personal care are not clear-cut. However, some studies find a correlation between the number of private

for-profit providers of home care in a municipality and its demographic and organisational characteristics. These studies show a tendency for more private for-profit providers in municipalities with a higher population and a large share of older people. These two factors could be indicators of a better potential customer base which attracts more private for-profit providers (Eskelinen et al. 2004; KREVI 2011).

In addition, there is a tendency for more private for-profit providers to operate in densely populated municipalities, in which geographical distances between the customers are smaller. In municipalities with low population density, the customers are potentially far apart, so that providers have to spend more time on transportation than they would in more urbanised areas, and this could reduce the profit margin for private for-profit providers. Moreover, the number of private for-profit providers is higher in municipalities with a higher tax base per person, which was also indicated in section 6.1.2. One possible explanation is that the markets for additional services are better in municipalities with stronger tax bases (Eskelinen et al. 2004) because more people are likely to purchase the additional services in these municipalities and thus make it more likely that the private for-profit providers make a profit.

The studies also tested potential correlations between the numbers of private for-profit providers of home care in municipalities and i) whether or not the municipality was merged with another municipality in the Danish municipal reform of 2007, and ii) the political affiliation of the mayor of the municipality (Eskelinen et al. 2004). No significant correlations were found. However, the studies did find a significant correlation between the number of private for-profit providers operating in the municipality and the municipal organisation of home care; that is, municipalities with a so-called 'district organisation', where home care is divided into smaller districts in which a provider can operate, have more for-profit providers operating than municipalities without district organisation.

Other studies (Ankestyrelsen 2004a; 2007) have tried to explain why some municipalities do not have private providers and the fact that many private for-profit home care firms provide only practical assistance and not personal care services in many municipalities. These studies have identified some of the reasons why many private for-profit providers, and especially private firms providing personal care, do not operate in more remote, rural areas. These include: a limited market in relation to the geographical distances; the obligation to provide round-the-clock services; the fact that staff members must have certain educational qualifications; recognition that it is a big responsibility to provide personal care; and an insufficient number of users due to the preference for publicly-provided personal care. All this helps to explain why private for-profit providers mostly prefer to set up contracts with municipalities to offer practical assistance rather than personal care.

6.3.2 Private non-profit and for-profit providers of nursing homes and nursing home services

Both private non-profit and private for-profit providers are active in either delivering services to nursing homes or in setting up private nursing homes as part of the Fripeljebolig scheme. Nevertheless, in 2009, it was estimated that less than 1% of the total market for residential care is private (Rambøll 2009), although many of these actually non-profit providers.

Looking firstly at the services delivered to nursing homes by private providers – both non-profit and for-profit – there are, as mentioned in Section 4.3, various options for local authorities to involve private providers: outsourcing to for-profit-providers after competitive tendering, independent non-profit-providers under delivery contract, and the independent non- or for-profit Fripeljebolig. In Denmark, the main private non-profit and for-profit providers of nursing homes and assisted living facilities are shown in Table 6.

Table 6. Main private providers of nursing homes and assisted living facilities

Private providers	Non- or for-profit	Number of nursing homes/ or assisted living facilities
Danske Diakonhjem	Non-profit	28, of which 4 are run as Friplejehjem
OK-Fonden	Non-profit	13
Fonden Mariehjemmene	Non-profit	6, of which 1 is run as Fripeljebolig
Aleris Omsorg	For-profit	4
Attendo Care	For-profit	1

Source: Private providers' own webpages.

An analysis of the effects of competitive tendering of various municipal activities conducted in 83 of Denmark's 98 municipalities in 2009, found that only four municipalities made use of private for-profit providers of residential care (Rambøll, 2009); that is, the use of private for-profit providers does not seem to have been on the increase. The study listed a number of reasons that could explain why as many as 79 out of the 83 municipalities in the study did not contract out eldercare in nursing homes. One contributing factor may be the existing market situation in which there is a lack of private for-profit providers and/or no interest from the private for-profit providers in delivering eldercare in the municipalities in question. However, the report also mentions lack of political will and cultural, ideological and administrative resistance to marketisation, which seem also to stem from a concern for

losing control over provision and the belief that care is best provided by a public provider (Rambøll 2009).

Turning to the providers active in the provision of Frippeje nursing homes, a recent evaluation from 2012 documented that 13 providers now operate in 11 municipalities in Denmark, the majority operating in Jutland. This is fewer than expected and one reason could be the high levels of bureaucracy related to setting up business, which providers interviewed for the study mentioned as a serious obstacle (Rambøll 2012).

Most private providers of residential care are established non-profit nursing home providers who turn existing homes into Frippeje nursing homes. In all, 441 dwellings were provided in 2012, with the majority of homes providing services for up to 40 residents. The report by Rambøll (2012) further states that the vast majority of providers are non-profit, however, no figures are provided as to the actual distribution of facilities between for- and non-profit providers.

7. Consequences of introducing marketisation

Marketisation and 'free choice' of provider in Danish elder care was introduced in order to improve efficiency, quality in care and user autonomy, and was expected to lead to more user-led services (Rostgaard, 2011) and to result in a more cost-effective and quality-conscious eldercare sector. This section deals with the implications and consequences of introducing marketisation in eldercare.

7.1 Economic consequences and impact on quality

Apart from user satisfaction studies (see Section 7.2), there have been few other investigations of the effects of introducing marketisation, and these have often been based on non-representative municipal case studies (Petersen et al. 2011).

One study conducted for Udbudsrådet (Rambøll 2009) estimates a reduction in total costs of 15%-25% yearly by introducing competitive bidding in nursing homes in Denmark. However, a meta-analysis (Petersen et al. 2011) of Danish and international studies of the effects of introducing competition was not as optimistic about the overall impact of marketisation on quality and costs, especially in eldercare. This study estimates that there could be a small potential economic gain, but found that this alleged economic gain is generally poorly documented, especially when it comes to eldercare. Moreover, the costs of price-setting and regulation are often not included in the calculation. Regarding the quality of eldercare, several studies have tried to document the impact of marketisation and free choice, and to assess whether the public

or the private for-profit providers provide the best quality of care. Petersen and colleagues (2011) conclude that no significant documentation exists establishing whether free choice in Danish home care has led to better quality of care. However, they report an increasing quality consciousness as a result of introducing choice in home care.

Petersen and colleagues (2011) also raise the issue of the potential negative impacts that setting up long term contracts with providers could have on normal practice in the municipalities, as this endangers democratic decision making at the local level.

7.2 Consequences for users

One way of studying consequences for users has been to investigate how different factors related to the introduction of markets in service delivery are rated by users. In a Danish study of the factors that are important for service users in different markets – for instance, trust, transparency and the opportunity to file a complaint – eldercare services were ranked the lowest compared to the other social service areas for which free choice is available (high schools, GPs, primary schools, hospitals, child care and eldercare) (Konkurrence- og forbrugerstyrelsen 2010, p. 10). The users ranked the eldercare market relatively low on key factors that were important to them, indicating that they experience difficulties with obtaining an overview of the different providers of home care and comparing the quality of care and services across different providers. Further, users did not feel that free choice of home care provider ensured a more satisfactory service. A study from the early years of the free choice scheme by Eskelinen and colleagues (2004) pointed out that users who needed both personal care and practical assistance often had to receive services from more than one provider if they wanted to make use of the private alternative to public provision, since many municipalities had, at that time, only entered into contract with private for-profit providers offering practical assistance.

Another way of measuring the consequences of the introduction of for-profit providers of home care for users is to conduct user satisfaction surveys. User satisfaction is relatively well-documented in the area of home care. National studies of user satisfaction within home care generally show that users are highly satisfied. However, the results vary depending on type of provision and provider; in the area of practical assistance, there is a tendency towards slightly higher levels of satisfaction among users of private for-profit than public providers. By contrast, in the area of personal care, a tendency for slightly greater satisfaction among users of public providers has been documented (Petersen & Hjelmar 2012).

A user satisfaction survey from 2011, conducted by Epinion (2011) on behalf of the Ministry of Social Affairs and Integration, documents a similar

tendency: according to the survey, 90% of users 65+ receiving practical assistance from private for-profit providers are either satisfied or very satisfied with the services overall, whereas the share is 85.5% for users receiving practical assistance from a public home care provider. However, amongst users of personal care, 94.4% of users of public home care are satisfied or very satisfied overall, compared to 85.7% of users receiving personal care from for-profit providers (Epinion 2011). On this basis, some minor differences are documented in the level of user satisfaction between public and private for-profit providers, however, the results heavily depend on the type of service provided.

According to the user satisfaction survey by Epinion (2011), home care users are more satisfied with private for-profit providers on measures including the numbers of care workers visiting the users' homes, and whether care workers' came at the arranged time,⁷⁰ and this may help explain why private for-profit home care providers are gaining ground.

Although studies show high levels of satisfaction, many users are still unaware of the possibility of choosing between public and private for-profit providers. Approximately one third of home care users are unaware of the free choice scheme (Epinion 2011). Many users also find it difficult to choose between providers, as the number of operating providers may be high. While, in principle, the case manager must not make the choice for the user, many users do in fact rely on the case manager to make this choice (Rostgaard 2011), leading to low transparency for the user as to what services the various providers offer and how providers differ. Should the user decline to make the choice, the non-choice alternative is the municipality (Udbudsrådet 2012). However, amongst the majority of older people who were aware of the possibility to choose between providers, 68% reported that having a choice of provider is either important or very important to them (Epinion, 2011).

However, Rostgaard and Thorgaard (2007) concluded from interviews with other older adults that, even though they appreciated the possibility of choosing between different providers, they would rather have chosen the person who provides care and to guarantee some continuity in the care relationship. Older adults were generally much less concerned with the 'ownership' of the provider, or the possibility of changing providers.

⁷⁰ Approximately 80% of users of private providers are satisfied or very satisfied with the number of workers visiting the users, only 63% of users of municipal providers are satisfied or very satisfied. Regarding the workers coming as arranged, 90% of older people receiving home care from private providers are satisfied or very satisfied, while 83% of older people receiving home care from municipal providers are satisfied or very satisfied (Epinion 2011).

7.3 Consequences for employees

There are few studies that compare working conditions with employees working in the public and for-profit sectors. An indication of working conditions for members of staff can be absence due to illness. A recent analysis by the liberal think tank CEPOS investigated the number of sick days in the private for-profit and non-profit vs. municipal eldercare sector. The analysis shows that the average number of sick days in the private sector is 7.8 days yearly while it is 16.1 days in the municipal sector (CEPOS, 2012). However, little is known about the employment contracts of privately employed eldercare workers and whether their salaries are covered during illness.

A study by Rostgaard and colleagues (2013), based on a survey among home care staff in private for-profit and public sectors, indicates that there are differences in working conditions as well as in their formal qualifications between the sectors. Employees of public home care providers have a higher average level of education than those in the private for-profit sector, and this presumably reflects, to some degree, the difference in services provided, with private for-profit providers more often providing practical care such as cleaning services. Employees in the private for-profit sector express higher satisfaction with the quality of the care that they provide, and gave lack of time as the reason for those occasions when quality was judged to be poor. Employees in the public sector more often report sickness among colleagues as having an impact on working conditions. Employees with private for-profit employers felt they had less say over the organisation of their work and fewer opportunities to develop themselves through their job. They also reported that they had to work during lunch breaks more often than do employees working in the public sector.

There are also no Danish studies that fully document the consequences for employees of introducing marketisation. Most studies looking into consequences for staff are based on only a small sample or are not nationally representative. This includes a study, conducted by Rambøll (2011) on behalf of Udbudsrådet in 2011, on the consequences of introducing marketisation in the delivery of assistive devices (*hjælpemidler*). The study investigated a number of municipalities that outsourced these services and compared, amongst other things, pre- and post-working conditions. Most members of staff reported no change in working conditions after their workplace was outsourced to a private provider, although a closer follow up indicated that the staff-to-user ratio dropped. On the other hand, level of training tended to increase and employees were in general as content with their work situation as were employees employed in the municipality.

However, according to the meta-analysis study conducted by Petersen and colleagues (2011) on the consequences of marketisation, several international studies point to the salaries and working conditions of care workers as often being negatively affected by introducing market forces in eldercare.

Danish studies of the implication for employees from marketisation in general, but not within eldercare in particular, point at somewhat mixed results. Some Danish studies only point to negative consequences (higher work intensity, stress, poorer working conditions, less job security and general dissatisfaction with employment), while other studies also point to positive consequences, such as more influence over the content of work (Petersen et al. 2011).

8. Conclusion

In Denmark, marketisation in eldercare has mainly been fostered by the Free Choice in home care legislation, implemented in 2003 by a centre-right government. This has changed the provision of home care, as private for-profit providers have established themselves in the social sector and now provide services to one third of recipients. The care provided is, however, still mainly in the form of practical assistance such as cleaning, as most recipients of personal care still receive such services from the municipal provider. There seems to be a combined reason for this: local authorities seem more reluctant to use a private for-profit provider for the provision of personal care, the private for-profit providers find that this is a less lucrative market and, finally, users seem less inclined to make use of for-profit providers in regards to the provision of personal care. One in three municipalities do not have a private for-profit alternative to the public provision of personal care, whereas this is only true for 5% of municipalities in regards to practical assistance.

Marketisation in nursing home care is much less widespread, and mainly takes place as private for-profit service delivery of separate tasks, such as administration or the provision of cleaning, but can also take place as private for-profit delivery of entire nursing homes under the new Frippeje nursing home scheme, which, however, also covers private non-profit providers. Overall, the degree of marketisation in residential care provision is rather limited and this seems to be related to both local authority scepticism of private for-profit provision in this sector and a reluctance to relinquish local authority control over this area of service provision.

Marketisation was introduced under the former centre-right government, but under the present centre-left government it has by no means been abolished or even reduced and new rules have been introduced which actually simplify the process of outsourcing of home care for local authorities. Taken together, the legislative framework of mandatory implementation of free choice in home care, the hard and soft regulation that has been implemented, and the various public institutions set up to document, foster and conduct policy making provide strong foundations for continued, and even increased, use of for-profit-providers in eldercare – at least as far as home care is concerned.

Whereas there is evidence of an increase in the scope of marketisation and in the number of providers and recipients of private services, there is only limited and ambiguous evidence concerning the consequences of marketisation. This includes a lack of any clear evidence to support the contention that the introduction of marketisation is cost-effective and leads to better quality of services, better working conditions, higher user satisfaction and/or new innovations in the provision of services. In fact, regarding employee satisfaction, there seems to be mixed results, with some studies pointing only at negative consequences (higher work intensity, stress, poorer working conditions, less job security and general dissatisfaction with employment), and others also pointing at positive consequences, such as more influence in the content of work etc. (Petersen et al. 2011). Likewise, there are indications, but no clear general findings, concerning the extra costs of simultaneously providing public as well as private services as well as running costly procurement procedures. Furthermore, more work needs to be done to explore the quality of care being provided as measured by the composition of staff and their educational backgrounds. Finally, there is need for research into the actual care that is being provided and the nature of the care relationships: does care by a private for-profit provider differ from the care provided by a public provider? Is there a difference in the cooperation between users of care and the care provider, in the care providers' cooperation with municipal care assessors and in the cooperation with the family members?

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Chapter 5

Marketisation in Norwegian eldercare: preconditions, trends and resistance

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1. Introduction

In Norway, eldercare forms a part of the comprehensive social infrastructure of statutory services provided through local authorities; that is, through 429 municipalities of varying size and population.⁷¹ This decentralised system of welfare provision is characterised by a combination of local autonomy and strong integration between central and local levels (Baldersheim 2003). Local care service provision is influenced by central government through legislation, regulations, judicial decisions, monitoring and substantial block-grant funding. Nevertheless, local governments are free to plan and coordinate service the way they prefer. The considerable diversity in the municipalities' demographic, geographic and economic character has resulted in diverse mixes of traditional residential care facilities, home-based care and intermediate solutions (Huseby & Paulsen 2009; Vabo & Burau 2011, Gautun & Hermansen 2011). It has also led to a diversity of organisational models, including inter-municipal organisation (Blåka et al. 2012).

Services are mainly provided by in-house municipal providers, although local authorities are free to replace their own provision with services purchased from external service providers – either private or other public providers (for example, from a neighboring municipality). In eldercare private provision is not a completely new phenomenon. A minority of private care providers – mainly non-profit, but also a few small family companies – have provided publicly funded eldercare ever since the modern eldercare system was established in the post-war era. In recent years, as competitive tendering

⁷¹ At 325,000 km², Norway is a large country (larger than the UK), but it is sparsely populated, having only 5 million people. Oslo has approximately 600,000 inhabitants, only five municipalities have more than 100,000 inhabitants, 47 municipalities have between 20,000 and 100,000 inhabitants and about half of the municipalities have less than 5,000 inhabitants.

and free choice systems have come into use, a new category of private for-profit providers has entered the scene. However, even though the concepts of competition and free choice of (private and public) providers have been lauded by many politicians, the extent of private for-profit provision remains limited. In comparison with other Nordic countries, local authorities in Norway have so far been reluctant to tender out services.

In this chapter, we explore the marketisation trend in more detail. The paper begins by outlining the context of Norwegian eldercare, paying particular attention to legislation and to different competing trends of governance. In order to explain the comparatively weak development of marketisation in Norway, we highlight the fact that marketisation is not the only set of ideas driving administrative reforms at the local level. Norway has a longstanding tradition of pragmatic and collaborative modes of governance, and this tradition has been continued by the trade unions who have initiated alternative strategies of modernisation. However, as in most other western welfare states, the global wave of New Public Management (NPM) reforms has, to some extent, influenced the way services are organised, managed and accounted for. We provide some evidence on the scope of these softer NPM tools of governance before we go on to answer the core questions of this report – the legal preconditions for marketisation, the scope of private provision, the consequences for quality of care, the cost, and the working conditions of care workers. Attention will also be paid to sources of opposition to marketisation. We will show just how contested the issues are with respect to competition, marketisation and the impacts of market forces in eldercare.

2. The institutional and legal context of Norwegian eldercare

The Norwegian health and social care system is characterised by a multi-level model in which hospitals (national level) have their role tightly confined to medical interventions that cannot be efficiently or safely performed in the community, whereas local authorities are assigned the responsibility for primary health care and for long-term care, which includes both residential care (nursing homes and special housing) and home-based care. In Norway, eldercare is regulated not by special laws but by general legislation. Care services are offered to all citizens in need of care, regardless of age, income, family relations and so on. Still, nursing homes are generally regarded as residential care facilities for the oldest and sickest people, whereas home-based care increasingly has been offered to people of all age groups, including psychiatric patients, drug addicts and terminally ill cancer patients (see further details below). The municipal care sector constitutes a

sector of considerable size – municipal spending for long-term care amounts to approximately 3% of GDP (Kjelvik 2011)

The autonomous role of local authorities was consolidated through a comprehensive set of decentralisation reforms which came into effect during the mid-1980s and early 1990s. Local authorities were assigned responsibility for a range of statutory services such as primary health care and various kinds of housing and care services (The Municipal Health Act 1982-11-19-66). In 1986, the funding system, which had been based on earmarked grants, was replaced by a system based on block grants. This meant that local authorities were encouraged to take a more comprehensive view of their service provision, prioritise services, and find cost effective solutions across service sectors. As subsidies were capped, and local authorities had to curb expenditures, most local authorities reduced the number of beds in residential care facilities and transferred services to the home care system (Vabø 2012). These developments arose out of a longer-standing trend of increasing levels of disability among nursing home residents and an evolution in the role of home care services. As the proportion of residents 80+ in residential care steadily increased from 52% in 1960 to 73% in 1997 (Daatland 1997), home care services gradually changed from a preventive role aimed at postponing residential care for older people toward the role of providing, rehabilitation, medical assistance and nursing care for the frail and sick elderly and terminally ill. Between 1992 and 2011, the number of clients (all ages) receiving only practical help declined by 39%, while the number of clients receiving only home nursing increased by 177%, and those receiving a combination of home help and home nursing increased by 27% (Statistics Norway 2012 a).

It is important to be aware that services provided for older people are not regulated by special laws, but by general laws – mainly the *Municipal Health and Care Service Act* (Act 2011-06-24-30), which recently merged, and replaced, both the *Municipal Health Act* and the *Social Services Act* (Act 1991-12-13-81). Whereas nursing homes are mainly used by the oldest and sickest people, home care is increasingly regarded as an option for younger people, for example, people with disabilities or chronic diseases, drug addicts and psychiatric patients. In addition, people who are terminally ill (for instance, cancer patients) are the responsibility of home care services, since many people prefer to receive terminal care at home rather than in a hospital. Currently, not more than 60% of total expenditure in the care sector is spent on older people (people aged 67 and more). By contrast, in 1998, 74% of spending went towards services for older people (Kjelvik 2011).

Both the earlier *Municipal Health Act* and the new *Municipal Health and Care Service Act* are typical framework acts. They do not specify in detail how local authorities should plan and organise their services. It was explicitly stated in the *Municipal Health Act* that local authorities may find it advantageous, from a health care perspective, to cooperate with ‘private

organisations and the like' (§ 1- 4). The same wording also appeared in the *Social Services Act* regulating home help (domestic tasks) and is similarly used in the new *Municipal Health and Care Service Act*.

The idea that local authorities should be given a free hand to govern and organise services in ways that accommodate local circumstances was at the heart of the decentralisation reforms of the mid-1980s (this will be further outlined below). Local autonomy in the organisation of service provision was also highlighted in the *Local Government Act* (Act 1992- 25-09-107). Still, this act also states that all local authorities are required to implement a system of internal control (internal audit). The idea of internal control was echoed in a new provision added in 1994 to the *Act Relating to the Public Supervision of Health Services* (Act 1984-03-30-15).⁷² Moreover, a sharpened focus on internal control systems was endorsed by the *Quality Regulation* (kvalitetsforskriften) of 1997, later amended in 2004 (Ministry of Health and Social Affairs 2004). These regulations called for all nursing homes and home care agencies to put their work procedures down on paper. None of the reform acts or regulations mentioned competitive tendering in particular. However, a case study conducted around the turn of the century and based on interviews with 30 home care leaders found that enthusiasm for these new tools of control was greater in local authorities that had planned to tender out services (Vabø 2002). The respondents argued that competitive tendering would require transparency and control, and so regarded these mechanisms for quality control as useful.

3. Competing trajectories of reform

Even though local authorities in Norway are free to decide how they govern and organise services, they have always been influenced by the views and recommendations of central authorities. In fact administrative reforms have, to a large extent been, conceived as joint central-local projects, with substantial elements of experiment, mutual learning, and replication across both municipal borders (Baldersheim 2003) and borders with neighboring Nordic countries.

In this section, in order to illuminate why a recommended marketisation strategy never really took off, we will briefly describe how previous reform ideas were framed. Although these reform ideas have been overlaid on one another, it should be noted that there is some tension among the different reform positions.

⁷² Internal control refers to a form of indirect control recognized by Power (1994) as 'control of control' in so far as it was acting indirectly upon systems of control rather than directly upon first order activities.

3.1 A national trajectory of reforms

As already mentioned, the new block grant funding scheme implemented in the mid-1980s meant that many local authorities had to curb expenditures. In order to make cost efficient decisions, local authorities were encouraged to take a broad and holistic view of their services. Medical treatment, rehabilitation and social care were supposed to be woven into a cohesive continuum of care. The public report *Om samordning i helse- og sosialtjenesten* ('On coordinating health and social care') (NOU 1986:4), commissioned by a Right Wing government (Willoch regjeringen), had a great impact on the way in which local authorities reformed their services. The report argued that the most cost effective way to organise care services was to integrate services to better utilise care staff resources, for example, by merging home help (domestic and social care) and home nursing services, and even by sharing staff between residential and home care. These ideas were echoed later in the so-called 'quality regulations' (Directive –I-13/97) (Rundskriv 1997), which emphasised that, even though local authorities are free to decide how services can best be organised, they should favour organisational models that create a cohesive continuum of care. In other words, care services should be holistic and coordinated from the users' point of view.

Recommendations in the wake of the decentralisation reform (for instance the Ministry of Local Government and Labour 1988) stressed that citizens should be involved in service provision. Generally, the buzzwords of the late 1980s and early 1990s stressed awareness of local problems, flexibility, proximity and user participation. Services should be provided and carried out in close consultation with users. These ideas also had an economical aspect in the sense that local authorities were encouraged to consider whether 'hidden' care resources could be mobilised through partnerships with families and voluntary actors. The ideas presumed that citizens are not just passive right holders; they have duties as well as rights. A report mandated to evaluate and discuss the further development of public care provision (Sosialdepartementet 1992) made a number of suggestions for stimulating family care through payment for care, information, support and respite services, and proposed ways of reinforcing the ability of care recipients to look after themselves, for example by technical aids, practical housing, rehabilitation and welfare centres. Moreover, while social democrats had previously had a deeply rooted antagonism towards philanthropic welfare solutions, they now came to acknowledge the mutual dependence between public and civil welfare resources (Selle 1991). In 1991, for instance, the Labour government launched an open-ended, bottom-up program in which the term 'voluntary centre' was applied to encompass a multitude of local 'experiments'. The idea was that these experiments should be publicly funded, but ideas and initiatives should be taken from 'below' (Lorenzen & Dugstad 2008, p. 2).

The above mentioned position on integrated services and partnerships with families and volunteers were suggestions and recommendations – not enforced changes. Many local authorities (more or less) integrated their home help and home nursing services in order to avoid replication of services and to better utilise care staff resources (Solem & Høistad 2000). However, it was, of course, a challenge for local authorities to control external actors (such as families and volunteers) (see Vabø 1998). Even though case studies from home care services revealed that pragmatic and productive collaborations existed between families and the home care system, the ‘responsible citizen’ was not a dominant image in public debates on eldercare. Rather, public debates increasingly focused on the rights and entitlements of citizens. The entitlement discourse was especially evident during a grassroots campaign (eldreopprøret; the elderly revolt) in 1990 – a media protest started by an old retired professor (Per Haga) who loudly complained about the poor quality of care provided to his wife (Vabø 2011).

The media protest in 1990 had a significant impact on eldercare policy. After days and weeks of media debates, the government was pushed to add additional earmarked grants for eldercare – the so-called ‘elder billion’ (eldremilliarden). The campaign also had a spill-over effect, as it set a sharper tone for public debate and contributed to the creation of a ‘crisis discourse’ (Lingsom 1997, p. 56). Even though scholars questioned the extent to which there was really a crisis in eldercare, it was often argued in public debates that more campaigns and more ‘elder billions’ were needed (Hole 1992).

An increased focus on the quality of eldercare also contributed toward pushing central governments to make extraordinary contributions. In the mid-1990s a Labour government (led by Gro Harlem Brundtland) presented the ‘Action Plan on Eldercare’ (Ministry of Health and Care Services 2000). The plan contained a series of investment grants awarded to local authorities to develop care services and to facilitate the construction and refurbishment of nursing homes and various other dwellings.

Focus on the quality of eldercare also went hand in hand with a quest for transparency. During the 1990s, a monitoring system was developed to provide the national authorities with adequate information on the demand and supply of health and social services – The Local Authorities State-Reporting system, today known as the KOSTRA-IPLOS system⁷³. The reporting system, which is mandatory, aims to provide central authorities with detailed

⁷³ KOSTRA (Local Authorities State Reporting system) is a national information system based on consecutive data records and annual reports from local authorities. Key indicators are published by Statistics Norway on the internet in a format that makes it possible to compare resource use in similar municipalities. In recent years, an additional reporting system, IPLOS, has been added to the national information system providing individual encrypted information about all recipients of care. IPLOS aims at providing comprehensive information on individuals’ needs.

knowledge about municipal service provision and also to function as a management tool for local authorities in their service improvement efforts (See Christensen 2013).

3.2 The global NPM trajectory of reform

The gradual quest for transparency and the concern for the quality of care during the 1990s overlapped with ideas and recommendations inspired by the global wave of NPM reforms.

The inspiration came from the Public Management Service of the OECD (PUMA), often channeled through private business management consultants (Vabø 2007). The core idea of this wave of reform was that public services should be reformed in line with ideas taken from private business and micro-economic theories which developed from modeling market exchanges between 'private actors'.

In the late 1990s, almost ten years after Sweden, but indeed inspired by Sweden, right wing politicians increasingly argued in public debates that competition from private providers would revitalise the care sector and make care services more cost effective. Norwegian economists calculated that competition reforms had the potential to reduce costs in long-term care by 20% (Erlandsen et al. 1997).

Marketisation was often talked about in an abstract manner as offering general instruments for public sector modernisation – not as an approach particularly suited to certain services. A telling example is the Norwegian official report *Should the public sector be exposed to competition?* (NOU 2000:19), which was commissioned by the center-right coalition government led by Kjell Magne Bondevik from the Christian People's party. The report aimed to examine the experience of competitive tendering in other countries, and concluded that competitive tendering was an effective instrument for cost savings, but that was no clear evidence about how it affects quality. It was emphasised that *private provision* in itself will not ensure improvements. *Competition* was seen as the driving force behind quality improvement. Accordingly, *various measures* to encourage and manage competition needed to be considered, such as deregulation of markets, competitive tendering, free choice models and benchmarking. The report recommended that public service providers (both on the state level and municipal levels) need to consider these alternative modes of governance.

