Three decades of marketisation in Swedish eldercare: trends, actors and consequences

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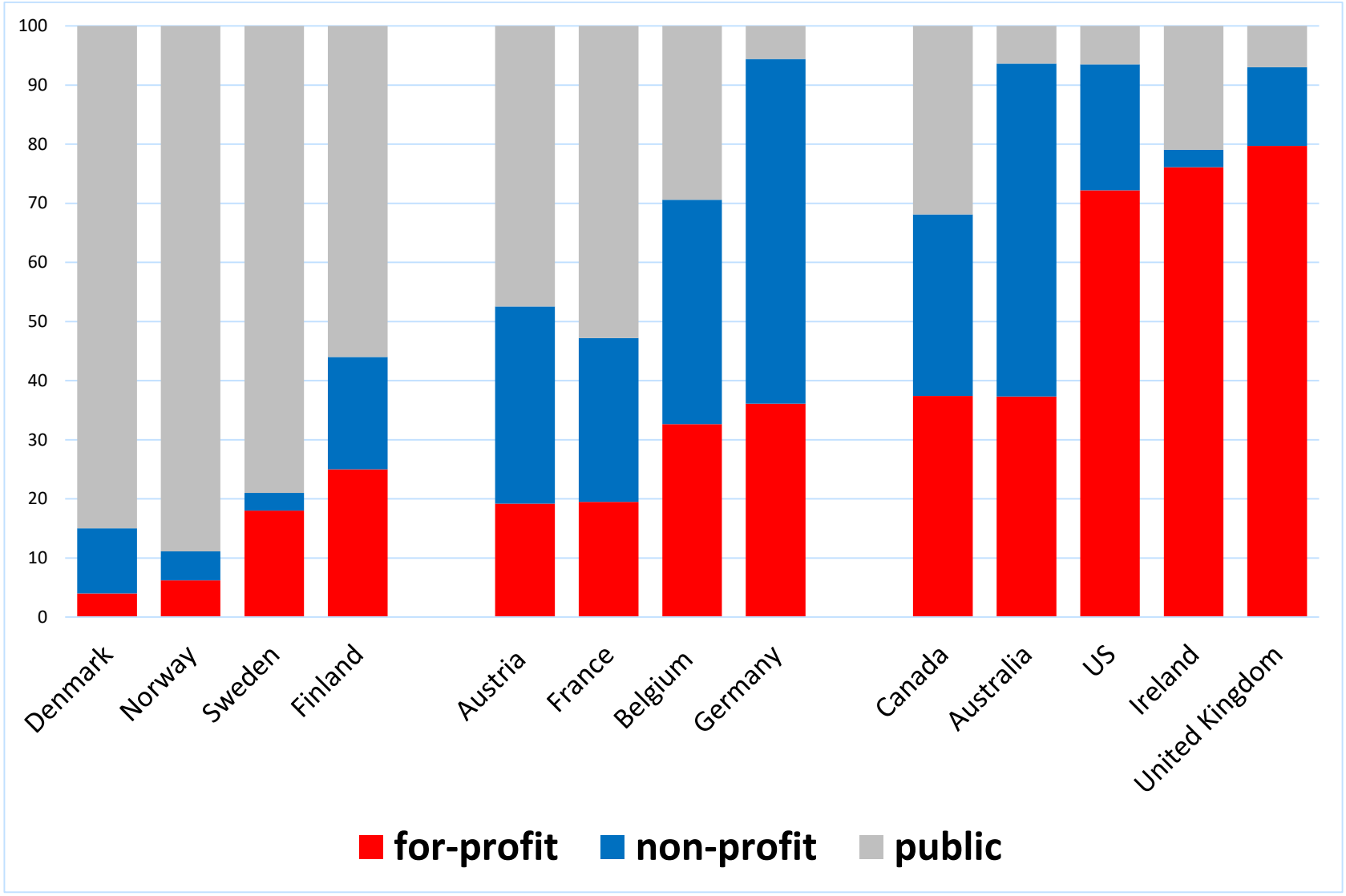
Point of departure: Universalism is an ideal in Nordic eldercare

- Publicly funded, publicly provided, high quality services directed to and used by all social groups according to need and not purchasing power
- **An equality ambition**: if the same services are used by all social groups the quality will improve for all
- Therefore not only mainly publicly funded but also publicly provided services

Still mainly publicly provided but…

- Trends of marketisation since early 1990s
- From zero for-profit eldercare before 1990 to around 20% in Finland and Sweden; less than 5% in Denmark and Norway
- Different size of non-profit sector, but no increase of non-profit anywhere