The report did not have the status of a government bill. Still, two of the members of the committee, Per Hovden (representing the municipality of Ørstad) and Tore Nyseter (representing the Norwegian Association of Local and Regional Authorities, hereafter KS) raised an objection to the conclusions. They argued that the report gave an incorrect impression that competitive tendering would almost automatically result in 'value for money'. Their

comments led to a dispute between KS and right wing politicians. Some of the right wing politicians warned that they would withdraw their membership in KS. After this dispute, the neutral role of KS was strongly asserted: KS should respect and take an open-minded attitude towards the choices local authorities make about the modernisation of services. Hence, it was determined that competitive tendering was a matter of local policy⁷⁴ – it is up to local politicians to decide whether or not services should be put out to tender.

Even though the NOU 2000:19 made no specific recommendation on eldercare, examples were mentioned from Sweden which claimed that local authorities there had achieved considerable cost reductions in eldercare (up to 26%) without any reduction in quality and without reductions in the salary of care staff (NOU 2000:19, p, 93-94). Narratives about the success of marketisation in Swedish eldercare have also figured in publications from the Confederation of Norwegian Enterprise (NHO). In a special issue in the NHO journal *Horisont* in 2003, the free choice model of the Swedish municipality Nacka was praised, as was the Swedish labor union, Kommunal, for being ‘less dogmatic’ and more open to change than its Norwegian sister organization, Fagforbundet. This special issue also claimed that the Norwegian people wanted to have free choice of providers (Ekelberg & Thompson 2003).

In the late 1990s, a few (mainly right wing) local authorities started laying the groundwork for contracting out care services (Nesheim & Vatne 2000). Above all, this meant that new organisational arrangements were introduced *within* municipal activities, such as purchaser-provider splits, autonomous budgetary units, fee-for-service reimbursement, and various forms of marketing and quality management systems (Vabø 2007). However, only a limited number of local authorities actually took the subsequent full step of actually putting services out to tender (for more details, see below). Instead, some local authorities chose a less stringent NPM strategy by making municipal organisations adopt more market-like and corporate-like structures.

Before we go on to present the laws and regulations of relevance to competitive tendering, we will first give a brief outline of some of the NPM elements that currently exist in the Norwegian eldercare sector.

3.3 The spread of NPM instruments

Processes of marketisation are commonly underpinned by a core organisational structure – the purchaser-provider split. The split links to the idea of contractual management, that is, the purchaser (the public authority) is able to specify the level and quality of services and is also able to control whether

⁷⁴ See: http://www.kommunal-rapport.no/artikkel/ks_kritisk_til_konkurranseutsetting and http://www.kommunal-rapport.no/artikkel/ksstyret_er_kritisk_til_konkurranseutsetting (in Norwegian).

the contract specified for the provider is fulfilled. The contractual relationship is a key structural precondition when inviting private providers to compete for contracts or customers. However, if public agencies are to compete with private companies on equal terms they have to be separated from the government and turned into autonomous budget units (see, for instance, Almquist 2004). Hence, not only outsourced activities and private providers, but also public providers, are affected by the purchaser-provider split.

In the late 1990s, many of the biggest local authorities in Norway implemented some form of purchaser-provider split. And some of them did so even though they did not plan to tender out services (see below). It was argued, for instance, by the Norwegian Association of Local and Regional Authorities (KS) (Pape 2000), that the purchaser-provider model would better position local authorities to demand quality and to control and manage quality at arm's length. A case study from five municipal home care agencies carried out in 1999–2000 revealed that the model was associated with radical changes when the responsibility for assessing and approving the granting of a contract for services became separated from the responsibility of providing care. Care needs are changeable and contingent on shifting conditions, and the splitting of purchaser and provider responsibilities was considered cumbersome by care staff, since they constantly found that needs had to be reassessed. However, executive leaders strongly believed that specialised care assessors would be able to take a more detached view of care needs than the care staff and would thereby enforce the legal rights of citizens (Vabø 2002).

The idea that specialised purchasers and 'overseers' should control work organisations went hand in hand with the new accountability arrangements of the KOSTRA-IPLOS system. Local authorities were encouraged to use statistics from KOSTRA-IPLOS to compare and learn from each other in order to increase cost-efficiency (see below).

A survey from 2006, which included respondents from all Norwegian municipalities, indicates that the purchaser-provider model spread rapidly in the care sector (Gammelsæther 2006). At that time, total of 51 out of 430 local authorities had some kind of purchaser-provider split in their care services, and a further 12 planned to introduce such a model. Gammelsæther found that these municipalities were comparatively large and he estimated that more than half the Norwegian population lived in a municipality with care services organised in line with a purchaser-provider model. However, only 60% of the local authorities which had implemented the model also reported that they bought services from private providers. In the same survey, respondents chose from a list of reasons as to why they implemented a purchaser-provider model. Only 27% of the local authorities that had implemented the model agreed that private service provision was an important reason, 46% agreed that cost control was important and 88% agreed that procedural rights/due process (*rettsikkerhet*) was important. The role of the

purchaser-provider model as a way of strengthening the procedural rights of citizens have been echoed in studies from Sweden (Blomberg 2008). Still, smaller case studies revealed that some local authorities had softened the contractual relations between purchasers and providers, while others had developed quite formalised and cumbersome routines for interaction, for instance, through a system of fee-for-service reimbursement (Vabø 2009). A more recent evaluation study, commissioned by the Association of Local and Regional Authorities (KS) (Deloitte 2012), confirms this impression and reveals that a broad variety of purchaser-provider models exist in Norwegian municipalities – more or less contractual, more or less collaborative. However, Deloitte did not find that any of these models was more cost-efficient than others.⁷⁵

Parallel to the implementation of a purchaser-provider model, many Norwegian local authorities separated municipal service providers into disaggregated, autonomous ‘responsibility centres’ (resultatenheter). This meant that managers of care services became responsible for the cost efficiency of service provision. These structural changes overlapped with a range of NPM-measures focusing on managing in-house municipal service provision, and involved the use of ‘advertisements’ or citizen charters, fee-for-service reimbursement (stykkprisfinansiering) and various forms of performance measures/quality measures, user surveys and benchmarking.

Some NPM measures are commonly associated with one another, for instance the free choice model and fee-for-service reimbursement. However, case studies of home care service provision demonstrate that some local authorities have implemented fee-for-service reimbursement without a free choice model (Vabø 2009). These same case studies also demonstrate that NPM measures sometimes are ‘bent’ to fit established rules and routines (Vabø 2006) and sometimes have an indirect impact on work organisations. For instance, performance measures may indirectly impact on work organisation because they provide strategic managers (and external consultancy firms) with ‘hard figures’ which may be used to justify changes in work organisation (Vabø 2012).

A recent report, based on the organisation database of the Ministry of Local Government and Regional Development⁷⁶ (Blåka et al. 2012, p. 131),

⁷⁵ In fact cost-efficiency does not seem to follow from purchaser-provider organisation at all. The report points to a range of weak points in the model and makes several general recommendations concerning how the model may work better, but it does not question whether the contractual logic of the purchaser-provider model is appropriate for organising care provision.

⁷⁶ The organization database [‘organisasjonsdatabasen’] of the Ministry of Local Government and Regional Development was established in 1995. The database is based on a descriptive survey conducted by the Norwegian research institute NIBR (Norsk institutt for by og regionforskning). The survey aims to describe organizational forms and practices in Norwegian

indicates that the number of local authorities making use of competitive tendering has increased slightly between 2008 and 2012 in both residential care and home-based care (see Table 1). The report also indicates that an increasing number of local authorities have introduced free choice systems in both residential and home-based care. 'Free choice' in this case does not, however, necessarily involve private providers. Citizens may either be offered a free choice between public and different private providers *or* a free choice between different public providers. In 2004, 3% of local authorities had introduced free choice, in 2008, 4% and in 2012, 8%.

The number of local authorities that allocate resources in line with a fee-for-service reimbursement system has also increased and, above all, the trend towards benchmarking has increased. In fact the number of local authorities making use of benchmarking has more than doubled between 2008 and 2012 (Table 1). This must be seen in relation to the development of the aforementioned KOSTRA-IPLOS system and also to the wide spread use of so-called Efficiency Improvement Networks, organised by the Norwegian Association of Local and Regional Authorities (KS). These networks have become increasingly popular among local authorities in Norway and have been arranged in several municipal service sectors, including the long-term care sector. Normally between 4 and 8 municipalities participate in a network and utilise different sources of digital information from their own local authority. The working method is *bench-learning*, which combines mapping and analysis with a focus on learning and improvement. With the aid of key figures, user satisfaction surveys and other broad quality indicators (level of educated staff, sickness absence among staff, etc.), individual municipalities are encouraged to compare themselves with other municipalities and to learn from 'best practice' municipalities.⁷⁷

local and county municipalities and how organizational forms and practices are changing over time (Hovig & Stigen 2008).

⁷⁷ See: www.bedrekommune.no (in Norwegian).

Table 1. Percentage of local authorities in Norway that use a given marketisation instrument

		2004	2008	2012
Competitive tendering	Residential	5	4	7
	Home care	2	3	7
Free choice of provider	Residential	2	2	4
	Home care	3	4	8
Fee-for-service reimbursement	Residential	1	2	6
	Home care	1	4	7
Benchmarking	Residential	22	25	60
	Home care	22	24	58

Source: Blåka and colleagues (2012).

Table 1 refers to the percentage of local authorities in Norway that make use of various kinds of marketisation instruments. According to this data, with the exception of benchmarking, marketisation measures seem to be very limited. However, since approximately half the Norwegian population lives in the 30 (7%) most densely populated municipalities (Statistical year book 2012), marketisation measures may still affect the services offered to a substantial number of people.

The previously mentioned report by Blåka and colleagues (2012) does not explore whether marketisation measures are more widespread in bigger municipalities. This topic is, however, briefly addressed in a survey among deputy mayors (n=198) (Deloitte 2011). This survey found that competitive tendering in the care sector occurs relatively more frequently in densely populated municipalities than in very small municipalities. In municipalities with 50,000 or more inhabitants, 70% had tendered out some of their care services. It is important to note that care services in this survey included a range of services, not only nursing homes and home-based care, but also personal assistance and various forms of support and activation services. In municipalities with less than 5,000 inhabitants only 11% had tendered out some of their care services.

The survey from Deloitte (2011) also indicates that competitive tendering in the care sector occurs more frequently in right wing municipalities than in social democratic municipalities. Only 16% of municipalities with a social democratic mayor had arranged competitive tendering, whereas 45% with a mayor from the radical right wing party (Fremskrittspartiet) and 35% with a mayor from the conservative party (Høyre) had arranged competitive tendering.

Still, the Deloitte study (2011) indicates that local authorities reporting that they use competitive tendering in the care sector have often only contracted out a small part of their care services. Whereas 90% had not tendered out nursing home services at all, 7% had tendered out less than 20% of costs, and only 3% more than 20%. Likewise 92% had not tendered out home help services at all, and 6% had tendered out less than 20% of costs and only 2% more than 20%. This indicates that, even in municipalities that are open to using private providers, public provision has, until now, remained the dominant source of care.

Among those who had tendered out services, 32% reported that outsourcing probably will increase, 52% reported that it will probably stay the same. Only 3% of those who had not tendered out services had plans to do so (Deloitte 2011).

4. Laws and regulations of relevance for marketisation

As far as we can see, there are no legal hindrances for contracting out care services in Norway. Whereas, for instance, the Norwegian private schools Act (Act 2003-07-04 no 84) imposes restrictions on schools making a profit, the acts relating to health and care services do not place any restrictions on private for-profit providers. According to the new Act on Health and Care Services (Act 2011-06-24 nr. 30), local authorities in Norway are required to ensure that services of sound quality are provided for citizens in need. Municipal services can be provided, either by in-house municipal care providers or by other legal entities (either public or private). The Act on Health and Care Services does not specify how local authorities should or can engage with private actors or whether these ‘other organisations’ should be non-profit or for-profit.

The way in which local authorities contract with private providers has, however, increasingly been inspired by a business ethos. Further, as a consequence of the European Economic Area (EEA) agreement between the European Free Trade Association (EFTA) countries and the European Union (EU), Norway relies on the EU procurement regulations for public sector contracts.⁷⁸

4.1 Norwegian procurement regulation

Following the EEA agreement, Norway passed a procurement act in 1992. The act was amended in 1999. The Norwegian procurement act (Act 1999-

⁷⁸ Even though Norway is not a member of the EU, it participates in the internal market of EU on equal terms as other European countries.

07-16- no. 9) states that public procurements ‘as far as possible should be based on competition’.

The new stress on competition following from the procurements act of 1999 meant that some local authorities reconsidered ‘older’ general agreements made with private, mainly non-profit, organisations (for more details see Section 5.1). When the city of Oslo tendered out nursing home provision, it invited both for-profit and non-profit providers to bid for a contract. After a few years, non-profit organisations realised that it was difficult to compete on the same level as private for-profit companies, basically because their employment agreements offered higher pension benefits to their employees, and so therefore their costs were higher than in private for-profit companies. (Non-profit service providers have committed themselves to offer care workers the same high level of pensions as public employers, see Section 4.2). Non-profit organisations who own nursing home buildings, as they traditionally they do, also found it difficult to compete for service provision taking place in their own buildings. In fact, the Salvation Army gave up running nursing homes because of the risk that local authorities would contract out services to for-profit companies offering the lowest price (Gulbrandsen 2012).

The difficulties experienced by the traditional non-profit service providers were addressed by both the center-right coalition government, led by Bondevik (2001-2005), and the red-green coalition government that came into power in 2005. The Bondevik government passed a procurement provision which was later included in the new regulation of 2006 (anskaffelsesforskriften [procurement regulation] 04-07 no 402 § 2-1(3), Lovdata 2006). The new provision explicitly stated that *the full procedure of the EU procurement Directive does not apply for the award of contracts for health and social care services provided by non-profit organisations*. Accordingly, local authorities in Norway are free to make agreements with non-profit care providers without being obliged to advertise their requirements on the national database for public procurements (Doffin) and without having to use competitive procurement procedures. This clause was regarded as ground-breaking for non-profit organisations’ role in public welfare and was an important reason why the City of Oslo decided not to proceed with their plans to put out to competitive tender services previously provided by the City Church mission. The willingness of the red-green coalition government to strengthen the position of non-profit organisations was demonstrated recently (3 October 2012) when a collaborative agreement was signed between the Government, the association of NGOs in Norway (Frivillighet Norge) and employer organisations (Virke and KS).⁷⁹ The parties have committed themselves to collaborating for the improvement of service quality

⁷⁹ For the text of the agreement, see:

<http://www.regjeringen.no/upload/FAD/Vedlegg/Konkurransopolitikk/Anskaffelser/Samarbeidsavtale.pdf> (in Norwegian).

and diversity and for the recognition that values-based organisations need to be able to plan and operate autonomously and in the long-term.

This agreement between authorities and the NGO sector holds promise as a new way of ensuring long-term collaborations. However, it does not rule out the fact that local authorities are free to plan and organise services the way they want. They are still free to tender out care services and to make shorter term contracts.

4.2 Employees' rights

An important aspect of competitive tendering concerns employees' rights – how people are treated if the competition for service provision is won by a private provider. The rights of workers under these circumstances are regulated by the Norwegian Working Environment Act (17.06. no 62) chapter 16, which is based on EEA agreements aimed at avoiding a worsening of working conditions for employees when local authorities transfer services from one provider to another (especially from public providers to private providers). It is expected that a new employer will open a dialogue with employee representatives as early as possible. Although new employers may find new ways of working, they are not allowed to fire existing employees or to offer them a lower salary. However, as wages are regulated by collective agreements every second year, the opportunity for new employers to change agreements will occur after a while (two years maximum). The option then exists for both downgrading and upgrading wages. For example, the new employer is allowed to use wages to attract specific workers (Mastekaasa 2008); as a consequence the wage differences between experts and routine staff may increase.

It is important to note that employees' rights to pensions are not transferred to a new employer. Due to substantial differences between public and private agreements on pensions, this provision is of great significance for employees whose employers change from being a public (or non-profit) provider to a for-profit company. Whereas public sector pensions are fixed on a rather high level (66% of earnings) private sector pensions are more flexible; that is, they do not guarantee a fixed level of pension. Because of their long-lasting collaboration with local authorities, non-profit organisations have agreed that they will offer employees the same pensions as in the public sector.

4.3 Regulations concerning staffing level and quality

Concerning the latitude of local authorities to enter contracts with private providers, there are not many restrictions relating to staffing level. According to the act on nursing homes and facilities with 24 hours service (Act-

1988-11-14 no.932 § 3-2), nursing homes are required to have a medical doctor and a registered nurse on hand around the clock. Apart from that, national guidelines are general guidelines requiring that the nursing home has 'sufficient staffing' and 'professional staffing', such as registered nurses and auxiliary nurses (Harrington et al. 2012). The Norwegian Healthcare Workers Act states that health care providers should be 'organised in a way that enables health care staff to fulfill their statutory duties' (Act-1999-07-02 nr 64 § 16). In short, the national guidelines do not make very detailed requirements on staffing levels.

As mentioned earlier, local authorities are required to provide services of sound quality and it is mandatory to have a system of internal control. These requirements are closely linked to the quality regulation of 2003 (Ministry of Health and Care Services 2004). The regulation addresses all agencies that provide long-term care, including private organisations and companies. The regulation states that services should be given in a timely fashion and planned in a way that assures coordinated care and continuity of care. The regulation provides a list of fundamental needs which service providers should attend to, for instance, the need for self-management, for rest and privacy, and for community and relationships. However, in line with the principle of internal control, the quality regulations focus attention on procedures rather than on outcome measures. The regulations require that written procedure are in place, but it is unclear how many procedures and how detailed these written procedures should be (Vabø 2002). The Norwegian health authorities recommended that local authorities would be wise to integrate their internal control systems within a more comprehensive quality system, though this larger system may be designed differently by different local authorities.

The internal control routines vary quite a lot from one local authority to another, both in terms of frequency and content. Inspection visits in the care sector of Bergen, for instance, focus on four main target areas spelled out in an electronic report and internal control system called 'the balanced score card' (styringskortet). The four areas: (1) 'users/residents' ('brukere'), (2) 'work procedures' ('arbeidsprosesser'), (3) 'staff' ('medarbeidere') and (4) 'economy' ('økonomi'). 'The balanced score card' system has the threefold function of providing a grid for all public care providers for: (1) delivering an annual report to the municipal authorities, (2) self-monitoring, and (3) guiding inspectors during the annual municipal inspection in which three inspectors visit each institution or organisation for a full day. Based on the above mentioned four target areas, eight aims are stated: (1) to take care of the basic needs of the patients; (2) to provide patients with knowledge of their own health status and possible changes in their health status; (3) to ensure a high degree of user participation in the planning of daily activities ; (4) to ensure good interaction with the municipal administration and the work organisations; (5) to have a competent and committed staff; (6) to provide an inclusive and secure working environment; (7) to ensure that

ethical reflection characterises the services of each institution; and (8) to provide good financial management.⁸⁰ Self-reporting from the management of each institution on subscales related to each of these eight aims provides the foundation for measuring and evaluating performance, both by the institutions themselves and by the municipal authorities. While the ‘balanced score card’ system is mandatory for all municipal service providers in Bergen, it is optional for private institutions. However, all long-term care providers, both private and public, are subject to annual inspections. While the inspection visits in Bergen are less formalised and complex than in Oslo, several other local authorities have even less extensive and less frequent inspections.⁸¹

The Norwegian Board of Health Supervision (Statens helsetilsyn) is responsible for monitoring and oversight of care services – to ensure that health and social services are provided in accordance with national acts and regulations. Monitoring and oversight are mainly based on regular system audits, but also include spot checks based on complaints, suspected breaches of the law, and nationwide investigations into specific prioritised areas (in 2010, for example, eldercare was included among other services). Between 2009 and 2012, special efforts were made to test and develop new methods of monitoring of services for the most vulnerable and frail older people. During this project, local authorities have been encouraged to use the results of monitoring as a basis for their work on quality improvement.

5. The scope of private provision

Figures from Statistics Norway (SSB) indicate that 6.6% of working hours (full-time equivalent employees) in the care sector are provided by private actors (SSB 2012c) and ‘services purchased from private actors’ amount to 8.1% of the total costs in the sector (SSB 2013). These data do not, however, make any distinction between for-profit and non-profit care provision. In this section we aim to describe the complex mix of public and private providers and, in particular, the scope of new private for-profit providers entering the scene after the trend of competitive tendering started in the late 1990s. To what extent have local authorities in Norway tendered out services and opened themselves up to having nursing homes and home-based care provided by private for-profit companies?

⁸⁰ See:

https://www.bergen.kommune.no/bk/multimedia/archive/00127/Presentasjon_av_ald_127700a.pdf (in Norwegian)

⁸¹ Rune Eidset, senior consultant Bergen municipality, personal communication 24 August 2012.

5.1 The complex mix of private providers in the nursing home sector

In current debates on eldercare, ‘private nursing home providers’ are mainly associated with the recent trend of competitive tendering and with a new category of commercial care companies most of which are subsidiaries of large international corporations. However, it is important to be aware that local authorities in Norway have collaborated with private nursing home providers for many decades. Norway has longstanding traditions of private, non-profit welfare provision, including nursing home provision. Local authorities have ‘old’ agreements with a range of single associations and foundations and with bigger non-profit organisations such as the Church City Mission (Kirkens bymisjon) and Norwegian Female Volunteers (Norske Kvinners Sanitetsforening). Today the Church City Mission runs five nursing homes and Norwegian Female Volunteers runs seven nursing homes on a basis of general agreements (Econ 2007).

The traditional collaboration with private providers also includes a restricted number of small family businesses or limited companies. Fagertun nursing home, situated in a rural area outside Oslo, is a telling example of the latter. Originally, in 1917, the building that houses the nursing home was used as a boarding house, Fagertun pensionat. In the 1960s, after the owner of the boarding house had been approached by civil servants from Oslo city administration looking for suitable locations for nursing homes, the boarding house was turned into a nursing home. Some of the traditional commercial companies like Fagertun are still running nursing homes, although others were closed down shortly after the turn of the century (Dahle & Bjerke 2001, Econ 2007).

In addition to the three different categories of private providers, – new for-profit companies, non-profit providers and traditional commercial providers (see Dahle & Bjerke 2001) – a fourth category may be added, the ‘public commercial’. Some municipalities, like Oslo and Moss, have chosen to set up a *municipal company* in order to come closer to the ideal that private and public providers should compete on *equal* terms. This is accomplished by creating a public provider that is clearly separated from the public authority.

It is hard to quantify the complex mix of nursing home providers. Figures from SSB indicate that the share of beds in private residential care facilities has remained quite stable during the last ten years (SSB 2012c). But again, these figures do not tell whether the mix of private providers has changed. Most likely new for-profit providers have increased slightly (see below) whereas some of the non-profit providers have handed over the responsibility for service provision to the municipality (see for instance Econ 2007).

Statistics on income in nursing homes from the Confederation of Norwegian Enterprise (NHO 2011) suggest that, in 2010, 89.9% of turnover was related to public providers, 4.2% to for-profit companies and 5.9% to

non-profit organisations. For-profit companies cover both the traditional family companies and the new international corporations. The share of new commercial providers had been increasing, but it has declined since 2011 due to the Adecco scandal (see below). Estimates made by The Enterprise Federation of Norway (Virke), which represents non-profit employers in the nursing care sector, indicate that the number of nursing homes run by non-profit providers is approximately 6% (70 nursing homes) (Borgen 2011). The Confederation of Norwegian Enterprise (NHO), which represents the for-profit employers in the nursing home sector, estimates that among 1040 nursing homes 80 are run by non-profit and 20 by for-profit providers. That corresponds to 8% non-profit and 2% for-profit (NHO 2012:9).

It may be worth noting that these figures reflect the national total, including a great number of small rural municipalities with only one (public) nursing home provider. However, a closer look at the pattern of nursing home providers in specific cities in 2007 reveals that the role of private providers may be more significant on a local level in some places (Table 2)

Table 2. The public/private mix in three Norwegian cities in 2007, number of nursing homes in different forms of ownership

	Public	Public companies	Non-profit	New for-profit	Trad-for-profit
Stavanger	10	–	9	1	–
Trondheim	22	–	4	–	–
Oslo	32	3	13	5	5

Source: Econ 2007.

The different categories of nursing home providers are (at least to some extent) characterised by different kinds of engagements between local authorities and providers. Originally both non-profit and family companies operated nursing homes based on a general agreement with the relevant local authority. These agreements have to a large extent been renewed continuously.

As competitive tendering was introduced in the late 1990s, new forms of engagement between local authorities and providers were introduced, based on contractual management rather than on general agreements. In line with the present procurement regulations this meant that more detailed contracts were set up between purchasers (local authorities) and providers. It is however important to note that the level of detail varies. In Oslo, the new terms of engagement were felt to be more cumbersome than expected, whereas contracts in Trondheim were more flexible (Nesheim & Rokkan 2004).

‘Traditional’ and ‘new’ private providers also differ regarding real estate ownership. Whereas ‘traditional’ private providers (both non-profit and

for-profit) normally own the nursing home building, new private providers (so far) are contracted to provide nursing home services in nursing homes owned by the local authority. Dahle & Bjerke (2001) found that 90% of Norwegian nursing homes were owned by local authorities, 7% were owned by non-profit organisations and 3% by (traditional) private companies.

5.2 Contracting out – an uneven development

Contracting out nursing home services started in the late 1990s. By the turn of the century seven nursing homes from five municipalities⁸² had been contracted out and 35 actors had made a bid – 26 new commercial companies, one traditional commercial company, three nonprofit organisations and six municipal companies (Dahle & Bjerke 2001). Among the seven tendering processes, five were won by new commercial companies and two by a municipal company. One other municipality (Asker) contracted with a commercial company (ISS) to run a newly built nursing home without a proper tendering process, but based on an agreement that at the nursing home would be run with 20% lower costs than public nursing homes) (Dahle & Bjerke 2001)

A recent report found that 47 calls for tender for altogether 29 nursing homes have been made by 15 municipalities between 1997 and 2012 (Herning 2012). The majority of contracts (38 in all) have been awarded to (new) for-profit companies and five have been awarded to municipal companies. Only one contract was awarded to a non-profit organisation and three tender processes were closed down and no awards were made. In 2012, 15 of the nursing homes were run by for-profit companies, 13 were in municipal hands and one was closed down (Herning 2012, appendix 2).

After the first rounds of tendering, it was commonly believed that the number of private for-profit companies would increase steadily. However, the process has been slow and uneven. A report commissioned by the Enterprise Federation of Norway (Virke) (Econ 2007) found that three of the five pioneer municipalities (Trondheim, Moss and Kristiansand) had returned to municipal provision only. Still other cities tried competitive tendering, for example Bergen, Stavanger and some of their neighboring municipalities. By 2007, 19 nursing homes had been contracted out following competitive tendering (Econ 2007). However, during spring 2011, after the so-called Adecco scandal, the number of (new) private for-profit contractors fell from 19 to 15. The scandal began with revelations by Norwegian Broadcasting that employees at Ammerudlunden nursing home in Oslo had worked 84 hours a week without overtime pay, and slept in beds in the basement of the building. As the scandal spread to other nursing homes operated by Adecco, the

⁸² These were Oslo, Bærum, Trondheim, Kristiansand and Moss.

company lost contracts with other municipalities. The company ended all of its operations in the care sector in 2011.⁸³

As far as we know, in 2012, only 15 nursing homes were run by private for-profit companies following a tender process. Nine nursing homes earlier run by new private for-profit companies have returned to municipal operation (Herning 2012). However, from announcements on public procurements (Doffin) and from statements made by local authorities in newspapers, new rounds of tendering are planned. The City council of Oslo has decided that eight more nursing homes will be put out to tender during the next three years.⁸⁴ This suggests that the Adecco scandal did not change the position held by right-wing politicians that competitive tendering will ensure ‘value for money’ in eldercare. Hence, the numbers of private providers is likely to increase in the near future.

The 38 for-profit contracts mentioned above were won by 11 different companies during the period 1997-2012. However, today there are fewer for-profit companies. New for-profit nursing homes currently operating in Norway are dominated by *four* large companies.

Aleris Omsorg AS is currently operating *six nursing homes*. The company is owned by Investor, a Swedish investment company owned by the Wallenberg family.

Attendo Norge AS is currently operating *three nursing homes*. The company is owned by Attendo Care AB, which is a Swedish company. Attendo Care AB is, in turn, owned by IK Investment Partners, which is a Swedish private equity firm.

Norlandia Care AS is currently operating *three nursing homes*. The company was owned by private equity from 2007 to 2011, but was in 2011 purchased back by the founders of the company, Kristian and Roger Adolfsen.

Unicare Omsorg AS is operating one nursing home (and provides home care to 11 districts in Oslo). The company was owned by the Swedish company Carema AS until 2011, which in turn was owned by Ambea AB.

The four ‘new commercial’ companies have gained the right to run nursing homes, not only by winning tenders themselves, but also by purchasing other private companies that had a contract for operating nursing homes. This indicates that restructuring and acquisitions within the industry seem to be the norm rather than the exception. Herning (2012) finds that in 33 of the 38 contracts the company that has been contracted had been acquired and/or restructured during the contract period.

⁸³ See: <http://www.newsenglish.no/2011/08/03/adecco-scandal-costs-firm-millions/>.

⁸⁴ Østlandssendingen 22 June 2012, see <http://www.nrk.no/nyheter/distrikt/ostlandssendingen/1.8215868>.

5.3 Private for-profit provision in home care

In Norway, home-based care has traditionally been segmented into two different services which provide overlapping types of support – on the one hand there is *home help* which involves domestic tasks (cleaning, laundry, shopping and preparing meals) and social support and, on the other hand, there is *home nursing* (around the clock) which also involves personal care, including bathing, managing bodily functions and preparation of meals. Some home care agencies also offer psychiatric nursing and/or intensive care nursing for people with severe and unstable health conditions. Home nursing is free of charge, whereas local authorities are relatively free to charge people for home help, although user fees are not supposed to exceed full costs and low income earners (that is, people at the lowest pension level) should never pay more than NOK 150 per month (approximately 20 Euro).

Following the reform track of the late 1980s (described earlier), many local authorities made efforts to integrate home nursing and home help (Solem & Høistad 2000). However, after entering the NPM trajectory of reforms a few years later, some (mainly large) municipalities reversed this process in order to bring in competition from private home help providers. The recommended, and presumably the most common, way to invite private providers to compete for home help provision was to invite them to be a part of a free choice system, not to tender out services *en bloc* (for instance in a certain geographical area). It was argued, in guidelines drawn up by a collaborating group of municipalities and published by The Ministry of Local Government and Regional Development (2004:41), that a free choice system requires that services are easy to delimit, to put a price on, and to control. Therefore the free choice system was regarded as being better suited to domestic services than to professional services like nursing care which were seen as more complex. This recommendation is rather contrary to the recommendations of the mid-1980s reforms, as it stresses that local authorities should cultivate home help as a domestic service distinctive from home nursing, rather than blurring the distinction between home help and home nursing and encouraging collaboration.

Agreements set up in the free choice model (between local authorities and private home help providers) are normally based on a tender process. In the tender process, private providers are required to document certain qualifications and to agree to standards and procedures and control routines as determined by the local authority and set out in the announcement of tender. This means that the local authority has a restricted number of providers in the choice model. Agreements may be made concerning a maximum number of customers, but private providers have no guarantee that they will get a minimum number of customers. People in need of care are expected to vote with their feet, that is, to choose what they believe are the best service providers

and leave those they perceive to be not good enough, on the assumption that competition drives up quality.

Whereas competitive tendering may often be used as a means to lower costs, the free choice model is regarded a way to win the favour of customers. The model has been introduced as a quality reform. Despite the positive image of the model, the majority of Norwegian municipalities still seem to rely on municipal providers only. Uptake of the model has been slow and uneven. By the turn of the century only two municipalities had introduced the free choice model – Oslo and Bærum (Edebalk & Svensson 2005). Today, only a few more municipalities have free choice of home help, including Bergen, Stavanger and Kristiansand. The aforementioned survey among deputy mayors in charge of municipal service provision found that 92% reported relying on public home help provision only (Deloitte 2011). The exact number of municipalities with a free choice model is, however, difficult to establish, partly because the system has been introduced and then abandoned in some municipalities (Haukelien, Møller, Vike 2011) and partly because the label ‘free choice’ may be used differently by different municipalities (it may or may not mean that private providers are part of the system).

Nevertheless, the total share of services purchased from private providers in the home care sector is small. Based on data from KOSTRA, Hermansen (2011) reports that 4% of home care services were purchased from private providers in 2003, rising to 6% in 2009. Statistics from The Confederation of Norwegian Enterprise (NHO) indicate that only 3.4% of expenditure on home care (domestic care) is paid to private providers (NHO 2011).

Most municipalities have restricted their free choice model to home help (domestic tasks). However, Bergen (in 2010) and Oslo (in 2011) have recently extended the model and invited private companies to also compete for contracts in home nursing.

6. Marketisation – a contested issue

With the trend of marketisation in eldercare in Norway, eldercare issues have become increasingly contested. Whereas eldercare policy had earlier been characterised by a general party-political consensus, questions concerning competitive tendering, or ‘putting grandma out to tender’, fueled a dispute between right and left wings in politics (Vabø 2012, see also Bay 1998, p. 292).

Efforts to increase the use of market mechanisms in Norway have been met with fierce resistance fronted by a large and well-organised labour movement. The most central actor is the Norwegian Union of Municipal and General Employees, *Fagforbundet*, a powerful union with more than 330,000 members. It has put this issue on top of its political agenda.

Fagforbundet's top priority is to halt privatisation, but it will also fight most measures related to NPM.

The stand of Fagforbundet is strongly opposed by the right wing parties and the Confederation of Norwegian Enterprise (NHO) who advocate that a larger share of grants for eldercare should be channeled through private provision and free choice. In this debate, the NHO has fought Fagforbundet's stance through campaigns that target the public and local authorities. For instance, since 2010, they have undertaken 'best practice analyses' for 200 municipalities, using the publicly available statistics (KOSTRA) (NHO 2013). Their analyses indicate that municipalities willing to tender out services could expect considerable cost savings – up to 25%. According to NHO, Norwegian municipalities would be able to save 18 billion kroner if they tendered out services. The reports from NHO received a lot of attention in the local media around the country where local right wing politicians used them to push the agenda for privatisation of services. In 2013 new, updated reports were released, indicating that NHO was pleased with the effect of the campaign.⁸⁵

The debate that followed the NHO's publication of these reports illustrates what is probably the most central feature of the Norwegian dispute over privatisation: the fight to define reality. Fagforbundet responded immediately to the reports from NHO by holding public meetings and publishing their own report deconstructing the facts and figures used by the NHO.⁸⁶ Fagforbundet has also taken the initiative in the debate by calling attention to reports and producing articles outlining the negative impacts of marketisation (Fagforbundet 2010, 2012, 2013). In this very public debate, all statements on privatisation are hotly contested, no matter who, or what, the source of information is.

Fagforbundet and NHO are not the only participants in this debate. On both sides of politics there are various outspoken voices. One important player emerged in 1999, when a broad alliance was established with the aim of joining forces against privatisation, deregulation and market liberalism. The alliance was labeled 'Campaign for the Welfare State' (For Velferdsstaten, see www.velferdsstaten.no) and involved six unions, including Fagforbundet. A year later, 20 national organisations (user organisations, student organisations, farmers- and small-holder unions etc.) had joined in. The alliance works systematically to raise awareness around marketisation issues in general and by monitoring marketisation trends in various forms of public service provision, including eldercare and other types of health and social care. The strategy of the alliance is based on consciousness raising through

⁸⁵ See: <http://www.nhoservice.no/article.php?articleID=2310&categoryID=235> (in Norwegian).

⁸⁶ See the report: <http://demokratiskstyring.no/2011/04/fagforbundet-mot-privatisering/> (in Norwegian)

information rather than through slogans, and on working from below with trade union representatives rather than lobbying in the parliament.⁸⁷

6.1 The union response. Alternatives to competition?

As the NPM reform trajectory gained momentum in the 1990s, the unions felt the need to come up with constructive alternatives because they saw that if they were simply seen as arguing against change, they would have little impact. The most prominent result of the search for alternative development strategies is the Model Municipality Experiment. This was based on a basic view that there is a close link between working conditions and conditions for good services. The idea was that skills, knowledge and initiatives from ‘below’ could contribute to enhancing cost-efficiency and quality – cooperation and not competition would produce better, more cost-effective services. The project was initiated by the Norwegian Union of Municipal Employees (which, after a merger in 2003, became Fagforbundet) and was carried out in ten municipalities from 1998 to 2003. Both the centre-right coalition and social democratic governments contributed funding. When the current red-green coalition government took power in 2005, they collaborated with Fagforbundet, all other public sector unions, and the Norwegian Association of Local and Regional Authorities (KS) to establish the ‘Quality Municipality Program’ that ran from 2006 to 2010. This time, 138 local authorities used the same basic principles as the Model Municipality Experiment to develop their services. In 2011, the same parties agreed to renew the program, now called ‘Together For a Better Municipality’, and it will run from 2012 to 2015. Currently 110 local authorities participate in the program, and more are expected to join. Both the Model Municipality Experiment and the Quality Municipality Program have been found to have positive, but modest, effects in evaluations commissioned by the Ministry of Local Government and Regional Development (Kommunal- og regionaldepartementet) and carried out by the recognised research centre NIBR (Skålnes et al. 2002, Hovik et al. 2010). Fagforbundet has tried to export this methodology through the Public Service International federation, but with limited success.

It is difficult to assess what impact this approach may have in the long run for the development of Norwegian municipalities in general and care for older people in particular. However, some observations can be made. The project has served its purpose of giving the unions a practical alternative to competitive tendering. Furthermore, collaboration between the municipal workers’ unions and authorities has contributed to a distinctive political-administrative culture which seems to persist through shifts of governments.

⁸⁷ The alliance’s political platform is available here:
http://www.velferdsstaten.no/english/english/?article_id=42399.

Even though all collaborative initiatives involving government participation have been initiated by left wing governments, right wing parties have not actively obstructed the efforts when they have come to power. It is also important to note that some of the local authorities that have reported greatest success with this approach are led by right wing parties. The program has grown both in terms of the number of municipalities using it and the number of collaborative actors involved. Hence, it seems to have become firmly established in the governance toolbox used by local authorities in Norway.

7. Impacts of marketisation – also a contested issue

Given the limited experience of Norwegian municipalities concerning competitive tendering, it is not surprising to us that research into this topic has been rather limited. In our efforts to review existing research, we found a few master theses,⁸⁸ local evaluations and a number of reports commissioned by stakeholders or published from think-thanks associated with stakeholders. Most of the available publications have been contested, that is, they have been a target for disagreement. This explains why our discussion of the impacts of marketisation is based on limited empirical evidence with few, if any, firm conclusions. Instead, we primarily provide a description of the most central topics of contestation related to: (a) the quality of services from the perspective of care recipients; (b) the costs of marketisation; and (c) the working environments for caregiver staff.

7.1 The impact of marketisation on quality of care

What are the consequences of marketisation for service recipients? Do competitive tendering and free choice of providers affect the quality of services? Has the threat of competition had the intended effect of enhancing quality? Or, has the focus on cost saving actually reduced the quality of care?

These questions of quality are frequently asked in public debates and are often included in evaluations commissioned by local authorities. Norwegian researchers are, however, not able to answer them. Rather they have been inclined to question the question of quality itself, asking how can quality be assessed in eldercare? So far, the most comprehensive and significant research on the quality of eldercare services is the work of Britt Slagsvold (1995), which focused on the validity of quality measurements. She found that studies of the same object often came to different conclusions depending on which indicators were chosen. This finding raises important questions about the validity of both the selected indicators and the conclusions based on them.

⁸⁸ Karen Christensen is the supervisor of the theses by Andersen (2008) and Lie (2011b).

The low validity of quality measurement helps explain why researchers have tended to avoid the fundamental question of how quality is affected by different modes of governance. Nevertheless, the formalisation of quality requirements and quality standards is a necessary prerequisite when public services are tendered out (Nesheim & Rokkan 2004). Various measurements of quality constitute a basis for contracts and provide managers with information to be used for making decisions, for instance, concerning whether or not contracts with private providers should be extended.

In Norway, user satisfaction surveys are the most widely used instrument for measuring quality. In Oslo, for instance, user satisfaction surveys are conducted every second year. Findings from these surveys are used in benchmarking and associated service development as well as in public debates. User surveys have been criticised as lacking sophistication and because they tend to have rather low response rates (Romøren 2005). A report from Statistics Norway concludes that satisfaction surveys in Norwegian municipalities are often 'homemade' and characterised by several methodological weaknesses (Rolland et al 2005).⁸⁹ Some efforts have been made by KS to standardise these surveys and thereby to make cross municipal comparisons possible.

So-called 'objective' quality indicators, including outcome indicators like pressure ulcers or sudden weight loss, are used in quality assessments in all nursing homes in Oslo (but, as far as we know, in no other Norwegian municipalities). So far, no sophisticated research has been done to determine whether or not these outcome measures differ significantly between public, non-profit and for-profit nursing homes in the municipality of Oslo.

In the previously described KOSTRA system (Municipality-State-Reporting), quality is measured based on eight rather broad structural indicators (level of educated staff, sickness absence among staff, proportion of single occupancies, or the number of physician hours per week per resident in nursing homes, etc.), although *not* staffing ratio. Still, they represent the most comprehensive measurement at the national level and enable the monitoring of quality across municipal borders. So far, data has not been analysed with regard to the different modes of governance. In fact, data are currently aggregated at the municipal level. A working group from the Directorate of Health has recently advised that data should be disaggregated by organisation type.⁹⁰ Accordingly, data based on these quality indicators may be of great value for future research comparing the different categories of care provider.

⁸⁹ See <http://www.ssb.no/ssp/utg/200503/06/>. For a shorter article describing the main findings of the report, see: <http://www.ssb.no/offentlig-sektor/artikler-og-publikasjoner/kommunal-bruk-av-brukerundersokelser> (in Norwegian).

⁹⁰ See: <http://www.kvalitetogprioritering.no/cases-by-year/kvalitetsindikatorer-pleie-og-omsorg> (in Norwegian).

As mentioned earlier, the free choice model was launched as a quality reform. Service recipients are invited to vote with their feet, that is, to choose 'the best' provider and reject poor quality providers. Local evaluations of the free choice model tend to reveal that people appreciate the opportunity to choose providers. Still, a restricted number of people use this opportunity to choose a private provider. In Oslo, 25% of those who were allocated home-based services chose a private company and 14% changed to a private provider after their initial decision (Agenda Kaupang AS 2011). In Kristiansand (Kristiansand kommune 2012), 9% chose a private provider, while in other municipalities with a choice model (for example, Stjørdal) the rate was even lower. An evaluation of the free choice model in Oslo, based on a user survey (N=400), found that a majority of service users appreciated the option to choose. They reported that they get enough information to make a choice and the majority – slightly more among those who have chosen a private company – were satisfied with the choice they had made regarding the contents of services as well as, when this was taking place (Agenda Kaupang AS 2011). Similarly, a user survey in Bergen (N=418) found that more users with private services knew who their primary contact was. Still, in choice models, the local authority decides the amount and content of the services. This means that the empowerment of users is confined to the choice of provider. Critics have also argued that the contractual management inherent in the free choice model has limited the ability of care staff to respond to the complex and shifting needs of older people. Thus, the model has indirectly contributed to making home care work more predefined and taylorised (Andersen 2008).

Findings from user surveys run contrary to the findings of a smaller qualitative study aimed at giving a deeper insight into the way in which older people make their choices and decisions (Lie 2011a). While the user surveys seem to find improvements in services, the qualitative study reveals that new problems may arise – for instance, that people sometimes do not have the capacity to make a choice. The extent to which the most vulnerable old have the capacity to assume the role of active consumer must be investigated. As an example of the kind of problem that can arise, an advertisement from a care company in a Bergen newspaper announced that people can get home nursing services free of charge if they use their company as the home help provider. An opinion piece points to the confusion this type of marketing may create for older people who may not know that home-based-nursing care is always free of charge (Christensen & Wærness 2011).

One of the consequences of the free choice model is that the system provides the option for users to buy extra services. Of course, it has always been an option for people (who can afford it) to buy services from the market. However, the free choice model creates an incentive for well-resourced older people to 'top up' with extra services from the same staff.

In the aforementioned user survey for Oslo, 41% regarded the option of being able to top-up with extra services as important, but only 6% had actually taken this option (Agenda Kaupang AS 2011).

Future research should explore whether the next generation of older people will act differently when given the option of buying extra services from service providers. According to a study in which people aged 53 to 78 were asked about their future plans for buying services from the market, 80% reported that they might be interested in this (Brevik & Schmidt 2005). Although this study is only about future *plans*, it might still be an indicator of a growing interest in buying services out of one's own pocket.

7.2 The impact of marketisation on employees' conditions

When public services are tendered out, the employment and working conditions of employees may be affected in the process of transferring their employment from the public to the private employer. As mentioned earlier (Section 4.2), the *Norwegian Working Environment Act* to some extent protects workers who have their employment transferred. Still a company take over in the Norwegian care sector is generally associated with risk and uncertainty from the perspective of employees (Bogen 2011, p. 24), mainly because there is a risk that salaries and pension benefits will be reduced (see Section 4.2). The feeling of risk and uncertainty may be intensified by the fact that it is difficult for the local authority to control the contractors and their way of treating care staff. A company take over will also be associated with instability. If the contractor of a nursing home for some reason withdraws from the contract (Lie 2011a, p. 15), the local authority has to take back the operational liability (in Norwegian called 'rekommunalisering', see Herning 2012). From the perspective of employees, this means that they are thrown back and forth between different employers. Being contracted out means that management and working conditions may change regularly (for example, every fourth or fifth year).

In her master's thesis, Müller (2010) interviewed nursing home staff who had experienced multiple changes of employer – first from a municipal employer to a non-profit organisation, and then from the non-profit organisation to a for-profit company. Above all, this study demonstrates how the process of tendering can induce uncertainty, stress and worry among care staff. Some of the interviewees observed that getting used to new routines and ways of working can be time consuming and exhausting; others reported that they welcomed changes in work routines, but were not happy that changes in working conditions had become a constant part of the way their workplace was being governed.

Since the previously mentioned Adecco scandal in 2011, a focus on workers' conditions has become a recurrent thread in Norwegian public

debates on eldercare (Lloyd et al. forthcoming). Care staff of Ammerudlunden nursing home, fronted by the trade union Fagforbundet, have strongly objected to the plans of municipal authorities to tender out services again. Over the past ten years, *Midtåsen* nursing home, also previously run by Adecco, has been run by five different employers (including the municipality of Oslo). Staff turnover in this nursing home is reported to be high. After the recent plans made by the City government of Oslo to tender out services again, care workers at Midtåsen are protesting loudly. They have written a complaint letter explaining to politicians that their working environment is deteriorating, that several people want to quit their jobs, and that an already low quality of care is in danger of getting even lower.⁹¹

One commonly assumed impact of competitive tendering on workers' conditions is that it will put a high pressure on wages and the pace of work. Even though local authorities normally focus on quality as well as on price in their announcement of a tender (Bogen 2011, p. 8; Lie 2011a, p. 26-27), for-profit companies may, in order to be profitable, save costs in various ways. These cost-saving strategies are likely to have implications for staff members. The work may be intensified, the proportion of staff with the highest formal qualifications and/or seniority may decrease, and, finally, staff pension benefits may be reduced. However, we have found next to no research work on the actual impacts of competitive tendering on working conditions for care staff.

In their study, Dahle & Bjerke (2001) gave examples from the nursing home sector showing that some private companies offered lower pension disbursements than the municipal agreement which guarantees 66% of wage and demanded an increase in the time that part-time workers are required to work, for instance, 50% time as against 40% in public employment. Moreover, while the pension payment lasts for a lifetime in the public sector, for-profits may stop pension payment at a certain age (for example, at 82 years of age). Dahle & Bjerke (2001) also touched upon the question of working conditions in a case study of a nursing home run by a for-profit company. They found that working hours were reduced by 9% after the private company took over the nursing home. The company reduced the length of shifts and reorganised shifts so that people were working two shifts a day. A survey among the care workers indicated that a majority felt that their conditions in general had worsened (higher work intensity, inconvenient shifts and poorer pension agreement). However, a minority of care workers who had had a wage increase reported that both their conditions and the quality of care had improved.

We have already mentioned that the Adecco-scandal in 2011 was about working hour violations and a failure to comply with wage regulations for

⁹¹Read the letter here: <http://www.ivarjohansen.no/dmdocuments/midtasen23092011.pdf>.

overtime. However, shortly after the scandal the Norwegian left wing newspaper *Klassekampen* revealed that a municipal nursing home in Moss (near Oslo) had also violated the *Working Environment Act* (Bogen 2011, p. 21), prompting questions about whether such breaches of the regulations were a problem in the sector more generally and not related to a particular type of provider. The lack of unbiased research on systematic differences between for-profit and municipal provision of care services has created the conditions for a heated debate among stakeholders. The battle is fought in a range of arenas and the combatants employ a variety of strategies to argue their case. In fact, staff of private for-profit nursing homes went on strike in August 2012 demanding pensions at the same level as their colleagues in municipal nursing homes. Partially, this can be understood as part of a long ongoing effort of the unions to bring to light what they see as a discrepancy in working conditions between for-profit and not-profit providers.⁹²

A report by KPMG (2012) commissioned by KS found that the greatest risk for 'social dumping' is to be found in the municipal health and care sector when employees are recruited from staffing enterprises (also known as labour hire companies). The main risk is, therefore, not related to whether or not the employer is private or public, but whether or not the care worker is employed by the provider or through a staffing enterprise.

Research comparing public and private eldercare services should take into consideration that various forms of competitive tendering may also affect municipal service provision. We have earlier described how the strategy of organising home care shifted as local authorities implemented a free choice system. As home help entitlements became defined in terms of predefined tasks, other tasks were tacitly off-loaded. A master's thesis by Andersen (2008) demonstrates how the free choice model in Bergen changed the work of municipal home helpers profoundly. Home help services became narrowly defined as purely domestic services (mainly cleaning) and service tasks were fragmented and strictly controlled and limited by minutes estimated for each task. Senior home helpers in particular felt that the most central part of their work, namely caring for older people, was taken away from them.

7.3 The impact of marketisation on costs

The financial impacts of marketisation are difficult to measure. No doubt outsourcing can reduce expenses for the municipality, but the relevant issue is whether or not marketisation can limit the expenses of the municipality *without* any negative impacts on the quality of services or staff benefits. There is no consensus regarding the consequences of marketisation for

⁹² For more about the strike, see: <http://www.world-psi.org/en/norway-fighting-equal-pay-and-pensions>.

quality of service and conditions for employees, as such, it is difficult to make substantive conclusions about either the costs of the benefits.

One potential problem for the local authority is that it can only outsource the provision of services, but not its responsibility for, or obligation to, the citizens of the municipality. This may result in high unforeseen costs. There is one example from Oslo where, in 2001, a private provider won a three-year contract to run a nursing home, but withdrew from the contract after just one year, leaving a deficit of seven million NOK. The local authority had to clean up the mess and reportedly spent ten million NOK in the process (Eilertsen & Bjerke 2004). This example is by no means representative of private providers in Norway, but it illustrates how risks related to outsourced services cannot themselves be privatised.

However, a report from the municipality of Oslo, which is the city with most experience in marketisation, has found that, on average, for-profit providers are able to run their nursing homes more cost-efficiently than in-house municipal provision.⁹³ The municipality is, however, careful to point out the factors that make comparison difficult and, once again, the stakeholders are very much at odds when explaining the differences. Private providers cite entrepreneurial spirit and the effects of competition as the source of cost efficiency, whereas the unions claim that costs are lower in for-profit homes because benefits (especially pensions) and staffing levels are lower.

Another source of contention concerns the transaction costs associated with contracting out services. In a report commissioned by Fagforbundet (Asplan analyse 2005), it is estimated that transaction costs are between 5% and 10% of the cost of fulfilling the contract. An EU-report⁹⁴ from 2011 pointing out that Norway has higher transaction costs in public procurement than most EU-countries has further fueled the debate among local stakeholders. Unions claimed this was an argument for leaving more services to municipal in-house provision, while NHO argued that the transaction costs were a greater problem for smaller contracts, and not that relevant for nursing homes. As far as we know, no research has looked at this issue in a Norwegian context.

⁹³<http://www.sykehjemsetaten.oslo.kommune.no/getfile.php/Sykehjemsetaten%20%28SYE%29/Intranett%20%28SYE%29/Dokumenter/Kosnadstal%20eldreomsorgsinstitusjoner%202011.pdf>

⁹⁴ http://ec.europa.eu/internal_market/publicprocurement/docs/modernising_rules/cost-effectiveness_en.pdf

8. Discussion and conclusion

Over recent decades, several changes have taken place in Norwegian eldercare. Some of these changes have been influenced by the global wave of NPM reforms, in particular, by doctrines stressing disaggregation, purchaser-provider distinctions and various forms of performance management. Still, steps taken to bring in competition from private companies have been smaller than those taken by the neighboring Nordic countries. Local authorities in Norway have implemented soft versions of some of the instruments associated with NPM. For instance, a substantial proportion of local authorities take part in bench-learning through efficiency networks (a soft version of best practice/ benchmarking). But only a few local authorities have actually tendered out their care services, and most of those who have done so have tendered out a rather small portion of their total services. Hence, the scope of private for-profit provision is, at this point in time, minimal.

There is no straightforward answer to why Norway has been a 'laggard' in tendering out services. One part of the answer may be that the need for cost reduction has been lower in Norway than in Sweden and Finland thanks to the prosperous oil and gas industry. Whereas Sweden and Finland experienced an urgent need for cost reduction during the recession of the 1990s, efforts to reduce costs in Norwegian public eldercare have constantly been counterbalanced by a push to spend more of the country's oil wealth on municipal services (Vabø & Szebehely 2012).

Secondly, it may be argued that marketisation is mainly an instrument suited to densely populated areas (see, for instance, NOU 2000:19). Hence, since Norway covers a large geographical area, but has a small population scattered across 429 municipalities, its low density population may provide some 'natural' obstacles to marketisation. In fact, some municipalities strive to find even one provider of high quality care and small municipalities prefer to collaborate across municipal borders (Blåka et al. 2012). It should, however, be noted that NHO has argued against this idea and has lauded the recent decision taken by some smaller municipalities to tender out all of their care services *en bloc*.⁹⁵

Last, but not least, we believe that Norway's strong consensus culture and well-organised power of resistance are important reasons for the relatively moderate level of marketisation. One of the reasons why Norwegian municipalities did not follow the example of Sweden in the early 1990s was probably that they had just entered a reform trajectory based on more collaborative and trust-based modes of governance. In contrast to the disaggregation and contractualisation typical of marketisation, the reform ideas of the

⁹⁵ The small municipality of Austevoll has already done this on a 6 +2 year contract with one of the large corporations, Aleris. See:

<http://www.nhoservice.no/article.php?articleID=4253&categoryID=329>.

time encouraged local authorities to blur distinctions between different care service elements in order to promote a holistic view of service provision and to better utilise care staff resources. A collaborative and bottom up manner of reforming services was further developed through initiatives taken by the trade union of care workers, Fagforbundet. The trade union played an proactive and 'pugnacious' role in resisting the forces of marketisation and in finding alternative strategies for the improvement of services. The opposition of the trade union must be viewed in the light of the fact that pension schemes offered by private for-profit companies are considered to be less generous than pensions schemes in the public and non-profit sectors.

The Norwegian Labour party has generally been regarded as wavering in relation to NPM reforms, but in the run up to the 2005 election it decided to campaign on an anti-NPM 'ticket' (Christensen & Læg Reid 2007, p. 40). During their reign, the red-green coalition government has taken actions to stimulate greater non-profit service provision. They have arranged agreements between different stakeholders to ensure that improvements are made that will stimulate sustainable non-profit provision. Furthermore, the red-green government has also supported and extended the alternative approaches developed by Fagforbundet.

It is difficult to predict how these alternative strategies of reform will be balanced against marketisation in the future. Will the previously slow and uneven trend of marketisation pick up speed? Or will Norway continue to develop alternative, more collaborative ways of reforming services? After the general election in September 2013, it may happen that a new right wing government will make deliberate efforts to stimulate competition and private for-profit provision in eldercare. It is however unlikely that the efforts to strengthen the private non-profit sector will be actively *obstructed* by a right wing government. We also find it unlikely that changes in the national government will do away with all collaborative projects initiated by the trade unions at the local municipal level. After all, local governments have the ultimate responsibility for governing and organising care provision and evidence suggests that local decisions will often be governed by pragmatic considerations more than by dogmatic beliefs (or lack of belief) in market solutions. Hence, it may be hard for local authorities to turn its back on the participation and civic spirit of values-based non-profit organisations and active, committed care professionals. The crucial question is whether these collaborative initiatives will be recognised and supported as adequate ways of making improvements in service provision, or whether they will be silenced and overshadowed by a new trend of marketisation.

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Chapter 6

The regulatory trap: Reflections on the vicious cycle of regulation in Canadian residential care

Albert Banerjee

1. Introduction: the trap of regulating care work

‘Because the regulations are so byzantine they can’t afford to properly implement [them]. So homes aren’t being inspected with their comprehensive inspection protocol. The level of detail is coming back to haunt them...It’s a big flop’.

— *Key informant discussing Ontario’s new Long-term Care Quality Inspection Process (LQIP).*

Although the marketisation of welfare services is a relatively new phenomenon in the Nordic context, it has a much longer history in Canada. One of the effects of marketisation, particularly in the context of long-term residential care for older Canadian citizens, has been a reliance on the regulation of care work as a means of ensuring that the imperatives of profit-taking do not compromise quality. However, these regulations have not generated the conditions for good care nor have they succeeded in creating safe and effective workplaces (Jansen 2011; LCTF 2012).

Rather what we have witnessed in provinces such as Ontario, which presently has the highest proportion of for-profit provision of residential care services in Canada, is a cycle of media scandals, third party investigations and the development of increasingly complex regulatory processes (CUPE 2009; Struthers 1997).⁹⁶ Furthermore, these regulations have not succeeded in mitigating capital’s power or tendency towards concentration. They have, instead, directly contributed to its concentration through the growth of large corporate chains and the development of a strong for-profit lobby group (Baum 1999). The growing power of for-profit providers has limited the state’s ability to direct the sector (Harrington et al. 2012; Tarman 1990), and thus government has increasingly resorted to regulating, monitoring and measuring care in an attempt to secure trust and quality.

⁹⁶ Ontario is also the most populous province in the country with 12.9 million citizens.

The result is that long-term residential care is presently the most highly regulated of the health and social care sectors in Canada. In some provinces, levels of regulation have become burdensome. The proliferation of regulation in Ontario, for instance, has prompted the Ombudsperson to initiate an inquiry, noting that ‘compliance staff must apply over 450 standards during inspections’ resulting in considerable ‘inconsistencies’ (Marin 2010). The province of Ontario has also recently completed an overhaul of the regulatory process, with the aim of instituting a more ‘person centered’ approach to accountability (MoHLTC 2010). However, by failing to address the complexity of current regulations, inspections are already years behind schedule (Welsh 2012).

This vicious cycle of regulatory failure leading to further and more detailed regulation is what I term the ‘regulatory trap’. The aim of this paper is to explore some of the causes and consequences of this trap. Specifically, I argue that the regulation of care work is *paradoxical* in that not only does it increase the workloads of already understaffed care workers but it restricts their autonomy and flexibility making it more difficult to provide good care. What’s more, I argue that regulation of care work is *ideological* because it operates in a reductive fashion, focusing on specific problem areas and proposing relatively simple technical fixes. In doing so, the regulation of care work diverts attention from challenging political questions such as the allocation of resources, the role of the state and the place of for-profit corporations in the provision of welfare services.

My reflections in this paper draw largely on Canadian research and are also informed by interviews and observations conducted both in Canada and Sweden as part of a major international study of promising practices in long-term residential care.⁹⁷ It is my hope that this analysis – and the Canadian experience with regulation more generally – may hold cautionary lessons for Nordic Europe and in, particular, for those governments that presume the challenges of marketisation can be solved through regulating care.

2. The paradox of regulation: tensions between regulation and relational care

While the regulation of care work is intended to secure a basic level of quality, research suggests that such regulation can make it more difficult to pro-

⁹⁷ The Canadian component of this research was funded by the Social Sciences and Humanities Research Council’s Major Collaborative Research Initiative, ‘Re-imagining Long-term Residential Care: An International Study of Promising Practices’ as well as a Canadian Institutes for Health Research postdoctoral fellowship. The Swedish component of this research was funded by the Swedish Council for Working Life.

vide relational care (Leach & Gillian 2011). Such regulation not only adds an additional workload component through the need to continually document tasks, as Armstrong notes in this report, but it also transforms the work of care.

In Canada, as in many other jurisdictions, there has been a growing move away from clinically focused, task-based approaches towards more person-centered forms of care. This transformation, which often goes under the rubric of ‘culture change’, is oriented towards the provision of holistic care, taking into account residents’ social, emotional, spiritual desires as well as their physical needs (Weiner & Ronch 2003). Culture change typically requires workplace transformation to enable greater care worker autonomy and flexibility (Cohen-Mansfield & Bester 2006). Central to the culture change movement is a recognition of the importance of relationships – not only as an outcome of good care but also as a method through which knowledge is produced and care provided. As Angelelli (2006, p. 428) explains: ‘preferences of elders and their hands-on care partners are realised *in relationships*, and decision making and self-direction proceed from there’ (italics in original). However, despite the fact that person centered care is widely accepted as preferable to task-based approaches and despite, in some cases, decades of effort to redesign organisations and labour processes to make them more supportive of care worker autonomy, the transformation of residential care facilities has proved to be more challenging than expected (Leutz et al. 2010, p. 340).

One reason for this difficulty is the reliance on the regulation and documentation of care work as a means of ensuring quality. Grounded in rules and standardisation, the regulation of care work does not empower care workers to make decisions nor does it grant them the flexibility needed to meet residents’ immediate needs and desires. Rather, ‘regulation drives routinised care’, as one manager of a highly reputed Canadian facility noted.⁹⁸ She went on to elaborate:

The harder we try and regulate, the more restrictive and routinised the environments become....You create duty lists, and then you are going to say: At 0700 you’re going to come in and have report. At 0730 you are going to start in room one and work up to room eight to get people up, because it is required that they be in the dining room for breakfast.

Surveys of residential care workers support this assessment. Many care workers described residents being ‘pushed through daily routines like an assembly line’ (Armstrong et al. 2009, p. 109). Another care worker in the same study explained the effect of regulations this way: ‘I fear that our care is in danger of becoming assembly line nursing due to government demands

⁹⁸ Site selection interviews, ‘Reimagining Long-term Residential Care: An International Study of Promising Practices’, Pat Armstrong, York University, Principal Investigator, 2012.

and lack of government funding, lack of time to care properly for our residents; not just their physical needs but all aspects of emotional care too' (Armstrong et al. 2009, p. 109).

Thus, rather than fostering partnerships between residents and care workers to determine the care to be provided, regulations tend to alter the organisation of caring labour, constituting it as the completion of tasks, which can be predetermined, standardised and then documented. This approach does not ensure quality, as the care workers above point out, so much as the mass production of bodies and a factory-like environment.

There is also an inherent tension between regulation and the psychological, emotional, spiritual dimensions of care, which are not easy to quantify nor to document as required by prevailing compliance measures. Thus, while it is possible to quantify and document how many baths a resident should receive a week, it is very difficult to regulate *how* that bath will be given. Will it be conducted in a compassionate manner? What will the quality of conversation be? And how will the resident's dignity be respected in the performance of this intimate act? Such tensions between regulation and relational dimensions of care are frequently noted by care workers. Taking the example of dining, one care worker observes: 'There is no consideration given for the residents' enjoyment of their meal, all they care about is the order in which food is served and that it is done properly' (Banerjee 2010, p. 229). Another care worker in the same study expresses the tension this way: 'It's not the food or personal care they appreciate most, it is the time you spend with them – even if it is a simple hug or a listening ear. Most days there is inadequate time to do so, as we are constantly focused on ministry needs and policies under the watchful eyes of management' (Banerjee 2010, p. 231).

3. The ideology of regulation: individualising problems with care

As Tarman (1990) notes in her history of long-term residential care in Ontario, the problem of poor quality care has been framed primarily in terms of insufficient regulation and inspections. This, she notes, has directed attention away from political questions of resources, ownership and the inherent tension between the profit motive and care. While she names the appeal to regulation as a form of 'symbolic politics', engaged by the state to placate both the nursing home industry and a concerned public, this doesn't explain why independent bodies so often look to the regulation of care work as a solution to quality problems. Regulation, it would appear, is more than a form of symbolic politics. It has become ideological, in the sense of seemingly natural and unquestioned way of thinking about and responding to

problems around the quality of care – one that leaves resources, structures and political issues unaddressed.

The recent and influential report, *The Best of Care*, released by British Columbia's Ombudsperson, Kim Carter (2012) offers an illustration of the ideological role that regulations play.⁹⁹ This report is the second in a multi-year investigation into senior's care and focuses on the residential care sector. The framing of the inquiry is worth noting, for it unfolds within a model of what has been termed the 'new regulatory state' (Braithwaite 1999). This is a view of the state as having a limited role in welfare service provision, concerned largely with facilitating consumers' access to information as well as monitoring and regulating service providers. Thus, despite the province's large involvement in the funding, organisation and delivery of care, the government's responsibility for social service delivery is not foremost in framing the Ombudsperson's agenda. Delineating her scope of inquiry, she writes: 'On August 21, 2008, I initiated a province wide investigation to look at seniors' care, with a specific focus on issues of access to information, access to services, quality of care, standards of care, monitoring and enforcement, and complaints processes' (Carter 2012, p. 2).

Within the conceptual framework of a regulatory state we can already expect that regulations will play an important role in the Ombudsperson's thinking. But what is perhaps surprising is the degree to which quality issues have become conflated with regulation. Indeed, the section addressing 'Quality of Care' (pages 273-282) is entirely devoted to the regulation of care work. There is no other alternative imagined in terms of how the state might support quality provision and/or improvement. And from within a regulatory perspective, there is little attention paid to the conditions that support good care, with most of the attention going to the regulation of specific problems.

Structural issues such as staffing levels would seem especially important to consider given the Ombudsperson's findings (BC Ombudsperson 2012). For instance, she identified a number of areas that were of particular concern to citizens: bathing, dental care, call bell response times and toileting specifically. However, while noting the lack of objective standards and calling for better regulation of these specific areas, the problems as described in the report appear to have more to do with insufficient staff than the inadequate regulation of daily care. Consider: 'We heard...seniors had missed their weekly bath due to staff shortages' (BC Ombudsperson 2012, p. 274). 'Staff who contacted us said they don't always have time to assist with thorough daily oral hygiene' (BC Ombudsperson 2012, p. 275). 'Several of the residents require feeding at meal times...With only two aides available this is difficult' (BC Ombudsperson 2012, p. 278). Insufficient staffing was also

⁹⁹ British Columbia is the third most populous province in Canada with approximately 4.38 million people. It also has the third highest proportion of for-profit providers of residential care services, behind Ontario and Prince Edward Island.

evident in the problems raised around timely access to the bathroom, an issue central to residents' dignity and wellbeing: 'due to staffing levels, the residents are toileted at specific times only, so for my mother ... if she needs to go to the bathroom outside of her times, she ends up going into the diaper as she cannot possibly hold on' (BC Ombudsperson 2012, p. 275).

While the problems identified above are clearly associated with understaffing, rather than call for legislation supporting increased staffing levels or openly addressing the political, ownership and resource questions that are at the heart of inadequate staffing (McGregor & Ronald 2011), the section on quality calls for specific regulation around each of these problem areas. In is here that we witness the ideological work of regulation.

The regulation of care work operates with a reductive lens. Such regulation individualises problems and thereby is able to propose relatively simple technical solutions for each specific problem area, while missing their underlying structural conditions. Consider, for example, the problem with delayed call bell response times. Call bells are used by residents to alert staff when they have an urgent concern or need immediate assistance. They are, therefore, important for good care, and delays in responding can pose serious health and safety risks. Yet delays were common, as the Ombudsperson (2012, p. 277) observed: 'A number of people complained to us that it regularly took 15 to 20 minutes before they were responded to when they used a call bell, and sometimes they were not responded to at all'. Here too, one might surmise that structural conditions such as insufficient staffing were a factor in these delays. Nevertheless, the regulatory optic isolated 'call bell response time' as a discrete problem that could be quantified, monitored and fixed. Thus the Ombudsperson remarks:

It is surprising, therefore, that neither the ministry nor the health authorities have established standards on acceptable response times to call bells. Technology enabling the measurement of call-bell response times is available, and some facilities are already using it. Without objective data, it is difficult to determine the extent of the problem. It would be useful for health authorities to collect objective data about actual response times and use it to support the development of appropriate standards and guidelines. Once this is done, compliance with these standards can be monitored (2012, p. 278).

The problem is therefore relatively simple to address: set standards and monitor. Such regulatory 'fixes' are offered for each of the problem areas the Ombudsperson encounters. Each problem therefore has its own specific regulatory solution and, taken individually, the regulations proposed seem sensible. It makes sense to have a call bell monitoring system just as it makes sense to have a toileting and incontinence plan. However, if we consider the whole – and particularly the obviously understaffed working conditions – then such regulatory solutions break down. As they so often do in practice. Indeed, to regulate and monitor call bell response time in the con-

text of understaffing, means that this problem will be solved at the *expense* of some other form of care – likely the relational care that while so important to residents is by comparison difficult to measure and monitor. This tension explains the frustration of one British Columbia manager, when asked about the regulation of care work without addressing broader structural issues. As she put it: ‘It doesn’t make sense. It absolutely doesn’t make sense’.¹⁰⁰

4. The transformation of regulation: measuring rather than producing quality

As noted in the introduction, the Ontario Ministry of Health and Long-term Care has recently made efforts to address some of the limitations the regulatory and inspection process through the development of a new ‘Long-term Care Quality Inspection Process’ (LCQIP), which came into effect in the summer of 2010. One of the key features of the LCQIP is the incorporation of the RAI-MDS 2.0, an expert designed, standardised, computerised assessment tool that includes over 450 resident assessment measures (Hawes et al. 1997). By integrating this assessment tool, the ministry hopes to move towards a more resident centered and outcome oriented form of accountability. Moreover, the RAI has additional benefits, according to the Ministry. It is able to produce data that can, on the one hand, guide the formulation of individual care plans as well as, on the other hand, enable an institutional level analysis of quality. For researchers, as well, the data will be rich resource if made available.

However, as a means of regulating quality at the level of everyday practice, research has identified a number of concerns. The RAI has been criticised for its emphasis on clinical indicators and its corresponding neglect of the personal dimensions that are so important to the work of direct care (Kontos et al. 2010). Reliance on the RAI can therefore push care in more institutional, clinical directions and away from relationship-based approaches, while contributing to the further marginalisation of frontline care workers and the personal knowledge they rely on (Banerjee 2011).

Equally important, systems based on complex surveys, data input and analysis, are not responsive enough to address the rapidly changing environment of long-term residential care. Problems with care are time sensitive; they need to be identified and resolved rapidly in order to make a meaningful difference for the resident. In our interviews with care workers, and nurses in particular, we heard considerable dissatisfaction with the RAI,

¹⁰⁰ Site selection interviews, ‘Reimagining Long-term Residential Care: An International Study of Promising Practices’; Pat Armstrong, York University, Principal Investigator, 2012.

noting that it adds another layer of work while not making a corresponding impact on daily care.¹⁰¹

The separation that care workers note between the effort that goes into assessing and documenting care and the actual work of producing care can be understood as form of ‘decoupling’, which is one of the side-effects of the auditing process according to Michael Power (1999). Decoupling has the consequence of severing the link between the production of care and the power of the state. Decoupling is prevalent in Canadian residential care, and occurs at a number of points: when reporting of violence does not take place because workers’ fear they will be blamed (Morgan et al. 2008), when attendance at training sessions are inflated because workers do not have time to sit (Banerjee et al. 2012), or when what matters is that the documentation is completed not that it is accurate. Exemplifying such decoupling, in their study of the regulation of resident care in Canada, Leach and colleagues (2006, p. 48) observe that in order to complete the ‘amazing amount’ of documentation required, it has to be rushed. ‘You just do it fast’, explains one care worker in their study, ‘you don’t even know if anyone is paying any attention to that form anyways so it is just – check, check, check’.

Perhaps more troubling is that decoupling allows for the documentation or assessment of care to trump the provision of care. Writing about regulation the US context, Eaton (2000) notes that residential care workers were often requested to document care that was not provided so that ‘the records say what they should’. This practice did not take place behind the backs of managers but was sanctioned by them. ‘Higher level supervisors also acknowledge...that they had created documentation for services not performed. They described this as common in the industry, as a way to deal with reporting requirements seen as too demanding’ (Eaton 2000, p. 600). Similarly in Canada, we find that the power of regulation comes to be invested in paperwork in lieu of residents’ care. As one Canadian care worker remarked: ‘I often feel the bottom line, or how it looks on paper is more important than what actually gives residents a better quality of life’ (Armstrong et al. 2009, p. 67). Another care worker in the same study put it this way: ‘All management wants is for all the paperwork to be in order, even if it’s the resident who suffers in order to make that happen’.

¹⁰¹ Pilot interviews, ‘Reimagining Long-term Residential Care: An International Study of Promising Practices’; Pat Armstrong, York University, Principal Investigator, 2012.

5. The conditions for regulation: supporting the production of care

By contrast to complex, expert-designed, informatics based systems such as the RAI-MDS 2.0 or the LCQIP, when we asked managers and care workers what was needed to provide good care, the responses we heard were comparatively mundane, with time, dialogue, leadership, trust and competence among the recurring institutional level themes.

In terms of improving quality, regular meetings to discuss residents was a particularly noteworthy means of ensuring good care. One manager we interviewed in a not-for-profit home in Stockholm for instance, observed that daily meetings enabled workers to identify residents' needs and address how they could be best supported by care workers. We were shown a room with several chairs around a table and white board. It was explained that every morning after the medications were given out, care workers would sit to discuss the residents and allocate the work for the day. The manager noted that this process was essential for care workers to identify and adapt to the changing needs of residents. She also expressed concern that such meetings and the staffing levels as well as overlapping shifts they required would be the first to be cut in any transition to for-profit ownership – a very real possibility given the rapid privatisation of Stockholm's nursing homes as this report indicates.

In another interview conducted at a municipally run facility, also in Stockholm, we were told that in addition to such regular meetings, the manager would hold monthly meetings with the interdisciplinary care staff. The goal of these meetings was to go over the condition of all residents on the unit and pick one or two residents to 'look a little bit deeper over the day', considering their capacities and preferences as well as what the staff could 'do from the morning to the evening' in order to support them. For instance, in these sessions, they would explore questions such as: Does Ingrid prefer to eat alone or in company? Can she help with laundry? If Henrik needs to do walking exercises, can such exercises be built into the process of going to the toilet? These questions were not intended to reduce staff workloads – indeed the manager noted they increased workloads – but to normalise the residents' life by integrating residents into daily routines and also give them a sense of purpose. This type of work, she noted, was 'the glue of life', and in her opinion, such mundane activities were far more important than the 'social events', which are increasingly prescribed through regulations.

In these interviews, we also raised the example of the RAI and similar assessments procedures. One manager cautioned that these attempts to individualise care through needs assessments can paradoxically 'miss the person'. 'It starts to feel more like a factory', she explained, 'you have to do breakfast, clean the room, make the bed'. What mattered, she went on to

observe, was very much in line with what we had heard from Canadian care workers. It was not just that the bed was made but *how* it was made that mattered to residents. ‘Do we make the bed like the resident likes it? Some people prefer a military bed, with the sheets all nice and tight. Others like the sheets loose. And still others don’t make the bed at all!’ These differences are important, she noted, because they make us feel like we are at home rather than in an institution. Interviews such as these helped clarify why the regulation of care work and standardised assessment procedures so often fail to produce quality. ‘The quality in this job is between these tasks and how you do it. What you do between helping someone go to the toilet and then eating breakfast. How you talk to the person? So you raise their self esteem? So that the resident feel important? That they see the meaning of why they are still alive?’

Our interviews also pointed to the importance of leadership not just at the managerial level but also among the staff. This was particularly important as workers do not care for one resident alone but must negotiate the needs and desires of a number of residents simultaneously and in collaboration with their colleagues. Despite all the emphasis on personalising care, care work in nursing homes is a collective endeavour, as one British Columbia manager describes:

I watch how the staff can figure it out here, they get to know through consistency, staff work and live in that community and they get to know these people so well that there is not that panic of ‘oh my gosh I’ve got to get these six people going in the morning’. They know what these people’s habits will support. The people who like to sleep in will allow them to help the early risers. If there isn’t somebody there right away and somebody needs to use the bathroom, it is a responsive team that turns around and says ‘who here can help?’

The above comments point to a number of structural conditions that enable good care: consistency and low staff turnover; a philosophy of resident centered care; a management style that empowers workers; a culture of teamwork, communication, and mutual respect; a trained and capable workforce; having the staff and time to care; recognising the worth of dialogical inquiry and problem solving. These conditions are *prior* to the regulation of daily care work, though they can be supported through regulations and policies that address the conditions of work (for example, see chapter 7, this volume). These conditions are also in tension with the for-profit provision of care, and their generally lower staffing levels (McGregor et al. 2005; McGregor et al. 2010). These conditions are also incompatible with under-resourced environments. Thus in order to support these conditions, it is necessary to raise the very sort of political questions that are so often skirted by a focus on the regulation of care work.

6. The politics of regulation: lessons for Nordic Europe?

‘The sector is regulated in some of the wrong spots. The regulations get far too granular in areas that really aren’t all that significant and they are almost non-existent in areas where it’s more important’.

– *Member of a non-profit association of providers*

In this paper, I have attempted to provide some explanation for both the growing complexity of the regulatory system in Canada as well as its failure to ensure good care. The above quote sums my argument up: We have regulated in the wrong areas. We have eliminated regulations around the conditions of care such as staffing levels, for instance, and we have avoided challenging political questions to do with for-profit ownership, resources and the role of the state. Instead, we have focused on the regulation of care work. Here, what the Canadian experience suggests is that there is a decoupling process wherein the resources and effort that are invested in the regulation of care work fail to contribute to the production of care. As a result the regulation of care work can detract from quality, paradoxically resulting in calls for further regulation.

The Canadian experience further indicates that regulations can aid in the concentration of capital and the development of a strong for-profit industry, weakening the ability of the government to respond and provide care in ways that meet the needs of older citizens (Jansen 2011; Tarman 1990). The regulatory state is a weak vision of government. This may yet be another form of decoupling, the decoupling of political power and responsibility over welfare services. Such decoupling could be why those we interviewed so often asserted that regulations had come to replace leadership or that ‘we get rules rather than resources’.

If jurisdictions like Ontario are to exit the vicious cycle of regulating care we will need to start regulating where it matters. This will involve, as noted, reasserting the government’s role in providing care as well as ensuring the conditions and resources for care are present. In the case of Nordic Europe, there is the opportunity to learn from the historical experience of countries such as Canada and avoid stepping into the regulatory trap in the first place. It is my hope that this analysis will offer pause for those who are inclined to believe that quality can be secured through the regulation of care work.

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Chapter 7

Regulating care: lessons from Canada

Pat Armstrong

1. Introduction

While deregulation is a central tenet of neo-liberalism, in North America at least regulation has frequently been presented as the means of solving the problems created by marketisation in long-term residential care. Based primarily on experiences in the Canadian province of Ontario, this paper argues that regulation cannot solve the problems created by the search for profit and for-profit methods in care. Some regulation is necessary, especially at the policy level, but the kinds of increasingly detailed regulations spawned by the scandals exposed have not served to create the conditions for accessible, quality care.

2. Regulation and deregulation at the policy level

The problem begins with the search for profit in care. Commenting on the failure of the UK corporate nursing home chain Southern Cross, Sarah Bell said it ‘illustrates the fundamental flaw in the private model: private operators looking to maximise profits are tempted to reduce the investment needed to provide the best possible care for the most vulnerable people in their charge’ (Neate 2011). Bell, a partner in an insolvency firm, identified the basic problem but she left out the vulnerable workers who were, according to a *Guardian* newspaper report, asked to sign away their employment rights and to accept ‘harsh new working conditions’ (Wachman & Mulholland 2011). She also left out the citizens who too often end up paying the bill. And she left out the fact that most of these workers and the vulnerable people in their charge are women.

This search for profit is assumed to require both competition and secrecy. Innovation in profit seeking is often about finding a way around rules and regulations that limit profits. Australians Jenkins and Braithwaite (1993, p. 221) argue on the basis of their study of nursing home residents that ‘the

pressure for lawbreaking comes from the top down and from profits'. Based on interviews with those he calls stakeholders in the UK, Holden (2002, p. 79) concludes that 'government regulation must be concerned with the structure of the market, as well as the conditions within care homes, if the interests of residents are to be protected'. However, those government regulations are not easy to develop or enforce when international corporations, their investors, banks and creditors are involved.

In my province of Ontario, Canada, governments have to some extent regulated the structure of the market in long-term care but too often that regulation is in favour of corporations, not the vulnerable workers and residents.

In 1998, the Conservative provincial government announced it would invest in 20,000 more beds through a request for proposals (or RFP) process. In this competition process, two-thirds of the beds went to the for-profit sector, and 40% of all the beds went to three major corporate chains. This was not a surprising outcome given that the bidding process required time, considerable expertise and capital – access to which few small for-profit and non-profit organisations had. Moreover, there were designated preferred locations that also helped these chains make their bids. There was virtually no risk for the corporations. The cost of construction was reimbursed by the province with interest at a daily rate over 20 years, after which ownership returned to the company. During the 20 years, clientele and their subsidies were guaranteed (McKay 2003a; 2003b; 2003c).

At the same time, the new physical standards put older, smaller homes out of service. While regulations such as those requiring security systems protected residents, others like the width of hallways, made little sense. One home in a small town was forced to close because the halls were inches too small, a factor residents attributed to years of paint. Some older regulations such as those relating to fees and means of access remained. All facilities received the same funding, based on levels of care required by residents, there was a limit on the number of private rooms for which fees could be charged and admission was through the local, government run Community Care Access Centre regardless of facility ownership. But other regulations that had protected residents were eliminated.

The new regulations benefitted the chain operators building new places. So did the removal of the regulations requiring minimum staffing and a Registered Nurse on every shift because they could hire cheaper and fewer care providers to replace them. Similarly, a reduction in the proportion of beds that must be offered at a lower fee and the removal of the requirement that the fees be shared with the government made more room for profit. The prohibition against strikes by the mainly female and often immigrant health care workers also added to the owners' power. In spite of a mountain of research on the importance of staffing levels, the Liberal Government that replaced the Conservative Government in 2003 has failed to set out minimum staffing levels. It has restored the requirement to have a Registered

Nurse on each shift, but has resisted all popular pressure to require minimum levels and mixes of staff. Although it has introduced some protections for workers who report abuse and other problems, it has failed to provide regulations that would protect this mainly female labour force from contracting out, job cuts, benefit or wage loss- all of which are more likely in for-profit homes. Meanwhile, the federal government has introduced legislation that would allow temporary workers to be hired at wages up to 15% below those paid to their Canadian equivalent – another regulation supporting profits (Yalnizyan 2012).

At the same time as some regulations benefitted chains, other regulations that seemed to protect residents had little effect. For example, when a subsidised privately-owned facility decided to close and move to another community, leaving residents with no local care, the government admitted it could do little. The required consultations with the community had no impact (Egan 1997). In 2003, the bankruptcy of Royal Crest Nursing home chain meant 11 nursing homes and 6 retirement homes closed in Ontario. A year before, the Ontario Auditor General had reprimanded the government for inadequate financial reporting, inspection and tracking. Data on staffing and other critical areas were not made public. Nor were the facts that a close relative of the owner had also declared bankruptcy at a similar chain in Ontario some years earlier, and that the extended family continued to live very comfortably (Armstrong et al. 2012).

There are multiple other instances of innovative strategies to avoid regulations. For example, facilities are paid based on fixed envelopes designating how the money from the government will be spent. Money allocated for nursing must be spent on nursing for instance. If it is not spent on nursing, it must be returned to the government. The same is the case with the supply envelope. Such envelopes cover care services and although facilities can charge for accommodation, these rates too are fixed by the government. In an interview I did recently with government people in charge of residential care, I asked how chains made their profits, given the highly regulated nature of fees and subsidies.¹⁰² I was told one way was to own the temporary help agencies that supplied the labour paid for out of the highly controlled nursing care envelope. The money still goes to nursing but a fee is taken for providing those doing the nursing work. Another way around the regulations was to own the company supplying the drugs allowed under the supply envelope. Profits are made from the sale of drugs to the facility. Another, more public example in Ontario of ways around regulations is the development of retirement homes. Although these homes accommodate people with quite heavy care needs, they are not mainly government funded but at least

¹⁰² Site selection interviews, 'Reimagining Long-term Residential Care: An International Study of Promising Practices', Pat Armstrong, York University, Principal Investigator, 2011.

some of the care is provided by government-funded home-care services. Until recently, retirement homes were virtually entirely unregulated. Fires resulting in deaths and media coverage exposing neglect have contributed to the introduction of new legislation covering these homes. The regulations requiring, for example, that care plans be developed and restraints limited clearly indicate these are nursing homes by another name. The legislation leaves these homes basically self-regulating, with accountability to their trade association.

The combination of deregulation and regulation to promote market structures amount to an affirmative action plan for corporations. Some regulations related to admission and fees do however support access. But under existing legislation, governments have little power when it came to enforcement related to market issues like closure. The failure to provide rules about transparency and fraud or an effective enforcement system mean that residents, workers and the citizens who fund these services have few protections and little guarantee that good care will be there. At the same time, those operating for-profit homes for the government have protected payments and guaranteed occupancy.

3. Regulating daily care

In addition to the regulations that set out the policy framework and the general conditions under which homes operate, there are a host of other regulations that address issues within homes. Most of these, as historian James Struthers (1997) points out, have resulted from scandals, coroners' reports and reports from the auditor general. The regulations have become increasingly detailed as more scandals, more coroners' reports and more government commissioned studies reveal poor quality and poor adherence to existing regulations. These regulations have been reactive rather than proactive, and have expanded along with the move to marketisation.

The following two examples illustrate the kind of detail to be found in the latest inspection protocols.¹⁰³ The first of these relates to the dining room.

- Resident eats with minimal risk of aspiration and choking
- Resident eats independently or progresses towards independent eating if possible
- Resident maintains 90 degree angle of hips, knees and ankles
- Resident maintains head in upright position with chin tipped forward
- Resident maintains stability of trunk

¹⁰³ Ontario Ministry of Health and Long-term Care (2012) Performance Improvement and Compliance Branch Inspection Protocol, Dining Observation, page 3 of 7.

- Resident does not slip forward, lean sideways, or lean back in chair
- Resident is positioned close to table with table level between waist and midchest
- Resident will have eye contact with person providing assistance who is seated at the same level
- Residents needs are anticipated.

The list makes it easy to see the issues identified in the scandals they are designed to address. While all the things on this list are reasonable to consider when feeding a resident, the fact that they have to be written into inspection protocols indicates the lack of trust and the failure to provide quality care.

The second, and even more detailed, example comes from the specifications for bedrooms.

Physical requirements of bedrooms

- 26 (1) A licensee must ensure that each bedroom meets the needs and provides for the health, safety and dignity of the occupant.
- (2) A licensee must ensure that each bedroom is directly accessible from a hallway without passing through any other room.
- (3) If requested by a person in care, and unless it would be unsuitable given the health and safety needs of the person in care, a licensee must ensure that the entrance to the bedroom of the person in care can be locked from the inside.
- (4) If a licensee provides a locked entrance in accordance with subsection (3), the licensee must ensure that, in an emergency, the bedroom entrance can be unlocked from the outside.

Bedroom floor space

- 27 (1) A licensee must ensure that each bedroom has at least the following amount of usable floor space:
- (a) in the case of a bedroom occupied by one person in care who does not require a mobility aid, 8 m²;
- (b) in the case of a bedroom occupied by one person in care who requires a mobility aid, 11 m²;
- (c) in the case of a bedroom occupied by 2 persons in care, neither of whom requires a mobility aid, 14 m²;
- (d) in the case of a bedroom occupied by 2 persons in care, at least one of whom requires a mobility aid, 18 m².
- (2) For the purposes of subsection (1), usable floor space does not include floor space occupied by the entrance and the swing of the entrance door, closets, wardrobe cabinets, fixed furniture or bathrooms.

Bedroom windows

- 28 (1) A licensee must ensure that each bedroom has a window that provides natural light to the bedroom, with coverings that block out light and protect the privacy of the occupant.

- (2) A licensee must ensure that the window of each bedroom can be opened easily for ventilation, unless
 - (a) it would be unsuitable to the health, safety or dignity of the occupant, or
 - (b) the community care facility is equipped with an air conditioning system or mechanical ventilating system.
- (3) If the occupant of a bedroom is non-ambulatory, the bedroom must have at least one window that provides visibility from a sitting position to the outside.

Bedroom furnishings

- 29 (1) A licensee must provide, at no cost to the person in care, each person in care with bedroom furnishings, including
 - (a) a safe, secure place in which the person in care may store valuable property, and
 - (b) a closet or wardrobe cabinet measuring at least 0.50 m².
- (2) Except as necessary to maintain the health, safety and dignity of other persons in care, a licensee must permit each person in care to bring into the community care facility, and keep in the person in care's bedroom, furniture, ornaments or other personal possessions.

Together, the lists above represent part of one of seven pages on this topic. While it is easy to see what is behind each detail, more and more detail in the regulations has not led to better care.

One reason is that the detailed regulations fail to take context into account. What people can see from that window may be as important as having a window and a narrower hallway may be less important than care near one's former home or near those of one's family and friends. Administrators in a non-profit facility we interviewed as part of our current research project on long-term residential care offered a clear example of the problem.¹⁰⁴ Their facility is old but has long had doors and elevators that require codes from those seeking to open them, thus preventing residents from leaving without permission. New regulations, responding to concerns about a resident who left a facility, require that doors be alarmed. Installing alarms consumed the entire maintenance budget for the year and were not necessary in this case. The new regulations result, according to one of them, because 'someone is trying to make a profit. I know that's why they have the legislation'. As this administrator put it, 'it's kind of imposing its will on every home very universally which I don't think totally makes sense'. The detailed regulations establishing universal standards fail to take differences among residents unrelated to diagnosis. They also fail to recognise that the majority of residents and providers are women, with needs and preferences that often differ from those of men.

¹⁰⁴ Pilot interviews, 'Reimagining Long-term Residential Care: An International Study of Promising Practices', Pat Armstrong, York University, Principal Investigator, 2012.

Another reason is that regulations, especially when responding to scandals, can significantly alter plans and preferences developed within a facility. Once again an example comes from our current international project. A media series that highlighted violence against residents made violence a major focus of regulations. According to our administrator informant, 'It's not an issue actually for us but now it's our number one priority. So everything else we're doing has to kind of get dropped for us to implement this new change'. While it is not easy to assess the claim that violence is not an issue in this residence, the point about changing priorities is important to acknowledge. Moreover, the concern with violence focuses on residents, virtually ignoring the violence faced by the women who provide care. Yet in our research on long-term care in Canada, 43 per cent of the personal support workers said they faced physical violence more or less every day (Armstrong et al. 2009, p. 127).

A third reason is that such detailed regulations require a great deal of reporting, with counting and recording understood as accountability. Both managers and workers complain about this reporting. It undoubtedly costs considerable time and money; time and money that could otherwise go to care. Although managers do their share, it is workers who have to fill in many of the numbers. An administrator we interviewed for our current project supported the MDS system required to record and plan resident care. However, she acknowledged that personal support workers 'think it's a big waste of time and they want to do care'. Meal helpers have to count liquid consumed, work that can take priority over actually encouraging intake. Not surprisingly, in our comparative survey of workers in Canada and Nordic Europe, Canadians were twice as likely as Danes and seven times as likely as Norwegians to say they have too much paper work (Armstrong et al. 2009, fig. 9, p. 56). The reporting requirements, although burdensome, do not guarantee quality care or quality working conditions either. The increasingly detailed regulations do not solve the problem of poor care, especially in for-profit homes.

A fourth reason for regulations not guaranteeing quality care has to do with enforcement. Complaints about the failure to follow regulations are one way the government claims to enforce them. As Margaret McGregor and colleagues (2011) have shown, verified complaints – those the government recognises as legitimate – are much higher in the for-profit homes than in facilities under other forms of ownership. The continuing pattern suggests that complaints do not result in significant change in quality.

Reporting to authorities when regulations are not followed is claimed to be another form of enforcement. Ontario legislation provides for whistle-blower protection but there is little evidence that workers, residents or family

members can plan on protection in practice.¹⁰⁵ In our Ontario survey, workers said they often do not report abuse because they are not believed, they are blamed, it takes too much time in terms of paper work and they don't want to hurt the residents. As Donna Baines explains on the basis of her research on violence in care, 'adversarial approaches such as the laying of charges against care recipients or employers fail to resonate with the ideology of caring that saturates the everyday life of this predominately female workforce' (2005, p. 132). Any approach to enforcing regulations has to take this commitment of the women into account.

Scandals and other pressures have led to a call for more inspections as a way of enforcing the regulations. Recently, when we attended a meeting of workers in long-term residential care, we were told that they usually had a warning that an inspection was coming and managers prepared the place to look like the regulations were being followed. But they said even surprise inspections resulted in what they called guided tours under the careful eye of the managers and with workers instructed to keep quiet. The Ontario government has promised more, and more thorough, inspections done on a regular basis. However, with the kind of detail we saw earlier, combined with a limited number of inspectors, the current estimates indicate the initial inspections will take five years to complete before each home is visited (Welsh 2012, p. A3). The more detailed the regulations to be checked in the inspections, the less frequently they are likely to occur. And it remains an open question whether such inspections will result in quality care. In addition to breaking the rules in ways that result in complaints, owners may seek ways around the rules altogether. It can be particularly difficult to enforce the regulations when the owners are powerful, international chains and when free trade rules prevent restrictions and transparency.

In short, our Ontario strategy of more, and more detailed, regulation has not worked very well especially in the absence of effective inspection and enforcement. Particularly glaring has been our failure to ensure appropriate staffing and work conditions and rights. At the same time, regulation and enforcement have become more necessary in the wake of privatisation – a process that has itself been promoted by regulations. Some of the regulations have had the effect, if not the explicit intention, of promoting for-profit chain ownership.

4. Lessons

A growing body of evidence demonstrates that for-profit facilities and especially international chains, provide the most inferior care and working con-

¹⁰⁵ Ontario Government, Long-term Care Act 2007, S.O. 2007, Chapter 8. Last amended 2010, Section 26.

ditions (McGregor, Tate et al. 2006; McGregor, Tate et al. 2010; McGregor, Bambusch et al. 2011; McGregor & Ronald 2011; McGregor, Cohen et al. 2012). Marketisation has at one and the same time been supported by some forms of regulation and created the demand for more regulation to counter the lack of trust as well as the poor quality of care. It is clear in Ontario that the privatisation of service delivery fundamentally shifts power in ways that greater and greater detail in regulations at the local level cannot solve. The most useful regulation in long term care would thus be one that prohibits the for-profit delivery of services. Prohibiting entry of for-profit companies into the field in areas not covered by the public services and prohibiting the for-profit takeover of existing long-term care facilities may be the most fruitful way to build trust and make care a priority without relying primarily on more and more detailed regulation.

Other regulations at the policy level can also be useful. Regulations can prevent any single election from resulting in the transfer of ownership and thus avoid quick decisions with long term consequences. A much earlier Conservative government in Ontario required every municipality to own at least one nursing home. It cleverly required that these nursing homes could not transfer their licenses and that any change required a time period beyond a single term for any municipal government. Thus when our new Toronto mayor wanted to sell off all but one of Toronto's homes, he was prevented from doing so by both regulations. Regulations that require transparency and effective local control, including worker participation in facility organisation and operation, could also limit the possibilities for privatisation while building trust as the basis for good care. Regulations at this level can also ensure equity in access and control fee structures in ways that allow security for residents.

As a recent Ontario report resulting from yet another scandal put it, regulations 'are not enough to eliminate abuse in long term care homes' (Donner 2012). More and more detailed regulations have not ensured either the quality of care or the quality of working conditions and have failed to provide flexibility in responding to individual needs or different environments. Instead of seeking standardisation through detailed regulations, it is useful to establish principles in five main areas within the facilities: care, food, physical environment, activities, working conditions (Murphy 2006). Regular inspections for proactive purposes would be guided by these principles. The focus should be on processes more than on outcomes, and on recognising that the conditions of work are the conditions of care.

In one area, however, experience tells us it is necessary to have clear regulations. It is essential to regulate the amount and kind of staffing and to ensure workers' rights, recognising this is primarily women's work caring for women. As Asbjørn Wahl, the Norwegian director of the campaign for the welfare state put it in his recent book, workers' 'commitment and creativity must be liberated, not bound and shut in by bureaucratic regimes of distrust and control from above' (Wahl 2011, p. 41).

In sum, some regulations are required to make the system transparent and accessible, and to make the goals clear. However, regulations have become more necessary, and necessary in greater detail, with the introduction of profit but have failed to solve the problems scandals have revealed. The power shift to for-profit chains makes regulations increasingly less meaningful, and the mainly female resident populations and female labour force more vulnerable.

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Chapter 8

Understanding the relationship of nursing home ownership and quality in the United States

Charlene Harrington

1. Introduction

This chapter focuses on the nursing home industry in the United States. First, it reviews structure of the U.S. nursing home industry. Second it describes the problems with the quality of nursing home care and nurse staffing levels. Third, the relationship between ownership and quality and staffing is discussed. Finally, it describes the relationship between government nursing home reimbursement policies, profits, administrative costs and quality of care.

2. The nursing home industry

In 2010, the United States had about 15,600 nursing homes with 1.4 million residents. For-profit companies have owned the majority of the nation's nursing homes for many years. In 2010, 68% of facilities were owned by for-profit companies, while non-profit organisations owned 26% and government owned 6% of facilities (Harrington, Carrillo, et al. 2011). During the 1990s, for-profit corporate chains emerged as a dominant organisational form in the nursing home field, promoted with the idea that they would be more efficient and have access to capital through the stock market. The proportion of chain-owned facilities increased from 39% in the 1990s to 55% of all nursing homes in 2010 (Harrington, Carrillo, et al. 2011). The promise of efficiencies of large chains has been refuted by studies that show they do not have lower short-term operating costs than independent facilities (Chen & Shea 2004; Kitchener et al. 2008).

The largest nursing home chains have been publicly-traded companies with billions of dollars in revenues. Many large nursing home chains own a number of related companies including residential care/assisted living

facilities, home health agencies, hospices, pharmacies, therapy organisations, staffing organisations and other related companies. These related companies refer patients to each other and use their corporate inter-relationships to maximise revenues (Harrington, Hauser, et al. 2011).

By 2007, private equity companies had purchased many of the largest nursing home chains (Stevenson & Grabowski 2008; Stevenson et al. 2009). Many of these companies have multiple investors, holding companies, and multiple levels of companies involved, in which property companies that own the building assets are separated from the companies that manage facilities, largely designed to avoid litigation (Harrington, Hauser, et al. 2011). According to the U.S. General Accountability Office (GAO), the lack of transparency in the ownership responsibilities makes regulation and oversight by government agencies problematic (U.S. GAO 2010).

3. Poor quality of care and weak regulatory oversight

Federal law and regulations cover all nursing homes that receive federal funding (about 98% of homes). The federal law requires comprehensive assessments of all nursing home residents to determine their functional, cognitive, and affective levels, and these assessments must be used in the care planning process (OBRA 1987). The law has specific requirements for nursing, medical and psychosocial services, designed to attain and maintain the highest possible mental and physical functional status by focusing on outcomes (such as incontinence, immobility, and pressure ulcers). The law also requires residents' rights to be protected (OBRA 1987). The federal regulations include about 175 quality requirements (CMS 2012c). The Centers for Medicare and Medicaid Services (CMS) also has separate fire and life safety requirements for all certified facilities (U.S. GAO 2004). The survey requirements include structural standards (for example, staffing), process requirements (for example, do not use physical restraints) and outcome measures (for example, prevent pressure sores).

Although the federal government sets the standards, in the U.S., oversight is delegated to the states in a decentralised regulatory system. State survey and certification agencies conduct annual surveys to verify compliance with federal regulatory requirements, in order for a nursing home to be certified to receive federal funds. Follow-up surveys may be conducted to assure that facilities correct identified deficiencies (CMS 2012c). Surveys may also be conducted to follow-up a serious complaint about quality. A complaint is a formal grievance against a facility that is filed with the state survey agency. States may establish additional quality requirements that nursing homes must meet, including nursing homes that do not receive federal funding.

Where a facility fails to meet a standard, state agencies are to issue a deficiency notice to the facility for failure to meet the regulation. Surveyors are required to rate each deficiency based on scope (isolated, pattern or wide-spread) and severity (no actual harm with a potential for minimal harm, no actual harm with a potential for more than minimal harm, actual harm that is not immediate jeopardy, and immediate jeopardy to resident health and safety) for purposes of enforcement. The deficiencies rated as causing actual harm or immediate jeopardy are the most serious (CMS 2012c). The law specifically provides for the use of intermediate sanctions including civil money penalties (CMPs) (fines), denial of payment for new or current admissions, and temporary managers for facilities with serious violations (OBRA 1987).

Poor nursing home quality has been documented in the U.S. since the early 1970s. To address the problem, the Omnibus Budget Reconciliation Act (OBRA) of 1987 was passed to improve the survey and enforcement system and ultimately to improve quality. In spite of the 1987 legislation, many studies over the past two decades have documented the serious ongoing quality problems and the poor federal and state survey and enforcement system (U.S. GAO 1999ab, 2002; 2003; 2007, 2008, 2009). In 2010, over 94% of nursing homes received a total of about 150,000 deficiencies for failure to meet federal regulations, for a wide range of violations of quality standards (Harrington, Carrillo et al. 2011). Many formal complaints were made to state regulatory agencies about poor nursing home quality and 23% of nursing homes were cited for causing ‘actual harm’ or ‘immediate jeopardy’ to nursing home residents in 2010. Overall, 43% of nursing homes failed to provide adequate infection control, 43% failed to ensure a safe environment for residents to prevent accidents, 39% had inadequate food sanitation, and 34% failed to meet care quality standards. In addition, 30% of nursing homes received deficiencies for failure to meet professional standards, 28% for failure to provide comprehensive care plans, 23% for giving unnecessary drugs, 21% for poor clinical records, 20% for failing to ensure resident dignity, 20% for poor housekeeping and 19 for failure to prevent pressure sores (Harrington, Carrillo et al. 2011).

In 2012, the official Medicare Nursing Home Compare website (CMS 2012a) reported that 21% of the nation’s 1.4 million nursing home residents received antipsychotic medications, 14% had a decline in physical functioning, 11% had uncontrolled pain, 8% had urinary tract infections, 7% had pressure sores and 6% had weight loss. Overall, these problems negatively impacted 60,000-300,000 residents.

The GAO has found that state surveys are conducted at predictable times and consumer complaint investigations are inadequate and not timely (U.S. GAO 2003, 2008). Further, state surveyors responsible for monitoring services are often unable to detect serious problems with quality of care and allow most facilities to correct deficiencies without penalties (U.S. GAO 2002, 2008). Some state survey agencies downgrade the scope and severity

of deficiencies (U.S. GAO 2003, 2008). Moreover, when violations are detected, the state agencies often do not take appropriate enforcement actions or sanctions against the nursing homes (Harrington et al. 2004; Harrington et al. 2008; U.S. GAO 2008). Overall, states are not using the regulatory process consistently and are not following federal guidelines (U.S. GAO 2003, 2007). These problems with state enforcement are related in part to inadequate federal and state resources for regulatory activities, which have declined by 9% between 2002 and 2007 when adjusted for inflation (Harrington et al. 2004; U.S. GAO 2009; Walshe & Harrington 2002).

A recent study documented the benefits of strong regulation in those states that more rigorously implemented federal regulations. The study showed that quality of care improves with the stringency of regulation. Regulatory stringency was significantly associated with better quality for four of the seven measures studied and that the requirements were cost effective (Mukamel et al. 2012).

In spite of the need for and value of stronger nursing home regulations, the nursing home industry has in general been able to prevent vigorous enforcement at the federal and state level. The industry is politically strong at the state and federal levels in terms of both organisational resources and political power, related in part to its political contributions to elected officials. The federal-state nursing survey and certification process and regulatory system give the appearance that government is addressing quality of care problems, but in reality the process does little to improve care.

4. Inadequate nurse staffing levels

Low nurse staffing levels are the single most important contributor to poor quality of nursing home care in the United States. Over the past 25 years, numerous research studies have documented the important relationship between nurse staffing levels, particular RN staffing and the outcomes of care (IOM 2003). The benefits of higher staffing levels, especially RN staffing, can include lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, catheterised residents and urinary tract infections; lower hospitalisation rates; and less weight loss and dehydration (Bostick et al. 2006; Castle 2008; Spilsbury et al. 2011; U.S. CMS 2001; Schnelle et al. 2004). Moreover, in states that have introduced higher minimum staffing standards for nursing homes, nurse staffing levels and quality outcomes have improved (Bowlis 2011; Harrington et al. 2007; Mukamel et al. 2012; Park & Stearns 2009).

The average U.S. nursing home provides a total of 3.9 hours per resident day (hprd) of total nursing care, provided by the Director of Nursing, registered nurses (RNs), licensed vocational or practical nurses (LVN/LPN)

and nursing assistants (NAs) (Harrington, Carrillo, et al. 2011). Of the total time, 62% is provided by NAs, who each provide care for an average of 11 residents and who have only about two weeks of training. Actual RNs time is an average of only 42 minutes (0.7 hour) per resident day. The time varies widely across nursing homes.

Actual total nurse staffing levels are, on average, well below the 4.1 hours per resident day (hprd) needed to prevent harm or jeopardy to residents, according to a report commissioned by the Centers for Medicare and Medicaid Services (CMS 2001). There should be 1 NA for every seven or eight residents on the day and evening shifts and 1 NA for every 12 residents at night at a minimum. Nurse staffing levels need to be increased beyond the minimum levels in nursing homes that have high resident acuity (case mix). Unfortunately, the federal government has not established clear minimum nurse staffing standards because of the potential increased costs to government (CMS 2001).

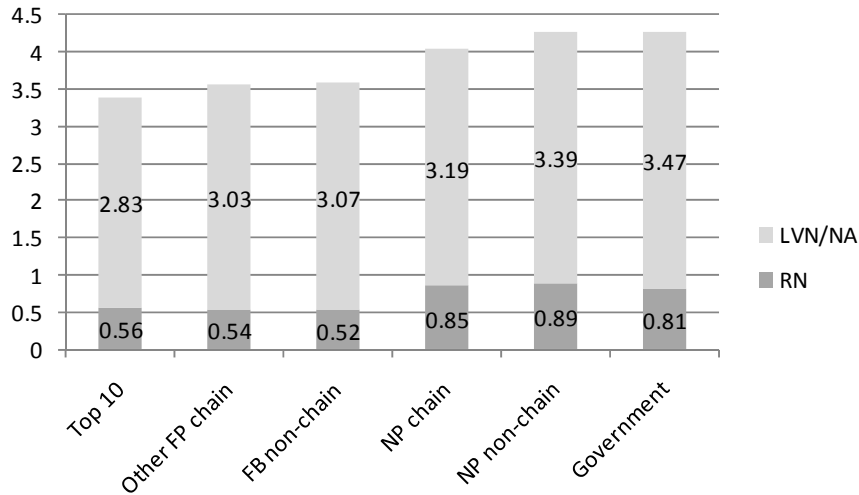
Poor quality of care in nursing homes has also been associated with low wages and benefits and high employee turnover rates (Harrington & Swan 2003). Nursing home wages and benefits are substantially lower than those of comparable hospital workers and lower, for the less skilled occupations such as nursing assistant, than those in many jobs in the fast food industry and other unskilled jobs and generally well below the level of a living wage (CMS 2001).

5. Relationship between nursing home ownership and quality

Many studies have shown that for-profit nursing homes operate with lower costs and staffing, compared to nonprofit facilities, which provide higher staffing, higher quality care and have more trustworthy governance (Comondore et al. 2009; Grabowski, Feng, et al. 2012; Hillmer et al. 2005; O'Neill et al. 2003).

A recent study compared the ten largest for-profit chains with other smaller for-profit chains, for-profit non-chains, non-profit chains, nonprofit non-chains and government nursing homes (Figure 1). The 10 largest for-profit chains had residents with the highest acuity and the lowest nurse staffing hours compared with non-profit and government nursing homes (Harrington, Olney, et al. 2012).

Figure 1. Nurse staffing hours per resident day by ownership type in all U.S. nursing homes, 2003-2008

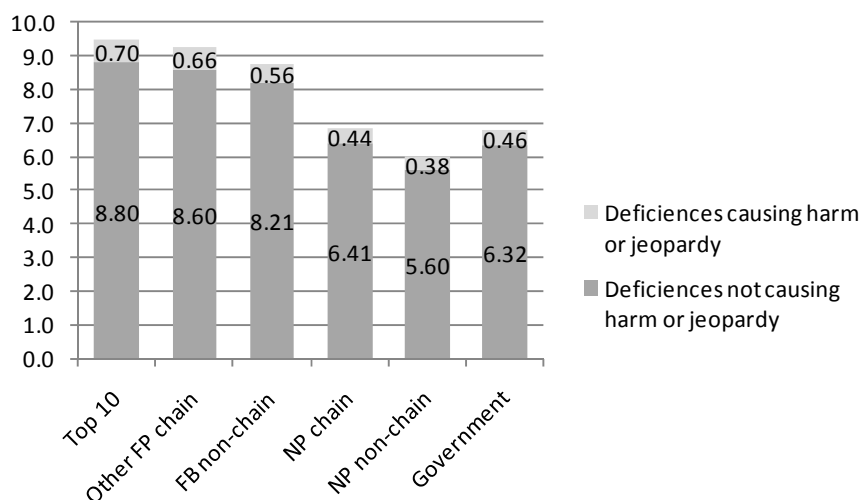


The study also showed that the ten largest for-profit chains had the highest numbers of violations of federal quality regulations and the most serious deficiencies that caused harm or jeopardy compared with non-profit and government nursing homes (Harrington, Olney, et al. 2012).

The study also found that the four largest for-profit nursing home chains purchased by private equity companies between 2003 and 2008 had more deficiencies after being acquired. This study was the first to show the connection between worse care following acquisition by private equity companies (Harrington, Olney et al. 2012).

The largest for-profit chains probably have poorer quality for a number of reasons in addition to their lower nurse staffing levels. Because they are debt-financed, they are expected to make managerial decisions to maximise profits at the expense of quality of care (Kitchener et al. 2008). They may be better able to control their financial costs and staffing levels because of their managerial experience, administrative resources and information systems than other types of owners (Banaszak-Holl et al. 2002). Large for-profit chains are able to market services to residents regardless of their actual quality (Harrington, Hauser, et al. 2011; Kitchener et al. 2008). Finally, large chains have more resources (e.g. attorneys and funds) to fight against or reduce the impact of regulatory sanctions than other types of owners (Kitchener et al. 2008).

Figure 2. Deficiencies (violations of regulations) by ownership type in all U.S. nursing homes, 2003-2008



6. Nursing home costs

U.S. nursing home expenditures increased from \$85 billion in 2000 to \$143 billion in 2010 (or by 68%) (CMS 2012b). Medicare covers up to 100 days of nursing home care after a medically necessary hospital stay of at least three days. Medicaid generally pays for those with low incomes who need long-term nursing home care. Medicare, Medicaid and other government sources paid for 63% of total nursing home expenditures in 2010 and the remainder is paid by individuals out-of-pocket (28%) or private insurance (9%). The nursing costs are paid directly to nursing homes by payers on a per day basis.

State Medicaid reimbursement policies have used prospective payment methods to establish very low payment rates to save money (Grabowski, Angelelli et al. 2004). Since 1987, Medicare has set prospective payment rates for nursing homes that take into account the resident case mix (acuity) in each nursing home in calculating the payment for needed nurse staffing and therapy services (Medicare Payment Advisory Commission [MedPac] 2012). Nursing homes, however, are not legally required to provide the actual staff and therapy time paid for by Medicare. As a result of this payment system, nursing home professional staffing decreased and regulatory deficiencies increased (Konetzka et al. 2004) and profits increased (Medpac 2012). The Medicare program does not set limits on profits and administrative costs.

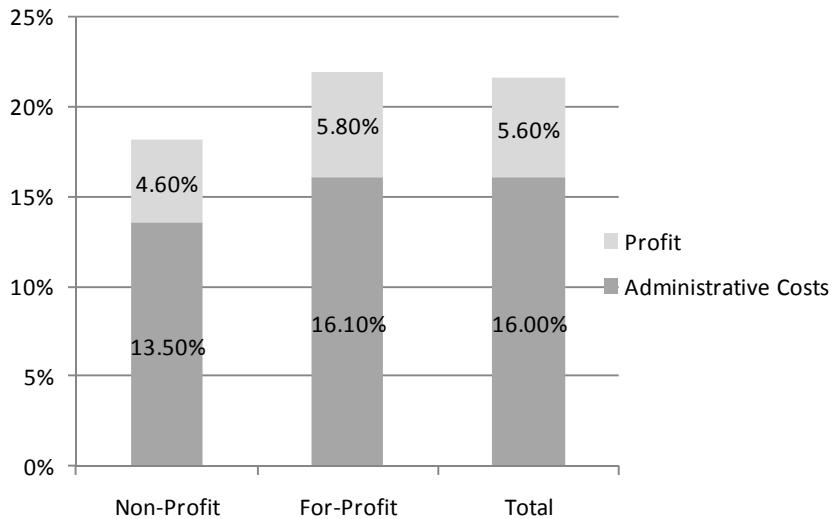
In 2010, the profit margins on Medicare payments in for-profit nursing homes was 21% while profit margins in non-profit nursing homes were 9.5% (Medpac 2012). Although profit margins are high on Medicare payments, total profits for all payers (including Medicaid, private insurance and self-pay) were

lower, because of low state Medicaid nursing home payment rates. Nursing homes with very high profits appear to be taking profits at the expense of quality. Nursing homes with profit margins greater than 9% were found to have higher deficiencies and poorer quality of care (O'Neill et al. 2003).

A study of nursing homes in California has found that administrative expenses as a percent of total nursing home revenues grew slightly (3%) while profits grew by 80% of total revenues during the 2007 to 2010 period. Administrative expenses averaged 16% with 10% of nursing homes having over 20% administrative costs and 1% having over 28% in 2010. Profit margins varied from a loss of 120% to a profit of 35% in 2010. Of total California nursing homes, 54% had administrative costs and profits above 20%. For-profit nursing homes had substantially higher administrative costs and profit levels were 3 times great than non-profit nursing homes (Figure 3) (Harrington, Ross et al. 2012). Administrative costs include expenditures for administrative staff, executive salaries and corporate management costs, but exclude licensing fees and other fees and capital costs for buildings, depreciation and interest rates.

One policy option is to revise the Medicaid and Medicare payment systems to specify the minimum proportion of the payments that must be used for nurse staffing and therapy services. If the minimum amount of payments for nursing and therapy services were regulated, nursing homes would be prevented from cutting nurse staffing and using the funds for profit making. A recent study has estimated that if profits and administrative costs were capped at 20% for all payers (Medicare, Medicaid, private insurance and self-pay), there would be about \$2.5 billion in annual savings in the U.S. (Harrington, Ross, et al. 2012).

Figure 3. California nursing home administration and profit as a percent of revenue, by ownership type, 2010



7. Summary

This chapter has described the U.S. nursing home industry with its many serious quality programs and its weak, decentralised regulatory system. The nursing home industry has been dominated by for-profit nursing homes and increasingly, large nursing home chains on the stock exchange and chains purchased by private equity companies. The largest for-profit chains as well as other for-profit nursing home companies have been found to have the highest resident acuity and yet the lowest nursing home staffing levels compared to non-profit and government nursing homes. Not surprisingly, this results in the worst quality of care in for-profit nursing homes and large chains.

The for-profit nursing home industry is driven to enhance shareholder and investor profits. For-profit nursing homes have been shown to have higher administrative expenses and profit margins than non-profit and government facilities. The profit margins are obtained by controlling staffing levels and labor market costs at the expense of quality. In addition the for-profit industry is politically powerful which makes government regulation of nursing homes difficult by blocking regulatory improvements and resources. The government needs to establish higher nurse staffing requirements and make nursing homes financially accountable for spending money on care rather than on profits and administrative costs.

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Chapter 9

Four Nordic countries – four responses to the international trend of marketisation

Marta Szebehely and Gabrielle Meagher

1. Introduction

The four Nordic countries analysed in this report share a history of universalistic ambitions to provide high quality, tax-funded eldercare services, and of a particular role for local authorities in providing those services. Local authorities have the primary responsibility for *implementing* the national legislation, for *funding* care services for older people and, historically, also for *providing* the vast majority of those services. In all four countries, voluntary organisations have long been important initiators of welfare programs and, to various degrees, have also provided services on a non-profit basis. More recently, market ideas and rationalities have started to frame and shape the eldercare sector in all the Nordic countries.

The implementation of market ideas and rationalities in Nordic eldercare have brought about a set of organisational changes that we call marketisation. The organisational changes include 1) the *importation* into public service systems of various market-like arrangements and processes, such as purchaser-provider splits, bench-marking and the designation of some parts of public sector operations as ‘profit centres’; 2) *competitive tendering and outsourcing* of care services to private providers; 3) the introduction of *choice models*, under which the older person chooses between providers contracted by the municipality and 4) various financial incentives such as *tax rebates* to support users to purchase services in the market.¹⁰⁶ As noted in Chapter 1, *private organisations* (mainly non-profit) have long been involved in providing publicly-funded eldercare in the Nordic countries, albeit to differing extents. Thus, the growth of *private* provision in itself is not what is essentially new about the organisational changes underway in Nordic

¹⁰⁶ All four forms of marketisation are discussed in the four chapters on the Nordic countries (Chapter 2-5). In this concluding chapter, however, we concentrate on the three latter forms of marketisation.

eldercare. Rather, under the pervasive influence of New Public Management, what is new is the introduction of *competition*, within both public and private eldercare, with the stated goal of driving efficiency and quality improvements. Nevertheless, within the private sector, the growth of *for-profit* provision is also mostly a new development, and this growth has mostly been tightly coupled with marketising measures designed to increase competition.

In this final chapter, our goal is to compare various aspects of marketisation in the four Nordic countries, including the scope of for-profit provision, the instruments of marketisation and the extent of their use, the consequences of marketisation, and the forms of its regulation. We also reflect briefly on the lessons that might be drawn from the analysis, in Chapters 6, 7 and 8, of marketisation in Canada and the United States.

Chapters 2 to 5 tell us that a process of marketisation is taking place in all four Nordic countries. Looking across the countries, we also see that the process started at different times and is unfolding at different rates, that different mechanisms and instruments have been used, and that the consequences vary. We can group the four countries differently depending on the criteria used. For instance, countries can be grouped based on timing of marketisation or on the intensiveness and extensiveness of the marketisation process.

Focusing on timing, we could argue that *Denmark* was the first – and so far the only – Nordic country to make it mandatory for local authorities to offer choice of provider in home care services and thus to open up tax-funded service provision to for-profit organisations (from 2003). From a legislative perspective, it could be argued that this has been the most radical step towards marketisation, and represents a significant break with the long tradition of independent municipalities in the Nordic countries.

However, despite the binding legislation in Denmark, we argue that *Finland* and *Sweden* are clearly more affected by marketisation than are Denmark and Norway. In particular, the for-profit sector is more extensive in the two Eastern Nordic countries, the growth of its share has been faster and large corporations have a stronger position.

Although we can confidently draw these general conclusions, our endeavour to map and compare the extent and impact of marketisation in the Nordic countries has been hampered by a lack of statistics within each country, and where statistics are available for one country, comparable data from the others often is not. As the Nordic countries are well known for their comprehensive statistics, the lack of data in this field reflects the fact that marketisation is a comparatively new and a politically fairly weakly institutionalised phenomenon.

2. The scope of private provision

2.1 For-profit and non-profit provision of eldercare

It is difficult to get a clear picture of the scope of private provision in all the Nordic countries. Firstly, official user statistics are often reported without information about the type of provider, although there is somewhat more information on the distribution of staff by provider type. Secondly, when there is information on provider type, data are usually divided into public and private, without distinguishing for-profit and non-profit providers within the private category. Thirdly, when for-profit and non-profit providers are distinguished, it is still not possible to get an overview of the for-profit share of the entire eldercare sector either because eldercare is reported together with other social services or because there is information on some forms of eldercare services but not others.

Despite the lack of good national statistics, let alone a harmonised Nordic data set, in Table 1 we present the best available information on private provision in the four Nordic countries, based on a mix of statistics on users, staff and expenditure. Unless otherwise stated, all information in the table and in the rest of this chapter is gathered from Chapters 2-5. Because of the mix of data sources and measures (expenditure, staff, users), comparisons between the countries should be made cautiously.

Table 1. Private provision of eldercare services in the Nordic countries 2000–2012. For-profit (FP) and non-profit (NP), respectively

	Around 2000	Around 2005	Around 2012
Norway			
Home care (% of expenditure)			3.1% FP, 0% NP (home help); 0.2% FP, 0.1% NP (home nursing) ¹⁰⁷
Residential care (% of expenditure)			3.5% FP; 5.9% NP ³
(% of beds)	10.7% (FP +NP)		9.6% (FP +NP) ¹⁰⁸
Eldercare and dis- ability services (combined)			6.6% of working hours (FP+NP); 8.1% of expenditure (FP+NP)
Denmark			
Home care (% FP of users)	2.5% of users	15% of users of practical assistance 3% of users of per- sonal care	47% of users of practical assis- tance only 31% of users of both practical help and personal care 6% of users of personal care only 37% of all home care users; 13% of all home care hours
Residential care (% of residents)		< 1% FP	< 1% FP (no information on NP)
Eldercare total (% of staff hours)			5-6% FP ¹⁰⁹ (no information on NP)

¹⁰⁷ NHO Service (2012). This is the only statistical source in Norway that distinguishes between for-profit and non-profit providers within the private sector. NHO Service (the Federation of Service Industries), is the interest organisation for private service providers, affiliated with the Confederation of Norwegian Enterprise (NHO).

¹⁰⁸ Statistics Norway (2012).

¹⁰⁹ Our estimation based on information by the Danish Ministry of Social Affairs and Integration (2013) that in 2011 there was 940,000 staff hours per week in residential care (with less than 1% for-profit provision) and 590,000 hours per week in home care (with 13% for-profit provision).

Table 1, continued

	Around 2000	Around 2005	Around 2012
Sweden			
Home care (% of hours)	7 % (FP+NP)	10% (FP+NP)	21% FP, 2% NP ¹¹⁰
Residential care (% of residents)	12 % (FP+NP)	14% (FP+NP)	18% FP, 3% NP ¹¹¹
Eldercare and dis- ability services total (% of staff)	8% FP; 3% NP	8% FP; 3% NP	17% FP; 3% NP (2010)
Finland			
Home care (% of staff)	4.9% FP; 4.6 % NP		13% FP; 2% NP (2010)
Residential care (% of staff)	Institutions: 1.2% FP; 14.1 NP Service housing: 16.4% FP; 42.6% NP		Institutions: 6.5% FP; 11.7% NP (2010) Service housing: 30.2% FP; 32% NP (2010)
Eldercare total (% of staff)	6.7% FP; 19.2 % NP		17.5% FP; 16.1% NP (2010)

Despite the data problems, Table 1 shows some clear differences between the West Nordic and the East Nordic countries when it comes to the share of publicly funded eldercare services provided by for-profit companies.

Overall, the data on *Norway* show that private providers have a small share of overall provision of care services for older people and people with disabilities¹¹² than in the other Nordic countries, and there is no evidence that their share is growing. According to the only statistics we have found that differentiate between for-profit and non-profit provision (NHO Service 2012), in 2011 3.5% of Norwegian residential care was provided by for-profit companies, as was 3.1% of home help and 0.2% of home nursing. Non-profit providers account for a larger share of expenditure in residential

¹¹⁰ Our estimation. Socialstyrelsen (2013a) reports that 23% of tax-funded home care hours were privately provided in 2012; Konkursverket (2013) reports that 93% of the private home care providers are FP and 7% are NP; we therefore estimate that 93% of the privately provided home care hours (21%) are FP and 2% are NP.

¹¹¹ Our estimation. Socialstyrelsen (2013a) reports that 21% of residential care beds were privately provided in 2012; Arfwidsson and Westerberg (2012) report that 86% of the private residential care facilities are run by FP provider and 14% by NP providers; we therefore estimate that 86% of the private residential care beds (18%) are FP and 3% are NP.

¹¹² These are generally reported together in Norway.

care than for-profits, but remain relatively small (5.9%), and their share of home care is negligible (nothing in home help, 0.1% in home nursing).¹¹³ Data for the share of private providers over time is available for residential care only (measured by beds), and does not distinguish between for-profit and non-profit (Statistics Norway 2012). These statistics suggest that there has been no *increase* in private provision of residential care in Norway (10.7% in 2001 and 9.6% in 2011) but they do not show whether there has been a *shift in the distribution* between for-profit and non-profit organisations during the period. Over the decade, there probably has been a shift towards for-profit provision, but in the most recent years there has been a decline due to the so-called ‘Adecco scandal’ (see Chapter 5).

In *Denmark*, like Norway, the extent of private provision of eldercare is small. Overall, we estimate that about 5-6% of the total staff hours in Danish eldercare are delivered by care workers employed in for-profit companies, and less than 1% of nursing home beds are provided by for-profit companies. Up-to-date statistics about non-profit private provision is not available; but non-profits do not provide home care services, while they have some role in residential care.

For-profit provision in Denmark is concentrated within home care, primarily in practical assistance (mainly cleaning), and the use of for-profit practical assistance has grown rapidly since Danish local authorities became legally obliged to open up their home care services to for-profit providers in 2003. In 2012, close to half (47%) of older people who received practical assistance only received their help from a for-profit provider, while 6% of those who received personal care only got their help from a for-profit provider. Of all home care users, 36% received help from a for-profit provider, and it has been estimated that *13% of all home care hours are provided by care workers employed in the for-profit sector* (see Table 1 and Section 6.1.1 in Chapter 4).¹¹⁴

In comparison to home care, for-profit providers have a marginal role in the Danish residential care sector, while non-profits have a larger, but still relatively small, role. Because private residential care providers enter the system via different routes, and because there is no regular statistical

¹¹³ In 2011, for-profit providers received 3.5% of the public expenditure on nursing homes and non-profit providers received 5.9% (Table 1, data from NHO Service 2012). In 2012, 2% of the nursing homes were run by for-profit providers and 8% by non-profit providers (NHO Service 2013). The different proportions reported in two sources may suggest that for-profit nursing homes are bigger than nursing homes run by non-profit organisations.

¹¹⁴ The ‘gap’ between 36% of users and 13% of hours is perplexing at a first glance. The explanation is probably that, on average, a user gets 5.6 hours of personal care and 0.8 hours of practical help per week. Further, one third of those receiving private home care receive also public care, probably combining a small amount of privately provided practical assistance with a larger number of hours of publicly provided personal care (Statistics Denmark 2012).

information on these providers, the picture emerges piecemeal. Chapter 4 established that one route to private provision of residential care – outsourcing after competitive tendering – is used extremely rarely by local authorities, and in 2009 a total of only four nursing homes were outsourced to for-profit providers this way (Rambøll 2009; see also below). Since 2009, private providers, both for-profit and non-profit, have also been able to enter the residential care system by setting up a ‘Friphejebolig’ – a form of nursing home, which may, after being certified, compete for a share of a national quota allocated to this kind of nursing homes. In 2011, there were only 14 ‘Friphejeboliger’ in Denmark, the majority owned by non-profit organisations, which housed a total of 1% of Danish nursing home residents (Rambøll 2012). The third – and most common – form of non-public residential care in Denmark is the so-called independent nursing homes (selvejende plejeboliger). This is a form of publicly funded non-profit residential care (Udbudsrådet 2011, p. 16). We have not been able to find any recent figures on the scope of this non-profit residential care. Meier and colleagues (2000, table 2) report that in the late 1990s 26% of Danish traditional nursing homes were run by non-profit independent organisations and 74% were run by the municipalities (no reference was given for the information). Since the traditional nursing homes are being closed down and replaced by more modern forms of residential care,¹¹⁵ the share of this form of private, non-profit residential elder care is likely to have fallen since then (Hansen & Syberg Henriksen 2001).

In *Sweden*, private providers currently have a higher share of both residential and home care services than in either Norway or Denmark: 23% of home care hours and 21% of residential care places are privately provided. Further, user statistics show a steady increase of private provision since the early 1990s – starting in residential care and, more recently, rapidly increasing in home care (see Table 1 in this chapter and Table 1 in Chapter 2).

Although regular statistics do not distinguish for-profit and non-profit provision, it is possible to estimate their shares from other sources (see Table 1). We estimate that, in 2012, *21% of home care hours and 18% of beds in residential care were provided by for-profit providers*; only 2-3% of both care forms were provided by non-profit organisations. Data from the Business Register distinguishes for-profit and non-profit employers in its measures of staff employed, and enables us to track the growth of the private sector over time. These data show that the size of the non-profit sector has been more or less stable since the beginning of the 1990s, and that growth of the private sector has been driven by significant increase in for-profit provision. In 1993,

¹¹⁵ In 1995 there were around 36,000 traditional institution-like nursing home beds in Denmark; in 2011, there were only 7,500; the majority of the places has been replaced by modern forms of residential care, with independent self-contained dwellings (Statistics Denmark 2012, Table 1).

the first year for which data are available, less than 1% of the care staff were employed by a for-profit provider; by 2010, the last year for which data are available, this had reached 17% (Trydegård 2001; Szebehely 2011).

In *Finland*, as in Sweden, the private sector is relatively large compared to Denmark and Norway, and the share of for-profit organisations in eldercare has grown significantly in recent decades. However, unlike all the other Nordic countries, in Finland *non-profit organisations* continue to play an important (although decreasing) role. *In the year 2010, the proportion of eldercare staff employed by a for-profit provider was 17.5% while the proportion employed by a non-profit organisation was 16.1%*. Thus the for-profit sector in eldercare seems to be more or less the same size in Sweden and Finland, while the Finnish non-profit sector is much larger than in any of the other Nordic countries. As we saw in Chapter 3, in Finland, the size of the for-profit sector differs significantly between the three forms of eldercare reported in the statistics. The lowest for-profit share is found in traditional institutions (6.5%) – a form of eldercare that is decreasing; the highest in modern service houses (30%) – a form of eldercare that is increasing (and today divided almost equally between the public, the market and the non-profit sector).

Although Finland, like the other Nordic countries, lacks regular user statistics distinguishing between for-profit and non-profit provision, there are some staff statistics that make it possible to track change in the size and composition of the private sector over time. The longest available time series refers to staff in the *entire social service sector* (Table 4 in Chapter 3) and shows that (as in Sweden), there was virtually no for-profit providers in 1990 (0.5% of the workforce). The increase of for-profit provision started later in Finland than in Sweden, but in 2009 (the last year reported), 14.5% of social service staff were employed by a for-profit organisation. As noted above, the non-profit sector seems to be larger in Finland than in any of the other Nordic countries, and, in contrast to Sweden, this sector has also grown: from 11.6% of the social service workforce in 1990 to 17.2% in 2009.¹¹⁶

In summary, in all four Nordic countries the majority of eldercare services are still publicly provided. There has been an increase in for-profit provision in *home care* in all four, where the for-profit share ranges from less than 3% of public expenditure in Norway to 21% of hours provided in Sweden and 37% of users in Denmark. Thus, measured as proportion of users, the for-profit home care sector is largest in Denmark, but measured as proportion of hours of help (and thus as share of expenditure or staff hours), the for-profit sector in home care is largest in Sweden. The for-profit share of *residential care* (institutions and service housing taken together) is marginal in both Denmark and Norway, considerably higher in Sweden and highest in Finland

¹¹⁶ However, as shown in Table 1, if we focus on eldercare only, the proportion of staff employed by the non-profit is smaller in 2010 than in 2000.

(varying from less than 1% in Denmark to 30% of service houses in Finland). The non-profit sector seems to have a marginal role in home care in all four countries, while non-profit actors have a more significant role than the for-profit sector in Danish, Norwegian and Finnish residential care. Only in Sweden has the non-profit sector a marginal role in both home based and residential eldercare.

2.2 Local variation and characteristics of the private sector

In all the Nordic countries there is large local variation behind the national average in particular related to local political majorities and level of urbanisation. For instance, in more than half of the Swedish municipalities all eldercare is still publicly provided, while in and around Stockholm, the majority of home care services as well as of residential care are provided by for-profit companies. In Denmark, for-profit take-up of home care is most common in and around Copenhagen and in affluent parts of the country. In Norway, the city of Oslo and the affluent neighbouring municipality Bærum were forerunners in introducing competitive tendering of nursing homes and choice models in home care. Both in Sweden and in Norway, municipalities with a right-centre majority have a higher share of private eldercare than municipalities with a social democratic majority (see Chapter 2 and 5).

The relative share of the private sector and its distribution between for-profit and non-profit providers are important measures of the extent of marketisation, but so too is the structure of the private sector. Accordingly, Table 2 gives some information on the structure of the private (for-profit and non-profit) eldercare sector by listing the largest actors (as reported in Chapters 2-5).

Table 2. Largest private eldercare actors; for-profit (FP) and non-profit (NP)

Sweden	Finland	Denmark	Norway
<i>Attendo</i> (FP): 98 nursing homes + 74 home care groups; <i>Carema</i> (FP): 81 nursing homes + 48 home care groups; <i>Aleris</i> (FP): 19 nursing homes + 18 home care groups	<i>Attendo</i> (FP): 80 care units; <i>Mainio Vire</i> (FP), <i>Mikeva</i> (FP), <i>Esperi Care</i> (FP), <i>Carema</i> (FP).	<i>Danske Diakon-hjem</i> (NP): 28 nursing homes; <i>OK-fonden</i> (NP): 13 nursing homes; <i>Fonden Maria-hjemmene</i> (NP): 6 nursing homes; <i>Aleris</i> (FP): 4 nursing homes	<i>Norwegian Female Volunteers</i> (NP): 7 nursing homes; <i>Aleris</i> (FP): 6 nursing homes; <i>Church City Mission</i> (NP): 5 nursing homes; <i>Attendo</i> (FP): 3 nursing homes; <i>Norlandia Care</i> (FP): 3 nursing homes.

Firstly, Table 2 shows that the largest actors are clearly larger in Finland and Sweden than in Norway and Denmark; secondly that while the largest actors in Denmark and Norway tend to be non-profit organisations (Denmark in particular has some non-profit organisations of considerable size), the largest actors in Finland and Sweden are all for-profit corporations. In both the latter countries' residential care sector there is a trend towards concentration, most strongly in Sweden, where close to half the private nursing homes are run by the two largest corporations (Attendo and Carema). In Finland, the ten biggest social service firms have 30% of the private sector. The three largest corporations (Attendo, Carema and Aleris) provide eldercare services in several of the Nordic countries.

The home care sector is generally more fragmented than the residential care sector, and besides the large actors there are also a large number of small companies, approximately 1,300 companies in the Finnish eldercare sector, 500 companies and 900 units in the Swedish home care sector and 500 home care companies in Denmark. In Finland 94% of the companies providing home care have fewer than 10 employees.

3. Instruments of marketisation

In the following section, we look at the instruments of marketisation used in the four countries to see whether there are differences that can help us to understand variation between them in the extent of marketisation. How the four countries have implemented procurement legislation may be one critical factor in explaining their divergent paths. A second may be whether or not legislation makes it compulsory for local authorities to offer a choice of provider.

3.1 Competitive tendering of residential care

3.1.1 Legislation on competitive tendering

Today municipalities in all the Nordic countries can outsource eldercare services to for-profit as well as to non-profit providers. In this respect the eldercare sector differs from the school sector, in which profit-making in publicly funded schools is permitted only in Sweden (Morin 2012). Note, however, outsourcing does not always follow from process of competitive tendering, so that while outsourcing happens to a greater or lesser degree in the four Nordic countries, competitive tendering is more important in the two Eastern Nordic countries, Finland and Sweden.

Finland was the first Nordic country to legislate to enable municipalities to outsource social services: since 1984, the Social Welfare Act has permit-

ted the use of state subsidies for social services provided by private organisations, including for-profit companies. In 1993, scope for municipalities to outsource increased considerably when earmarked state subsidies were dismantled and strict regulation of outsourcing of services was abolished (see Chapter 3).

Swedish municipalities were enabled to outsource eldercare and other social services to for-profit providers during the early 1990s. The legislative basis was the new Local Government Act implemented in 1992 and an amendment to the Social Services Act the same year. From 1992, Swedish municipalities could choose between providing all services in-house or outsourcing any kind of service to private providers (see Chapter 2).

Procurement legislation has been critical to developments in both Finland and Sweden. The two countries introduced similar procurement legislation in 1992 and amended it in 2007 following the EU procurement directive 2004/18/EC. Importantly, the EU directive was implemented more strictly than necessary:¹¹⁷ in both countries, welfare services (such as eldercare) are treated in the same way any other service in the procurement legislation. This means that the outsourcing of, for example, a residential care facility in Sweden has to be preceded by competition following the principles of non-discrimination, equal treatment, transparency and proportionality. The contract has to be given either to the bidder with the lowest price or to the most economically advantageous bid (a predefined mix of quality and price). Direct award of a contract without competition is only allowed when the value of the contract is small.

Identifying the legislation enabling competitive tendering in Danish eldercare is not entirely straightforward. In home care, competitive tendering in eldercare appears to be subsidiary to the policy on free choice of provider in force since 2003 (discussed in more detail in the following section). Under this choice policy and a 2012 revision to the Social Services Act, municipalities have been required to establish procedures for private providers to enter the home care 'market'. These procedures allow for competitive tendering but this is rarely used in home care. Also in residential care, competitive tendering has been available to local authorities, but, as discussed below, is little used. Denmark has also introduced procurement legislation in 2004, following the EU directive, and service contracts with a value of more than DKK 500,000 must be put out to tender. However, as we shall see, this has not affected local authority behaviour in the way it has in Sweden and Finland.

In Norway, as discussed in Chapter 5, there does not appear to be any restriction on contracting out of eldercare services. But nor has there been, within the social services policy field, specific legislative change to *encourage* outsourcing. Nevertheless, as in the other countries, the impact of

¹¹⁷ See Section 3.1.3, below.

European procurement regulation has been also felt in Norway, which passed a procurement act in 1992 and amended it in 1999, and some local authorities began to use it to contract out nursing home provision. This created some problems which Norway has addressed in a way different to the other countries, and which we discuss later.

3.1.2 Actual use of competitive tendering of residential care

Competitive tendering of residential care is a marketisation measure that seems to be much more widely used in Finland and Sweden than in Denmark and Norway (here we report only tendering of whole nursing homes or other facilities, not the process of outsourcing certain services such as cleaning or cooking in a nursing home which is probably relatively common in all four countries).¹¹⁸

In 2009, only four out of the 98 *Danish* municipalities had outsourced a total of six nursing homes after competitive tendering (resulting in two nursing homes run by a for-profit organisation and four by for-profit companies) (Rambøll 2009, p. 27). In *Norway* in 2012, 7% of the municipalities had used a process of competitive tendering of nursing homes (Blåka et al. 2012).¹¹⁹ Altogether there have been 47 calls for tenders for 29 nursing homes in Norway over the last 15 years (1997 to 2012). In 2012, of these 29 nursing homes, 15 were run by for-profit companies, 13 were back in public hands and one had closed down. None was run by a non-profit provider (Herning 2012). Thus, the nursing homes currently run by non-profit organisations in Norway have not gone through a process of competitive tendering. Instead they usually own their premises and ‘sell beds’ based on an often unlimited and less formalised contract with a municipality (Gautun et al. 2013).

We have not found information on how many *Finnish* and *Swedish* municipalities that have used the instrument of competitive tendering and outsourcing of residential care. However, it is obvious that, at least in Sweden, competitive tendering is much more common than in Denmark and Norway. In Sweden there were 70 cases of competitive tendering of nursing homes during 18 months (2011-2012; Almega et al. 2013.); so that approximately 45 nursing homes per year were put out to tender compared to 3 per year in Norway. However, in Sweden it is also the case that a majority of the

¹¹⁸ For instance, in Sweden in 1993, altogether 44% of the municipalities had already contracted out some part of their eldercare services such as cleaning or meal delivery (22% had contracted out residential care facilities and 5% home care services in a geographical district) (Socialstyrelsen 1994). In Finland, in 2010, 86% of all municipalities had contracted out at least some social services to private providers (Väyrynen 2011, p. 3).

¹¹⁹ NHO Service 2013 reports even lower figures on competitive tendering in Norway: according to the organisation, in 2012 fewer than 10 out of the 429 municipalities in the country (2%) had outsourced nursing homes after competitive tendering.

municipalities have *not* outsourced their nursing homes (in 2012, 65% of the Swedish municipalities had no privately provided residential care; Socialstyrelsen 2013a).¹²⁰ As in Norway, also the Swedish non-profit sector has been less successful in the bidding process (SOU 2001:31; SOU 2007:37).

3.1.3 Positive discrimination towards non-profit actors?

This report is not the place for a deeper analysis of the EU directive 2004/18/EC, but the distinction in the directive between the so-called B-services (including social services such as eldercare) and other services is important for understanding variation in the extent of outsourcing, and more generally, the different paths to marketisation in the Nordic countries.

The directive (article 21) states that in relation to B-services, member states do not have to follow the entire directive. Member states are, for example, permitted to exclude profit-making companies from providing welfare services such as eldercare, as long as domestic non-profit organisations are not favoured over international non-profit organisations. The most well-known precedent is the so called *Sodemare* case in the European Court of Justice, following which for-profit providers in the Italian region Lombardia were excluded from providing publicly funded social services. The EU court ruled that the EU Treaty does not 'preclude a Member State from allowing only non-profit-making private operators to participate in the running of its social welfare system'. The court argued that this was in line with the EU regulation as both domestic and international for-profit providers were treated in a similar way (Lex Europa 1997; see also Shekarabi 2012 and Almega 2012).

As Finland and Sweden have chosen to follow the full EU regulation for social services, there is no special treatment of non-profit providers in their procurement regulations, although this option would have been to them. Traditionally, the Finnish slot machine association had an important role in funding eldercare facilities run by non-profit organisations. A legislative change in 2001 put an end to this by reference to the EU-directive on procurement with the argument of competitive neutrality (see Chapter 3).

However, the other two Nordic countries have chosen to treat non-profit providers differently than for-profit providers, in various ways. In Denmark, as mentioned above, there is special legislation covering delivery contracts of residential care without competition regarding the so called independent nursing homes (*selvejende plejeboliger*). Such a home can only be run by a non-profit organisation, which also owns the building. The Danish Competi-

¹²⁰ There is no information on whether the 35% of Swedish municipalities with some privately run residential care actually have outsourced nursing homes after competitive tendering but as direct awards are no longer accepted according to the Swedish procurement legislation we expect that in most of these municipalities competition has preceded the tender.

tion authority has investigated whether local authorities' right to enter a long-term contract with these organisations without competitive tendering is in conflict with the EU directive on competition. The authority concluded that it was not. The independent nursing homes can be regarded as 'in-house production' and therefore the local authority can normally enter a contract without competitive tendering (Konkurrencestyrelsen 2010)

The Norwegian case seems to be similar. As mentioned earlier, Norway has a long history of outsourcing eldercare to private providers without competition, and no particular legislation was introduced to make this possible. We also noted that Norway introduced EU-style procurement legislation that stressed that public procurement in principle should be based on competition. However, after a few years, it became clear that the non-profit sector had difficulties in competing with for-profit providers, partly because the two sectors had different pension agreements (see Chapter 5 and Gautun et al. 2013). As the Norwegian municipalities have had positive experience of the quality of residential care provided by non-profit organisations, the Norwegian government was concerned about the difficulties the non-profit sector was facing. Therefore, in 2006, the government introduced a new regulation on public procurement (Regulation No. 402; Forskrift No. 402 om offentlige anskaffelser), which enables local authorities to choose to make agreements with non-profit care providers without opening up a competition with for-profit providers. This clause is regarded crucial for protecting the role of non-profit organisations in public care services. A for-profit corporation subsequently brought a complaint to the EFTA Surveillance Authority, but in 2010 the Authority decided to close the case. It argued that (referring to the Sodemare case) 'EEA States are allowed to exclude commercial operators from the market for public social services and a fortiori for child care and welfare services'. The Authority concluded:

'... taking into account that, with regard to the present award procedures, profit-making companies from other Member States do not seem to be in a less favourable factual or legal situation than Norwegian profit-making companies, the Authority concludes that Section 2-1(3) of the Norwegian Regulation No. 402, and the way it is interpreted and applied by the Norwegian Government, does not amount to a restriction on the freedom of establishment or the freedom to provide services under EEA law.' (EFTA Surveillance Authority 2010, p. 3)

Between 2001 and 1 July 2007, Sweden had a similar piece of legislation, colloquially called the Stop law, which forbade county councils to outsource emergency hospitals to for-profit providers. The legislation was introduced by a Social Democratic government, and was abolished when the centre-right government came in power in 2006. In 2001, shortly after the implementation of the Stop law, a government commission on procurement (SOU 2001:31) suggested that local authorities and county councils should have

the right to exclude for-profit providers to compete for providing health care or social services (including eldercare). In contrast to the Stop law, the proposed legislation would leave it open to the local politicians to decide whether or not they wanted to open up competition on the running of care services to for-profit companies or to non-profit organisations only (or to keep the services in public hands). The arguments were similar to those made in the Norwegian case (Regulation 402), (see SOU 2001:31, pp. 327-333). The proposed legislation, however, was not implemented.

3.1.4 Summary: Instruments of marketisation in residential care

Table 3 summarises some important differences between the Nordic countries in the legislation and actual use of competitive tendering. The two Western Nordic countries (Norway and Denmark) where non-profit providers are legally favoured make much less use of the tender instrument, and, as we saw in Table 1, the for-profit residential care sector is considerably smaller than it is in Finland and Sweden. The non-profit sector is smallest in Sweden – the country where non-profit providers have not been favoured in recent decades (as far as we have been able to discern), while Finland, with its history of strong support of non-profit residential care, still has a large (but declining) non-profit residential care sector. It is an important question for further research to analyse the role of the differences in the competition legislation between the Nordic countries; in particular in relation to the role of non-profit providers in the eldercare sector in the different countries.

Table 3 Summary of legislation and actual use of competitive tendering of residential care

Sweden	Finland	Denmark	Norway
Local Government Act 1992; Amendment of Social Services Act 1992.	Introduced 1984 (Social Welfare Act) but controlled by the state until 1993 with the end of earmarked state subsidies.	Law on independent nursing homes (2007)	No specific legislation that made outsourcing possible.
Procurement legislation 1992/2007	Procurement legislation 1992/2007	Implementation of EU directive on procurement (2004)	Procurement legislation 1992/1999
Competitive tendering <i>relatively widely used</i> (approx. 35% of municipalities)	Competitive tendering <i>relatively widely used</i>	Competitive tendering <i>rarely used</i> (4% of municipalities)	Competitive tendering <i>rarely used</i> (2-7% of municipalities)
Non-profit providers not favoured	Non-profit providers favoured until 2001; not since	Non-profit providers favoured in residential care (selvejende plejeboliger)	Non-profit providers favoured since 2006 (Forskrift No. 402)

3.2 Choice models and vouchers in home care services

Increasing diversity of providers has been part of the rationale for outsourcing via competitive tendering, but the primary goal of such policies has typically been increasing efficiency and reducing costs. However, offering a choice of (diverse) providers is the central rationale for another marketising measure that has also been introduced in Nordic eldercare systems: the various ‘consumer choice’ models. These models have in common that service users have the opportunity to choose a service provider from a range of possible providers. Competitive tendering and choice models overlap when would-be providers are required to tender in a competition for access to the choice system. However, as we report in this section, this is by no means the dominant approach to implementing a choice system.

3.2.1 Legislation on choice models

Home care services can be outsourced after competitive tendering where the organisation with the winning bid takes over the provision of home care

services of a geographical area. In Sweden in the 1990s, this was a fairly common form of marketisation. However, it did not offer a choice of providers to consumers within that geographical area. More recently, the Nordic countries have increasingly come to use various forms of choice models instead, where home care users who have been assessed eligible to receive publicly funded/subsidised home care services can choose between several providers authorised by the local authorities. Such models can be introduced following the procurement legislation, presented in the previous section. This was the case in Sweden up until 2009. More recently, all the Nordic countries except for Norway have introduced a specific legislation for choice models in home care.¹²¹ With or without specific legislation, in the choice models providers are not guaranteed a certain number of ‘customers’ after a process of competitive tendering; instead there is an element of continuing competition as each older person eligible for home care services decides which provider they will receive services from, and can change providers if they wish to.

In Finland and Sweden choice models in home care were already used on a small scale by a few municipalities in the 1990s, but the first country to implement choice legislation was Denmark (2003) followed by legislation on a voucher system in Finland (2004) and the Act on System of Choice in the Public Sector in Sweden (2009).¹²² In all four countries, the introduction of choice models has been justified with arguments about empowering users by enabling them to exercise consumer sovereignty. For example, the Swedish government commission that preceded the 2009 legislation expressed the goal of the new law as to ‘move power from politicians to citizens, to increase the choice and influence of users and to promote a diversity of providers’ (SOU 2008:15 p. 28). In contrast to outsourcing after competitive tendering, choice models do not involve competition on price

¹²¹ The Danish legislation applies only for home care while in Finland and Sweden the choice legislation can be used also for residential care. However, in both countries the instrument is used mainly for home care services (in Sweden the choice legislation is used for residential care in only 2% of municipalities; Konkurrensverket 2012 p. 69). However, even if the choice legislation is not used, it is not uncommon that an older person can choose between residential care facilities even if lack of available places in practice may limit that possibility. The right to choose a residential care facility seems to be most formalised in Denmark, where 71% of older people moving to residential care have refrained from their right to get a place within 2 months and instead actively have chosen a particular facility without the waiting list guarantee (Statistics Denmark 2012).

¹²² A voucher model was introduced also in Denmark in 2009. The main difference in relation to the Danish free choice legislation is that the user can act as employer; also a family member can be employed and if a company is used it does not need to be authorised. In 2012 the voucher system was in actual use only in one municipality, and in that case only for shopping (Socialstyrelsen 2012a).

and are not supposed to cut public expenses. Instead the users' right to choose and to exit a provider if dissatisfied is expected to drive up quality.

Despite similar aims, there are also some important differences between the legislation in the three countries. As already mentioned, it has been mandatory for Danish local authorities to open up for for-profit providers and to offer choice in home care (for practical assistance and/or personal care) since 2003, while the municipalities in the other countries are able to decide whether they prefer to provide all home care services in-house or not. In Sweden, the introduction of the choice legislation was followed by yearly state subsidies to encourage municipalities to implement the legislation (by the end of 2012 these state incentives have been taken up by 88% of the Swedish municipalities, although not all of them have decided to introduce choice models; see Chapter 2 and below). The government has announced that if the pace of introduction is too slow, 'compulsory legislation will be considered' (Government Bill 2010/11:1, p. 163).¹²³

Following the choice legislation in all three countries, the municipalities that decide to introduce choice models cannot restrict the number of providers that offer needs assessed home care services. All companies that meet the requirements set by the local authorities have to be accepted and authorised.¹²⁴

Choice systems offer service users the opportunity to choose a service provider from several (or many), but they do not, perhaps cannot, *oblige* them to do so. Each country with a choice system deals in a different way with allocating a provider to a user who does not want to actively choose. In Finland, for those who do not want to use the voucher option, local authorities are required to offer either public or outsourced home care services; in which case the user cannot choose provider. In Sweden the choice legislation states that there has to be a 'non-choice' option. In around half of the Swedish municipalities that have implemented the choice legislation, this option is the public provider, while most of the remaining half apply a rotation system between the authorised providers. Swedish legislation does not require local authorities to provide any services in-house, and a couple of local authorities no longer provide public home care services. The Competition Authority has recently argued that the 'non-choice' option should be required to circulate between all authorised providers (Konkurrensverket 2013). The authority stresses the interests of the private providers and argues that to have the local

¹²³ Since 2010 the county councils in Sweden are obliged to have a system of choice in place in the primary health care system.

¹²⁴ The Danish legislation allows also a tendering model based on competition which gives the local authority a possibility to restrict the number of providers, but if the municipality does not submit one of the best bids it will not be part of the choice model. In 2012, of the 98 Danish municipalities, 97 used the so called endorsement model, in which the number of providers may not be restricted. In 2013 the Danish legislation was amended and opened up for greater leeway for the municipalities in how they introduce choice models (see Chapter 4).

authority's own provider as the default option is a barrier to entry for private providers. By contrast, in Norway, it has been suggested that if a municipality introduces a choice model, those who cannot choose should be offered publicly provided services (Kluge Advokatbyrå 2009). This proposal is based on an argument that the municipality is the safest option for those who cannot choose, which stresses the needs of users over providers. To our knowledge, the public provider is the 'non-choice' option in all the (few) Norwegian municipalities that have introduced the choice model. Also in Denmark users receive services from the local authority provider unless they actively choose a private provider (Udbudsrådet 2012, p. 21).

There are some other differences between the choice legislation in the Nordic countries. In Denmark, all home care services are free of charge, and thus the user does not pay for the needs-assessed services regardless of whether he or she chooses a private or a public home care provider. In Norway, home nursing (including personal care) is free of charge while the user pays for home help services in the same way as home care users do in Sweden: they pay the same fee for privately and publicly provided services, and they pay that fee to the local authority, not to the provider. In Sweden, there has been a national maximum fee since 2002, but local authorities still have discretion in setting fees up to that maximum (currently €205 per month). As a consequence, user fees vary considerably between municipalities, particularly for those assessed as needing only small amounts of help. Finland does not have a national maximum fee, and in general a larger share of the costs for eldercare services are paid by the user out of pocket compared to the other Nordic countries. An individual who chooses a voucher for her needs-assessed home care may end up paying more for the help provided than those who choose municipal home care or vice versa. In some cases, combining a voucher with a tax rebate of home care services (see Section 3.3 below) leads to lower costs for the individual than using municipally arranged services. Particular to the Finnish voucher system is that it is very difficult for the user to calculate the actual cost beforehand because of the complex system with different rationalities and payment policies. This complexity has recently been recognised by the Ministry of Social Affairs and Health (see Chapter 3).

A notable feature of choice systems is that private providers are able to offer *additional services* that users pay for out-of-pocket. This possibility to 'top up' the needs-assessed offering is likely to make private providers, which are mostly for-profit, more attractive to home care users, especially those with a higher income. The opportunity to offer top-up services is important for the profitability of the private providers, and a competitive disadvantage for public providers, which are not allowed to offer them in Finland and Sweden. Interestingly a handful of municipalities in Denmark and Norway have also allowed public home care providers to offer additional services (see Chapter 4 and KS FoU 2013, p. 53).

3.2.2 Actual use of choice models in home care

In 95% of the *Danish* municipalities there is at least one for-profit provider of practical assistance in home care and in 2/3 of the municipalities there is at least one for-profit provider of personal care. The largest number of competing companies is found in densely populated and more affluent areas. While there are at least six competing for-profit providers of practical help in more than half of the Danish municipalities, only a few municipalities have that many providers of personal care (Krevi 2011). As shown in Table 1, only a small proportion of the users have chosen a private provider for their personal care. This probably reflects both the fact that fewer private companies are interested in offering personal care and that the users tend to prefer the public home care workers for these more intimate tasks. It has also been suggested that those with more complex needs find it difficult to make use of the choice option (Konkurrencestyrelsen 2009, p. 82).

In December 2012, 45% of the *Swedish* municipalities had implemented the choice legislation and another 16% of the municipalities had decided to do so (Socialstyrelsen 2013b). In contrast to Denmark, Swedish local authorities normally include all forms of home care (both practical assistance and personal care) in the choice models, and most home care providers offer both types of services. Consumer choice has primarily been introduced in densely populated urban municipalities (87% of the suburban municipalities compared to 15% of the sparsely populated municipalities) (Konsumentverket 2012). While there are many competing providers in densely populated areas, one out of every six Swedish municipalities that have introduced the choice legislation has not managed to attract any private providers at all (Konkurrensverket 2013, p. 89). The Competition Authority has suggested that to attract private providers, the local authority could start by outsourcing the home care services in geographical areas before introducing the choice model (Konkurrensverket 2013, p. 130). The citizens in these areas would then be allocated to a specific home care company, and as continuity is an important aspect of quality in eldercare, they would be expected to stay with the provider after the introduction of the choice model. In contrast to Denmark, this form of competitive tendering and outsourcing of home care districts preceded the introduction of choice models in some parts of Sweden, which could explain the higher share of privately provided home care in Sweden.

Stockholm is one of the municipalities that had already outsourced home care districts in the 1990s, and at present more than 60% of the home care services are privately provided. An older home care user in the city of Stockholm can choose between around 100 companies (Chapter 2). Frail older people often find it difficult to make a choice; in particular when there are so many providers to choose between. Recently a Swedish government commission has recognised the problem of free establishment of home care

providers following the choice legislation, both for the individual user and for the local authority's capacity to follow up the providers (SOU 2013:12).

In *Finland*, half of the municipalities have introduced vouchers for health or social care services. Vouchers are often used for eldercare services but there are no statistics on the number of municipalities offering them for home care or other forms of eldercare. However, in 2011 the number of voucher users in home care was 9,000 individuals, which corresponds to 9% of home care users (Chapter 3).

As mentioned there is no choice legislation in *Norway*, and only a handful of municipalities have introduced choice models, usually for practical help only (not for personal care). Only two municipalities (Oslo and Bergen) have included also home nursing (personal care) in the choice model. The exact number of municipalities with choice models including private providers is not known – according to one source 8% of the municipalities have implemented some form of free choice in home care but the choice does not include private providers in all of these municipalities (Chapter 5).

3.2.3 Summary: choice models in home care

As Table 4 summarises, in the last decade three of the four Nordic countries have introduced choice legislation that either explicitly covers home care (Denmark) or in practice is used for home care rather than residential care (Finland and Sweden). With the exception of Norway, choice models in home care are relatively widely used. Common to all the countries is that the introduction of choice models represents an ideological shift such that older home care users are increasingly seen as consumers, who are supposed to make an informed choice and to exit a provider if dissatisfied.

Although older people in general appreciate the possibility to choose, not all can or want to make an active choice. Therefore all the countries have a 'non-choice' option. However, the actual solutions vary between the countries. Based on arguments about protecting weak users, in Denmark and Norway the default option is public home care. However, in Sweden, an increasing proportion of municipalities have the 'non-choice' option rotate between all authorised providers. Recently, based on arguments about protecting private providers, the Competition Authority has suggested that this should be mandatory for the municipalities.

In Denmark, municipalities are obliged to introduce choice models while in the other countries such models are introduced at the discretion of the local authorities, and are more often used in more affluent and densely populated areas. Also the number of providers varies. In sparsely populated areas few or no private companies are willing to offer services. In contrast, as the local authorities that have implemented the choice legislation cannot restrict the number of providers, in some cases, especially in and around Stockholm, the number of providers is so high that it had created difficulties

both for users to make a choice and for the local authority to oversee the quality of services.

Table 4. Summary of legislation and actual use of choice models in home care

Sweden	Finland	Denmark	Norway
Act on System of Choice 2009 (not mandatory). Free establishment for all providers that meet quality criteria; number of providers cannot be restricted.	Vouchers legislated in 2004/2009 (not mandatory). Free establishment for all providers that meet quality criteria; number of providers cannot be restricted.	Free choice legislation 2003 (mandatory). Free establishment for all providers that meet quality criteria (in all but one municipality); number of providers cannot be restricted.	No specific legislation on choice; usually based on a tender process; number of providers can be restricted.
<i>Choice models are relatively widely used (piloted since the 1990s; today used in 45% of municipalities; another 16% decided to implement; rapid increase (2012).</i>	<i>Choice models are relatively widely used (piloted since the 1990s; today used in half of the municipalities (not only eldercare); used by 9,000 individuals for home care, corresponding to 9% of home care clients).</i>	<i>Choice models are widely used. Choice of practical assistance in 95% of municipalities; personal care in 2/3 (2010). Vouchers introduced in 2009; in use in only one municipality (2012).</i>	<i>Choice models are rarely used (8% of municipalities in 2012; maybe fewer). Mainly only for home help but in Oslo and Bergen also home nursing.</i>

3.3 Tax rebate for household services

3.3.1 Legislation on tax rebate

The third form of marketisation instrument discussed in this chapter – the tax rebate for household services – differs from the previous two in that it is actually not part of the formal eldercare service system. However, it intersects in several ways with the eldercare services, in particular with choice models of needs-assessed home care.

This form of marketisation instrument has been introduced in three of the Nordic countries, and, once again, Norway is the exception. Denmark was the first country to introduce tax rebate for household services (1993) followed by Finland (1997) and Sweden (2007). In all three countries the tax rebate covers domestic services as well as home repairs, and the schemes have been introduced on the basis of similar arguments: to facilitate every-

day life for women and men, to create new jobs and promote small business and to turn 'grey market' jobs 'white'.

In *Denmark* the tax rebate for domestic services was introduced in 1993 and became permanent in 1997. Fifty per cent of the actual cost was reimbursed, there was no ceiling on the amount deductible, all age groups were eligible and the scheme soon became very popular. In 1999, it was used by one in seven households, mainly for cleaning and window-cleaning. In 2000, the Danish Office of the Auditor General criticised the government for not having conducted a cost-benefit analysis of the increasingly expensive scheme (Rigsrevisionen 2000). As a result, in 2002, the level of the tax rebate was reduced to 40% and it was no longer possible to use it for window cleaning. In 2004, the rebate was further limited: only older people (65+) and those with a disability pension remained eligible, and a ceiling of the rebate of DKK 24,000 per year was introduced (Økonomi- og Erhvervsministeriet 2003). In 2009, the level of the rebate was further reduced to 30% of the expenses. In 2011, the legislation was changed to include all age groups again and to cover also home repairs and child care, not only domestic services, but at the same time the ceiling of the rebate was further reduced to DKK 15,000 per year (€2,000) (Finansministeriet 2011). In 2013 the scheme was converted into a scheme for energy-saving renovations and domestic services were no longer to be covered but already after a couple of months the old scheme was reintroduced covering *one third of the cost for domestic services, care or home repairs up to €2000 per year* (Chapter 5).

The *Finnish* tax rebate covers purchase of cleaning, care of children or older people and home repairs, and the ceiling for the deduction is €2,000 per individual and year (lowered from €3,000 in 2012). It can be used either to employ a worker directly or to purchase services from a company. In the latter case *45% of cost of the expenses is deducted* (Chapter 3). Since 2005, the tax rebate can also be used for the purchase of services carried out in the home of a parent (Government Bill 2006/07:94, p. 26).

The *Swedish* version of the tax rebate for household services is the newest and presently the most generous of the three Nordic schemes. It can be used for the purchase of domestic services, care and home repairs, *50% of the costs are deducted up to the maximum amount SEK 50,000 per year (€5,700)*. When the scheme was introduced in 2007¹²⁵ care of older people was explicitly mentioned in the Government Bill, which referred to research showing that the decline of needs-assessed home care services in the 1990s had been followed by an increase in informal care, in particular among the daughters of older people with fewer resources. It was argued that introduc-

¹²⁵ In 1993, a temporary tax rebate for home repairs had been introduced in order to counter the recession by encouraging home owners to renovate their homes. The measure was used several times following the business cycle, but before the introduction of the 2007 legislation, domestic services and care had not been included (Government Bill 2006/07: 94).

ing the tax rebate would reduce the cost of purchased assistance and enable these women to increase their gainful employment (Government Bill 2006/07:94, p. 31). As in Finland, in Sweden is it also possible to use the tax rebate for the purchase of domestic services and care in a parent's home.

3.3.2 Actual use of the tax rebate for household services and care

The tax rebate schemes have been used by an increasing number of people in all three countries. We have not been able to find any statistics on the uptake of the Danish rebate after 1999, but as mentioned above, at that time around *14% of the Danish households used the rebate for domestic services*. In Finland the rebate also became increasingly popular and *in 2011 around 10% of all Finnish households used the rebate for home repairs or domestic services*. There are no statistics on the number of users of the rebate for domestic services and care, but in 2009, roughly one fifth of the amount withdrawn was used for domestic services (16%) or care (3%) and the rest for home repairs (81%). Older people are overrepresented as are those with higher income (Chapter 3). According to a survey conducted in two Finnish city regions (Tampere and Jyväskylä) in 2010, close to 15% of the population 75 years and older used the tax rebate to purchase domestic services, mainly cleaning (Anttonen & Häikiö 2011).

Only *Sweden* seems to have regular statistics on the uptake of the rebate for household services or care among older people (see Chapter 2). In 2011, *8% of older people (65 years+) used the rebate for household services or care*, and as in Finland the rebate is used more among older people than in younger age groups, and more among those with higher income than in lower income groups. Only very few individuals reach the ceiling for the rebate; on average the rebate was around €350 in 2011 among older people, corresponding to approximately 20 hours of help per year.

3.3.3 Summary: interplay between tax rebate and choice models in home care

Various forms of tax rebate for domestic services have been used in Denmark since 1993, in Finland since 1997 and in Sweden since 2007, while Norway has not introduced any such scheme. Today the Swedish tax rebate is the most generous, both in terms of the share of the expense covered (50% compared to 45% in Finland and 33% in Denmark) and in terms of the ceiling (€5,700 in Sweden compared to €2000 in both Denmark and Finland). The uptake of the rebate seems to have increased in all the countries, although only Sweden provides more detailed and up-to-date statistics. Where we do have information (Finland and Sweden) older people and those with higher income are overrepresented.

The rebate interacts with the formal home care services in several ways. In Finland, the threshold for entering tax-funded home care services has been significantly raised since the early 1990s, and increasingly those who need practical help only are referred to the market to purchase services. In Sweden a similar decline of home care services has taken place and there has been a significant increase of unpaid family care in particular but also of privately purchased help (Szebehely & Trydegård 2007; Szebehely & Ulmanen 2012).

In both Finland and Sweden, the tax rebate makes it cheaper for those with medium to high pensions and smaller care needs to buy services at the market than to use needs-assessed home care services. This incentive to turn to the market is not present for Denmark, where home care services are free of charge for the user. However, in all three countries, needs assessments have become increasingly strict, which certainly is an incentive to turn to the market for those who no longer are eligible for home care or for those who do not receive the amount of help they regard reasonable. Thus, it is likely that, in all three countries, an increasing proportion of older people, in particular those with higher incomes, use the tax rebate to purchase services at the market, either instead of home care services or to top up the needs-assessed offering.

For the private companies in the choice models of home care services the tax rebate is probably crucial. Besides needs-assessed home care, they can offer domestic services both to the general public and to home care users who in both cases pay a considerably lower price for the services thanks to the rebate. And, as the private but not public providers can offer additional services, in practice, the combination of choice models and the tax rebate creates an incentive for well-to-do older people to choose private providers for their tax-funded and needs assessed home care services, which they can complement by buying extra services from the same staff, at a reduced price using the tax rebate. For older people from the same social group who have smaller care needs, the tax rebate serves as an incentive to entirely refrain from formal home care services and buy private help instead. In both cases, these citizens receive a subsidy for assistance via the tax rebate. Whether this leads to a dualisation of care, with publicly provided services increasingly dominated by older people with fewer resources is yet to be seen.

Table 5. Summary of legislation and actual use of tax rebates for household services and care

Sweden	Finland	Denmark	Norway
Introduced in 2007.	Introduced in 1997.	Introduced in 1993. Between 2004 and 2010 only older people and people with a disability pension were eligible; today all age groups are eligible.	No tax rebate available
Covers 50% of the cost up to a rebate of SEK 50,000 (€5,700) per person and year for services (domestic help + care) and home repairs.	Covers 45% of the cost up to a rebate of €2,000 per person and year for services (domestic help + care) and home repairs.	Covers 33% of the cost up to a rebate of DKK 15,000 (€2,000) per person and year for domestic help, child care and home repairs.	
Rapid increase; 8% of population 65+ uses the rebate for services (2011); higher uptake in high income groups.	No data on users of the rebate for services; only on home repairs and services combined: rapid increase; used by 10% of all households in 2011; the majority of the amount for home repairs; higher uptake in high income groups.	No current data on up-take, used by around 14% of all households in 1999 (rapid expansion in the 1990s).	

4. Regulation of service quality under marketisation

4.1 Legislation governing quality

In general, when governments fund private provision of services to vulnerable social groups, the question arises of how the public funder is going to ensure that collective resources are not wasted and that the services provided are of the quality expected. A range of regulatory strategies has emerged in the attempt to drive and measure the efficiency, effectiveness and quality of social care services in different marketised systems, including in the Nordic countries. We begin with an overview of the regulations and institutions that directly govern service quality in the four Nordic countries, and discuss how marketisation has been associated with a new suite of ‘soft’ regulatory tools and institutions.

As far as we can discern, there are no major differences between the Nordic countries in their framing legislation governing service quality. Along with their universalistic ambitions, the Nordic countries have shared a long-standing tradition of trust in the professionalism of public sector workers, and democratic steering and oversight of services at the local level. Accordingly, legislated quality requirements have historically taken the form of general guidelines, such as the obligation under the Norwegian Act on Health and Care Services that local authorities must ensure that services of sound quality are provided to citizens in need (see Chapter 5) or the stipulation under the Swedish Social Services Act that the quality of services should be good, and ‘monitored on a regular basis’ (see Chapter 2). Overall, there is relatively little detailed, binding regulation that prescribes how quality should be defined, measured and monitored.

In each country there is a national supervisory body, which operates largely through ‘soft’ regulatory strategies such as developing and disseminating quality guidelines and offering support to local authorities as they develop service quality and quality monitoring. Sweden’s national supervisory body, the National Board of Health and Welfare (NBHW, Socialstyrelsen), promulgates binding guidelines about how *systems* of quality assurance should be developed, but not on the elements of quality that should be assured. The Board also had, until 1 June 2013, responsibility for inspection to monitor quality in eldercare. Since that date, a new institution, Health and Social Care Inspectorate, has taken over this role (see Chapter 2). In Finland, Valvira (the National Supervisory Authority for Welfare and Health) coordinates supervision of social care, with each of the six Regional State Administrative Agencies supervising within its own region (see Chapter 3). The Danish National Board of Social Services (Socialstyrelsen) provides guidance, advice and ‘inspiration’ on how municipalities can improve their services.¹²⁶ In Norway, the National Board of Health Supervision works with the Offices of the County Governors to inspect services and to assist local authorities with quality management (Helsetilsynet 2013).

Thus, although national supervisory bodies exist in all four countries, local authorities are legislatively required to monitor and develop the quality of services, and how they do so is generally left to them to decide. In Norway, legislation requires local authorities to have internal control procedures for quality management, but does not specify their form or content (see Chapter 5). Danish local authorities are required to monitor the quality of eldercare; under the law on the supervision of nursing homes for residential care and under the Act on Social Services for home care. Nursing homes must be inspected annually by independent inspectors (which may be private providers). Home care service providers are also subject to inspection, but

¹²⁶ See: <http://www.socialstyrelsen.dk/om-os/about-us>.

the law does not specify that these inspections must be independent (see Chapter 4). Likewise, the Swedish Social Services Act specifies that the quality of services should be developed and monitored systematically and on a continuous basis, but does not stipulate measures or methods (see Chapter 2). In Finland, local authorities also have responsibility for monitoring service provision (see Chapter 3).

Because local authorities are delegated the authority to define and measure most aspects of service quality, there is little binding regulation of critical determinants of quality such as staffing ratios and training levels. While Norwegian facilities offering 24 hour services are required to have a doctor and a registered nurse on hand around the clock, the only other specifications in relation to personnel are that nursing homes have ‘sufficient staffing’ and ‘professional staffing’ (see Chapter 5). In Finland, the Regional State Administrative Agencies *recommend* but do not require staff ratios for residential care (see Chapter 3). There are no staffing requirements specified in the Swedish Social Services Act; the only stipulation is that staff should have ‘adequate skills’ (see Chapter 2).

With the establishment of what quality means and how it is to be measured being largely left to local authorities, the quality of privately provided services is regulated under the contracts through which private providers enter the market. Where services are outsourced, the call for tenders includes service specifications, some of which will be quality measures; in a consumer choice model, the authorisation rules contain any quality specifications. Once local authorities have made agreements with private providers, they are responsible for ensuring that those providers adhere to agreed standards. Again, variation between municipalities must be assumed, and local autonomy makes it impossible to account comprehensively for how local authorities establish quality measures and follow them up. Chapter 2 reported that, in Sweden, several recent reports have found that follow up by local authorities is poor. In Finland, private providers are required to report on their activities to the relevant local authority or to the Regional State Administrative Agency if the organisation provides services with 24-hour assistance (Chapter 3)

Formal regulatory measures such as setting standards (albeit vaguely), requiring inspections and monitoring contracts come from the ‘top down’. There is also formal provision for quality monitoring from the bottom up, through complaints mechanisms for users and reporting requirements on staff. We do not have comprehensive knowledge about these mechanisms for the four countries – not least because responsibility for them is frequently devolved to local authorities. However, we do know something about arrangements in Sweden (see Chapter 3), where there is a Law on the Patients’ Advisory Committee that sets out specific arrangements for patient complaints in health care but no corresponding legislated requirement for user complaints in eldercare. Several recent reports have found that practice

varies and is often underdeveloped in local authorities. Further, there is a mandatory reporting system in Sweden under *lex Sarah*, which requires social care *staff* to report deficiencies in care to the local care providers who in turn are to report serious breaches to the Health and Social Care Inspectorate (before June 2013 to NBHW) (see Chapter 2).

To the best of our knowledge, public and private providers are, in general, subject to the same formal quality regulations in the four Nordic countries. An exception that we are aware of relates to processes and protections for mandatory reporting and freedom of information in Sweden. Chapter 2 explained that reports of deficiencies can be made by staff directly to the responsible political board of a local authority for public organisations, but only to an internal manager within private organisations, who is then required to report to the relevant political board. Further, employees of private eldercare providers do not have the same rights to whistleblower protections as public employees. Related, citizens do not have the same access to the documents held by private providers as they do under their normal rights of access to public documents under Freedom of Information laws. These arrangements may reduce capacity to oversee the operations of private providers.

4.2 ‘Soft’ measures of quality management

The facts that ‘top down’ quality regulation remains largely devolved to local authorities, and that public and private providers are mostly subject to the same quality requirements might suggest that marketisation has had little impact on quality monitoring in the Nordic countries. However, that would be a mistaken conclusion: a wide range of ‘soft’ or non-rule-based measures that are connected to marketisation have emerged as part of quality management and development in Nordic eldercare. We note three trends here, but cannot provide an exhaustive analysis, partly for reasons of space and partly because we do not have all the relevant information.

The first is that, under the pervasive influence of New Public Management, performance and other forms of information have assumed an increasingly important role in the administration of social care services. There is a mix of ideals and goals here, including increasing consistency and accountability of service provision, and supporting competition. Information is typically collated and overseen by the relevant supervisory body in each country. Assembled into databases which demand consistency and comparability in measurement, information is supposed to drive comparison and standardisation of services and organisations, and to inform decision-making by various actors.

In Sweden, *Äldreguiden* (the Elderly Guide) is an internet database that enables users to compare residential and home care services at the level of municipalities and of specific providers, while *Öppna jämförelser – Vård*

och omsorg och äldre (Open comparisons – eldercare; established in 2007) is aimed at officials and politicians within local authorities, and compares and ranks the performance of eldercare services by municipality. In Denmark, the process of developing tools to increase accountability and comparability began in the 1990s with the ‘common language’ (see Chapter 4). This is a standardised set of categories for needs and services, which provides the conceptual foundation for statistical indicators that can be used at the local political level as well as for benchmarking between local authorities. The common language became very useful when service marketisation began in earnest in 2003, enabling the easy comparison of public and private tenders. In 2007, an online database, Tilbudsportalen (the Tender Portal), was established to enable providers, service professionals and local, regional and national governments with information about prices and services currently available.¹²⁷ Another database provides similar information, but is also directed at users (Fritvalgsdatabasen; the Free Choice Database).¹²⁸ In Norway, the KOSTRA-IPLOS information system, also established during the 1990s, supports widespread benchmarking between municipalities. Interestingly, in Norway, inter-municipal *co-learning*, rather than competition, seems to be an important outcome of benchmarking exercises (see Chapter 5). We do not have information about whether such information systems and databases exist in Finland.

Second, these information systems have become closely entwined with another important marketisation measure designed to improve service quality through competition: the consumer choice models operating in Sweden and Denmark. In consumer choice models, consistent and reliable information that enables users to compare different providers becomes important. In Sweden, for example, the Elderly Guide has been established to assist older people make an informed choice of service provider, and to contribute to quality improvement. The idea is that providers offering high quality services (as assessed by the measures included in the guide) will be chosen more often and those offering poorer quality will either improve or exit the market – the expected net result is higher quality overall. The Free Choice Database in Denmark is designed to play a similar role.

In both Sweden and Denmark, ‘consumer satisfaction’ measures have become integrated into quality measurement systems, which themselves feed back into steering the composition of the sector via consumer choice. In this way, market roles and discourses further penetrate the eldercare system. Further, research has found that the use of these information-based technologies of management can change the quality of services – their ‘texture’ and

¹²⁷ See: <http://www.tilbudsportalen.dk/om-os> (in Danish).

¹²⁸ See: <http://www.fritvalgsdatabasen.dk/indhold?system=databasen&id=databasen.formaal> (in Danish).

experience – even when the services remain publicly provided (see Chapter 5, also Dahl 2009; Lindgren 2012; Rostgaard 2012; Szebehely 2006; Vabø 2006, 2012; Trydegård 2011).

The third trend we note is the proliferation of institutions associated with the development and management of information and the oversight of service quality in eldercare, particularly in Sweden, and to a lesser extent in Denmark. Chapters 2 and 4 documented the array of old and new institutions at the national level that have been marshalled to organise, promote and monitor outsourcing, competition and service quality in Sweden and Denmark. These developments are evidence of the consolidation in these countries of a new regulatory approach that extends the ‘soft’ regulation we have just been discussing.

4.3 Lessons from the English-speaking countries

This regulatory approach is well-established in the English-speaking countries (Braithwaite et al. 2007), and Chapters 6 and 7 offer some salutary evidence about the feedback effects of the growth of for-profit provision and increasingly detailed regulatory oversight in the Canadian eldercare system. Decades of extensive empirical research on nursing home regulation in the United States, England and Australia has shown that, as for-profit provision has expanded, the following has happened: ‘In all three nations, the density of rules and resources to enforce them has increased and this capability has become more centralized in national regulatory agencies’ (Braithwaite et al. 2007, p. 219). This increase in rules has been driven by scandals about poor quality care, to which politicians respond with increasingly detailed rules, resulting in a ‘regulatory trap’: detailed regulation increases, but does not solve problem of poor quality. Rather, these regulatory systems are themselves plagued by a range of predictable and well-documented problems.

One of these is a tendency for ritualistic responses from all actors in the regulatory system (Braithwaite et al. 2007, pp. 219-259). Braithwaite and colleagues explain how politicians create more and more rules that give the appearance of being tough in a ‘ritual of comfort’ towards the electorate. Inspectors, who are not resourced to do their job properly, cannot possibly enforce all the detailed rules that emerge from the cycle of scandal and rule-making, and so many rules are ignored in ritualised inspections. Nursing home administrators learn how to get good results from inspections by managing the paperwork rather than the care process. Similar experiences are reported from Canada in Chapter 6 and 7.

Another general problem is ‘provider capture’: for-profit providers become a strong lobby group which succeeds in shaping the regulatory regime at least partly in their own interest (Braithwaite et al. 2007, pp. 187-198). These providers strongly resist regulation of essential structural quality

measures, such as staffing ratios, which do not exist in Australia, the United States, or Canada.

The proliferation of rules has unintended perverse consequences at several levels (Braithwaite et al. 2007). There are effects at the level of the composition and structure of the industry. The more complex, demanding and centralised is the monitoring system, the more large companies are favoured, because they are more likely to have the resources needed to manage the documentation demands and other costs of regulation. The monitoring process itself is distorted by the number and misleading specificity of the criteria of monitoring – how things are measured may not capture how they really are. Meanwhile the care process becomes distorted by rituals of compliance as regulation drives routinised care, and takes time away from care in documentation.

Central to these developments is the loss of trust in professionalism and in public sector ways of doing things, and increased trust in markets and regulation of market externalities (Braithwaite et al. 2007, p. 260; see also Chapter 6). Yet, as Chapter 8 shows, in the United States, the most market-oriented organisations – for-profit firms, especially corporate chains, and most especially those owned by private equity firms – are those with the poorest average performance. This suggests that trust in market ways of doing things may be misplaced, and proliferating regulatory responses ‘across’ the public-private boundary may not be effective.

The findings of researchers in English-speaking countries show the dynamic effects of marketisation on service quality and quality management over many decades. The processes Braithwaite and colleagues describe are in their early phases in Sweden and Finland, and to a lesser extent in Denmark, and the outcomes starkly illustrated in Chapters 6-8 are not evident yet.

5. The consequences of marketisation

5.1 Marketisation in theory and in reality

Marketisation of eldercare has been introduced with similar rationales in the Nordic countries as elsewhere in the world. Neo-classical economists have argued that competition between providers, in the form of competitive tendering or choice models, will reduce public spending, improve quality and – in the case of choice models – empower the users by enabling them to choose between different providers of care and exit if dissatisfied (see, for example, Le Grand 2011). In theory, certain conditions must be met for marketisation to function this way. There must be several providers, and they must be able to enter the market – and be put out of business if they do not provide good enough services. Service users and the public authorities that

purchase services on their behalf must have access to information about the quality of services offered by different providers, and be able to use that information to inform their choices, including the choice to change providers (to 'exit') if they are not satisfied (Le Grand 2011, p. 85).

The consequences of marketisation are partly determined by extent to which these preconditions are met when competition and choice are introduced into eldercare services either in outsourcing models when local authorities choose providers, or in customer choice models, when users choose. Our focus is primarily on whether the preconditions are likely to be met in consumer choice models, since they are the marketisation measure most used now, and most likely to be used into the future in Nordic eldercare. Further, against the background of Nordic universalism, it is also important to investigate the *distributional* consequences of marketisation. Finally, as discussed in the previous section, the co-evolution of markets and regulation in the English-speaking countries has revealed the very significant *regulatory* challenges in marketised social services.

Several international scholars have argued that the preconditions for marketisation to deliver the predicted benefits are unlikely to be met in markets in care (for example, Land & Himmelweit 2010; Brennan et al. 2012). These scholars argue that the relational aspects of care make its quality difficult to measure and evaluate, especially beforehand. This suggests a gap between the informational requirements of a well-functioning market and the reality of care as a practice and relationship. Another set of reasons relates to the extent to which the efficacious agency expected of consumers in markets is exercised by older people as they choose providers and exit those that are unsatisfactory. Several scholars have stressed the difficulty people have making well-informed choices at the stage of life when eldercare is on the agenda (for example, Meinow et al. 2011). When faced with making a choice about eldercare, most older people are vulnerable due to frailty and, often, cognitive impairment. Even if older people are, in principle, positive towards the opportunity to choose a provider, they can still find making the actual choice stressful. Further, not all eldercare users feel empowered by the possibility to choose provider; instead 'values such as confidence, security and trust may be more appreciated by users than the opportunity for choice' (Barnes & Prior 1995, p. 58). One reason why older people can find making a choice stressful is that the consequences of a bad choice can be severe, partly because it is not easy to 'exit' when one is very frail (Glendinning 2008). Important in this context is that continuity of care is a crucial aspect of care quality so exiting a care relationship when they find that quality is inferior can be too costly a strategy for an old person receiving eldercare services. This critically limits the effectiveness of market mechanisms in ensuring care quality (Eika 2006; Brennan et al. 2012).

We noted in the introduction of this chapter that there is limited information in the Nordic countries about the extent of marketisation. When it comes to empirical studies of the *consequences* of marketisation the scarcity of knowledge is even more striking. A recent Swedish Government Commission noted: ‘It is surprising how little information there is today about public procurement and its effects on individuals, business, contracting authorities and society at large’ (SOU 2013:12, p. 551).

There are, however, some recent reviews of existing research in Denmark (Petersen & Hjelmar 2012), Norway (Gautun et al. 2013) and Sweden (Szebehely 2011; SKL 2011; Socialstyrelsen 2012b). We have not been able to find similar overviews for Finland, and as noted in Chapter 3, national evaluations are very rare which is remarkable given that marketisation is comparatively extensive in Finland. In this section we summarise the information given in Chapters 2-5 and in the reviews just listed.

5.2 Summary of findings: Consequences of marketisation

In line with the previous sections of this chapter, we summarise the consequences of marketisation for residential care and home care services in two separate tables (Tables 6 and 7). In practice, this will mainly (but not entirely) reflect a distinction between consequences of competitive tendering and choice models. Unless otherwise stated the information in the tables is gathered from Chapters 2-5.

Table 6. Consequences of marketisation: residential care

	Sweden	Finland	Denmark	Norway
Costs	Some evidence of saving in first generation contracts; no recent studies; no studies of transaction costs.	Limited evidence; one larger study on service housing; mixed results: lowered costs in some municipalities, increased in some and unchanged in some.	Some evidence of saving in first generation contracts; transactions costs not included.	Limited evidence; study of Oslo shows lower costs for outsourced nursing homes; transactions costs not included. ¹²⁹
Quality for users	Based on large national data sets: FP compared to NP and public: Lower staffing level; lower training level and more hourly employment; higher process quality; no difference in user satisfaction.	Limited evidence; one larger study on service housing; mixed results; Staffing ratio higher in private sector (not controlled for care needs).	Limited evidence; no major difference.	Virtually no evidence; Oslo: no difference in user satisfaction; ¹³⁰ critique of quality measures. ¹³¹
Employment- and working conditions	Staffing ratios and hourly employment, see above; few studies on working conditions; no major difference reported.	Limited evidence; one larger study see above; staffing ratios, see above; more stress in public; more critique of management in private.	Limited evidence; no major difference.	Limited evidence; cost saving strategies likely to affect workers: pension agreement in FP care less generous; case studies indicating lowered staffing level after FP takeover and that process of tendering is related to uncertainty and stress among staff.
Other consequences reported	Privately employed care workers report less connection to local politicians possibly affecting legitimacy of democratic steering		Reduced democratic control.	

¹²⁹ Study conducted by Oslo Economics (2013), reported in Gautun and colleagues (2013, p. 35).

¹³⁰ Gautun and colleagues (2013, p. 37).

¹³¹ In particular, PhD theses by Slagsvold (1995) and Eika (2006); see Chapter 5.

Table 7. Consequences of marketisation: homecare services

	Sweden	Finland	Denmark	Norway
Costs	Some studies. No evidence of saving; some evidence of increased transaction costs (more time for control, needs assessment and for travel between clients).	No studies reported.	Few studies. No evidence of cost saving; some evidence of more administrative costs as a result of the introduction of choice models.	No studies reported.
Quality for users	Based on large national data sets: FP compared to NP and public: lower training level and more hourly employment; higher process quality; no difference in user satisfaction. No difference in user satisfaction between municipalities with and without choice models. Smaller studies: users appreciate the right to choose but find choice difficult, especially when many providers are competing.	No studies reported.	User satisfaction surveys comparing public/FP: slightly more satisfaction with FP practical help and with public personal care; users appreciate the right to choose but find choice difficult; 1/3 or users are not aware of the right to choose; higher formal training on public home care.	Few studies; users appreciate the right to choose; no data on differences in user satisfaction between municipalities with and without choice.
Employment- and working conditions	Hourly employment, see above; small private companies in choice models tend not to have collective agreements; otherwise no major difference (few studies).	No studies reported.	Few studies, no clear evidence. Mixed results; more stress, poorer working conditions but more influence in work in FP; recent survey – FP workers more satisfied with quality of care but report more demanding working conditions.	Case studies: stricter regulation of care tasks have negatively impacted care workers possibilities to flexibly respond to complex and shifting care needs (also affects publicly employed workers).
Other consequences	More awareness of quality issues; risk that less resourceful groups are disadvantaged in choice models.		More awareness of quality issues.	

5.3 Discussion

It is not obvious how findings on consequences of marketisation that we have summarised in Tables 6 and 7 should be interpreted. Although the empirical base is relatively weak, there are some studies in each of the countries, based on various methods. Larger scale studies are mainly reported from Sweden, based on national data collected within the framework of Open Comparisons (see Chapter 2). Several of the (relatively few) Nordic studies compare public and private services, with the latter only rarely divided between non-profit and for-profit. Fewer studies have examined change over time or have compared municipalities with and without marketised eldercare. Studies usually focus on public expenditure and/or quality for users. Studies of employment and working conditions for care staff are rare, and even rarer are studies of the consequences of marketisation for the public sector more generally and for the distribution of social goods (equality impacts).

Some clear conclusions, can, however, be drawn. First is that there is *consensus on the need for more research*. Second, based on existing literature reviews and Chapters 2 to 5 in this book, there is *no clear evidence that introducing competition and choice into Nordic eldercare services has led to cost savings or quality improvements*. Some studies show some cost saving, especially in the first generation of procurements of residential care, but these do not seem to include calculations of transaction costs, for instance the costs related to contracting out or to monitoring a larger number of providers in choice models. Indeed, there seems to be some evidence that choice models have entailed higher costs. Some studies show somewhat better quality in public services, others point in the opposite direction. The findings are similar when it comes to *employment- and working conditions*: no clear differences are reported between public and private eldercare services. The conclusion by the Tendering Council in Denmark (Udbudsrådet) that commissioned the literature review conducted by Petersen & Hjelmar (2012) is representative of the studies we have found:

No clear tendency in a positive or negative direction can be identified in the literature in relation to measures of efficiency, quality, conditions for workers and users or other impacts on, for example, innovation (Udbudsrådet 2012, p. 8)

Even though Nordic researchers broadly agree that the hopes expressed by proponents of competition and choice have not been met, there is not a consensus among actors in the field. Because research results sometimes point in different directions, the *findings are highly contested* (a fact discussed in Chapter 5 on Norway, but also clearly the case in Sweden).

The contest in Sweden is a case in point. For instance, regarding service quality, Swedish large scale surveys have shown that for-profit providers have lower staffing ratios, a larger share of workers employed by the hour and lower levels of formally trained staff than the public eldercare sector. In contrast to these poorer structure-related aspects of quality, the for-profit sector shows better results on process-oriented quality indicators, such as the residents' participation in formulating the care plan or the rate of execution of various risk assessment procedures (risk of falling, pressure ulcers and malnutrition). Finally, when it comes to user satisfaction, no differences are found at a national level between public and for-profit providers. No outcome data, such as the rate of pressure ulcers or fall injuries have been reported. Various actors in Sweden have interpreted these findings differently. For-profit providers tend to conclude that they are more efficient as they can provide better care (measured by process quality indicators) with less staff. The National Board of Health and Welfare (Socialstyrelsen) has drawn the conclusion that there are no clear differences between public and private providers. Finally, some scholars have argued that the structural measures of staffing levels and mode of employment (permanent or paid by the hour) are more relevant measures of quality than process measures and user satisfaction (see Chapter 2). These scholars draw on care research that stresses the importance of enough time in the encounter between staff and the care user, and of continuity of care for most care users. Whether more research on the consequences of marketisation would solve this kind of disagreement is far from certain, but there is obviously a need for more research in this field. Not least is there a need for research on the relevance and validity of measures of care quality (see discussion in Chapters 2 and 5).

Another general conclusion that can be drawn from the Nordic research is that the (limited number of) Nordic studies show a more mixed picture than international research, which presents a more unequivocally negative picture of the consequences of marketisation (see Chapters 6-9 for evidence from Canada and the United States; for international meta-analyses of care quality in public/non-profit and for-profit eldercare, see, for example, Comondore and colleagues 2009). The reason for this difference is not clear, but it has been suggested that it could be because labour markets in the Nordic countries are more regulated:

Moreover, it is noteworthy that the international articles are more unambiguously negative than the Danish (and Swedish) studies. In the case of contracting out, this may possibly indicate that, in Denmark, factors related to regulations and labour market agreements ensure that employees have better terms than in some other countries (Petersen et al. 2011, p. 9).

Norway seems to be different from Denmark and Sweden in this respect, as the general agreement on pensions in the for-profit sector is less generous compared to both the public and the non-profit sectors (Gautun et al. 2013).

A handful of studies have focused what might be called *unintended consequences* of marketisation affecting both privately and publicly organised care services. For example, in Section 4.2 above, we discussed how information-based ‘soft regulation’ that seeks to codify and measure care services can change how services are delivered and experienced. In different ways, studies such as Szebehely (2006), Vabø (2006; 2012), Dahl (2009) and Rostgaard (2012) use mainly qualitative methods to explore how a focus on measuring time and quality of care and the stricter definition of work tasks negatively affect the actual care work for both publicly and privately employed home care workers. A few other studies have touched upon the *distributional effects* of marketisation, in particular the risk that those with more resources have greater chances of finding the best services, which in turn may increase differences in the quality of care. This issue has been raised mainly in Sweden, by public authorities as well as by scholars (for example, Socialstyrelsen 2011; Szebehely 2011), but as yet no empirical studies have been carried out.

6. Conclusions and ideas for further research

In this concluding chapter we have tried to summarise the rich information in the four Nordic and three Anglo-Saxon chapters of this report. We have pointed to clear differences in the *extent of marketisation*, particularly in the form of increasing private, for-profit provision of eldercare services (Chapter 1, Figure 1, Cell 1). In the Eastern Nordic countries, Finland and Sweden, the increase of for-profit provision of eldercare has been most rapid, the for-profit sector is largest and large corporations dominate, especially in Sweden. The for-profit sector is considerably smaller in the two Western Nordic countries, Denmark and Norway. The non-profit sector has a comparatively strong position in residential care in three of the countries (the exception is Sweden). Measuring and comparing the extent of marketising practices within the public sector (Chapter 1, Figure 1, Cell 2) is less straightforward. However, evidence suggests that this form of marketisation is more extensive than private provision in all four countries.

We have noted some differences in the *legislative basis* for marketisation. In all four countries, acts governing social services and municipalities permit, but do not require, local authorities to outsource eldercare services to private providers (for-profit as well as non-profit) after competitive tendering. In Sweden, Finland and Denmark, but not Norway, specific legislation has introduced choice models, and tax rebates for household services. All four

countries have introduced procurement legislation implementing EU directives but they have not all had the same approach on the inclusion of social services, which include eldercare. In Sweden and Finland, procurement legislation and practice applies across all services, without exclusion, which means that non-profit provision cannot be organised outside the strictures of competitive neutrality. By contrast, in Norway and Denmark, a more selective approach has been taken, which allows local authorities to establish long-term contracts with non-profit organisations offering residential care, under longstanding associational or civic organisational logics.

In all four countries, marketisation has been associated with new forms of *regulation of competition and quality* of eldercare services. ‘Soft’ regulation, in the form of more measurement, comparison and standardisation has been most pervasive, typically drawing on a mix of industrial and market logics, as well as arguments about equitable (because standardised) provision. For regulation of service quality, all four countries also have a mix of some national supervision combined with delegated responsibility to relatively autonomous local authorities. In Sweden we found the strongest evidence for the proliferation of regulatory institutions to monitor and oversee the mixed economy of service provision. The emergence of new regulatory institutions is also evident to some extent in Denmark.

Regarding the *consequences of marketisation* on cost efficiency and quality, we concluded in the previous section that information is limited, but that existing studies do not show that the hopes expressed by proponents of marketisation have been fulfilled. However, we also noted that, compared to the experience in the English-speaking countries, there seems to be fewer negative consequences.

Before discussing the possible relationship between the differences in legislation and the extent of marketisation, we would like to stress the *similarities*. In all the Nordic countries care services are *still mainly publicly funded* – even when they are privately provided. And at a national level the vast majority of care services are still *publicly provided* – although there are municipalities where the majority of tax-funded services are provided by for-profit companies in Sweden and Finland. Thus, *municipal variation* is also a common trait.

A further common trait is a *lack of knowledge* both regarding the extent of marketisation and even more regarding the consequences for users, workers and the larger society. Despite a tradition of well-developed national statistics on social services, there is no solid data base for monitoring the scale and impact of for-profit provision. Governments in the Nordic countries usually make an effort to evaluate the consequences of significant reforms, but in this case they do not seem to have seriously tried to monitor the intended and unintended consequences of the introduction of competition and choice, and the relatively rapid growth (in three of the four countries) of private, for-profit provision in one or more areas of eldercare. Finally, in all

four Nordic countries marketisation is a *contested issue*: there are both strong opinions for and against marketisation, and strong economic and political interests. Not only do different actors *evaluate* marketisation in different ways; there is also dispute over how marketisation, and its impact, is measured, as debates about quality differences in public and for-profit sectors showed.

It is our hope that the compilation of material in this report is one step towards a more informed knowledge base for political discussions as well as for further study. In the rest of this section we will raise a number of questions to inspire future research.

One set of questions relates to the differences in the legislative basis for, and extent of, marketisation in the Nordic countries: comparative research could fruitfully investigate *why* the countries differ.

Is it mainly an *issue of politics*? As most market reforms at the national level have been introduced under right-centre majorities, can the differences in marketisation be explained by different political majorities at crucial points in time? Or is it rather the position taken by the social democratic parties on one hand, and labour unions on the other, that differ? What role have organisations such as the associations of local authorities in each country played in disseminating or resisting marketisation?

Related to this question is whether *public finances matter*. Finland and Sweden were more severely hit by recession in the early 1990s, at a time when market models were flourishing internationally, and it has been argued that the expectation that competition would lead to cost containment made market models more attractive for left parties than they might otherwise have been. In the same vein, has its oil wealth cushioned Norway from cost pressures, removing one strong, if unproven, motivation for certain kinds of marketising reform?

And related to this: *does resistance matter*? Which actors took which positions along the way? Are resisting voices organised more, or differently, in some countries compared to others? Have organisations of older people themselves advocated for or against marketisation? Danish local authorities of different political colour seem to have been more sceptical to opening up their residential care facilities to competition than the national government – why? In Norway, labour unions and municipalities have formulated an alternative bottom-up response to competition (the ‘Model Municipality Experiment’; see Chapter 5), to address demands for innovation and empowerment without marketisation. What can we learn from those experiences? How transferable might such responses be?

The question of policy transferability itself raises questions about *the processes of transmission of marketisation ideas*. There has been some research about the epistemic communities at the national level, which, integrated with wider groups internationally, have brought marketisation ideas ‘home’ for implementation (see, for example, Ryner (2002) and Meagher & Szebehely

(2013) on Sweden). Research has also found that, within a country, even local authorities with a left majority are somewhat susceptible to the ‘contagion’ of marketisation ideas where they lie adjacent to municipalities with marketising right-centre leadership (Stolt & Winblad 2009). How and why marketisation policies are transmitted, and the actors involved, could be better understood.

Another set of questions where further research is needed relates to the *consequences of marketisation*. Such studies can be carried out at the local or national level. However, comparative studies of the differences and similarities among the Nordic countries would also be particularly useful because of the traditions they share in the context of their now somewhat divergent paths.

Proponents of choice models argue that the right to choose has a value in itself and that, with more information about service quality, choice systems will lead to improved quality. In contrast, critics argue that the relational aspects of care make quality difficult to measure and so to disseminate useful information about, and that frail older people cannot be assumed to act as rational customers. What might be the consequences of the increasingly strong focus on choice models in eldercare? Are different groups of users affected in different ways? As the skills required for making use of market information are not equally distributed, several scholars are worried that an increased focus on choice favours those with more resources and education. Is there a risk for *increased inequalities*? Further, how might the process of reframing ‘users’ into ‘customers’ affect the relationships between older people as *citizens* and the local and national political communities to which they belong, and the politics of welfare more generally (Eriksen & Weigård 2000)?

Related, it is important to understand the dynamic effects of marketisation on the structure and development of the eldercare system. One set of dynamics is set in train by choice models, as suggested in the previous paragraph. Nordic countries have traditionally shared the ambition of *universalism*: the idea that the same publicly funded and publicly provided services are offered to all social groups according to need and not purchasing power. In this social democratic tradition, it has been argued that services should be of such high quality that middle class people are also willing to use them, on the assumption that, if different social groups use the same services, the stronger voice of middle class users leads to better quality of services for all, including those with fewer resources. If, under choice models, those with more educational resources have more opportunities to find the best services, will less well-functioning services be left to those with fewer resources? In the case of residential care it is not likely that the less well functioning facilities would be closed down (the argument behind hopes that competition would improve quality). Would the service quality in these less good facilities deteriorate with the loss of the more resourceful residents? Is there a particular risk that those with more resources will leave the public services? Privately run nursing homes and private home care providers can offer extra

services, which might make them more attractive for better off groups of older people. In three of the countries (Norway is the exception), this risk is exacerbated by the interplay between choice models and tax rebate for household services. In Finland and Sweden the tax rebate in many cases makes it cheaper to turn to the market than to formal home care services, for those with smaller needs. And for those with larger care needs, in all the countries (with the exception of three Danish municipalities), there is an incentive to turn to private providers of needs assessed care services as only they are allowed to offer additional services – that the users pay for out-of-pocket, subsidised by the tax rebate (with exception for Norway). Could the interplay between choice models and tax rebate for household services lead to a *dualisation of care* with increasing differences in access to good quality services between different social groups? *Is the Nordic universal model challenged by marketisation?*

Another set of dynamics may be set in train by the emergence of a considerable for-profit private sector in the publicly funded eldercare system. This establishes new interest groups in welfare politics, with potential to influence the direction of policy. The experience of the English-speaking countries points to a range of potential effects, including industry concentration and regulatory capture. What role are private providers playing in the politics of Nordic eldercare?

The trajectory of development of the private sector itself is also of research interest. Diversity of provision has been a major argument in favour of opening the sector to private providers. What is the profile of private providers? Has the diversity advocates hoped for been achieved? If not, how might it be promoted? Chapter 2 noted the complex fragmentation and concentration evident in Swedish eldercare, and the risks this poses for service quality. How stable and sustainable is the structure of the private eldercare sector in each country?

Finding answers to these questions can engage researchers in a wide variety of disciplines. The answers can contribute to a more informed political debate about the future of eldercare policy in the Nordic countries. The wide variation between the four Nordic countries (and even more between municipalities in each country) in the extent of private provision and the correlation between the level of private provision and political majority is stark evidence of the extent to which marketisation remains under political control. This suggests we should be cautious about understanding – and projecting – marketisation as an unavoidable process, and that we should be open to the possibility that quality improvement, service innovation and user empowerment may be achieved by other means.

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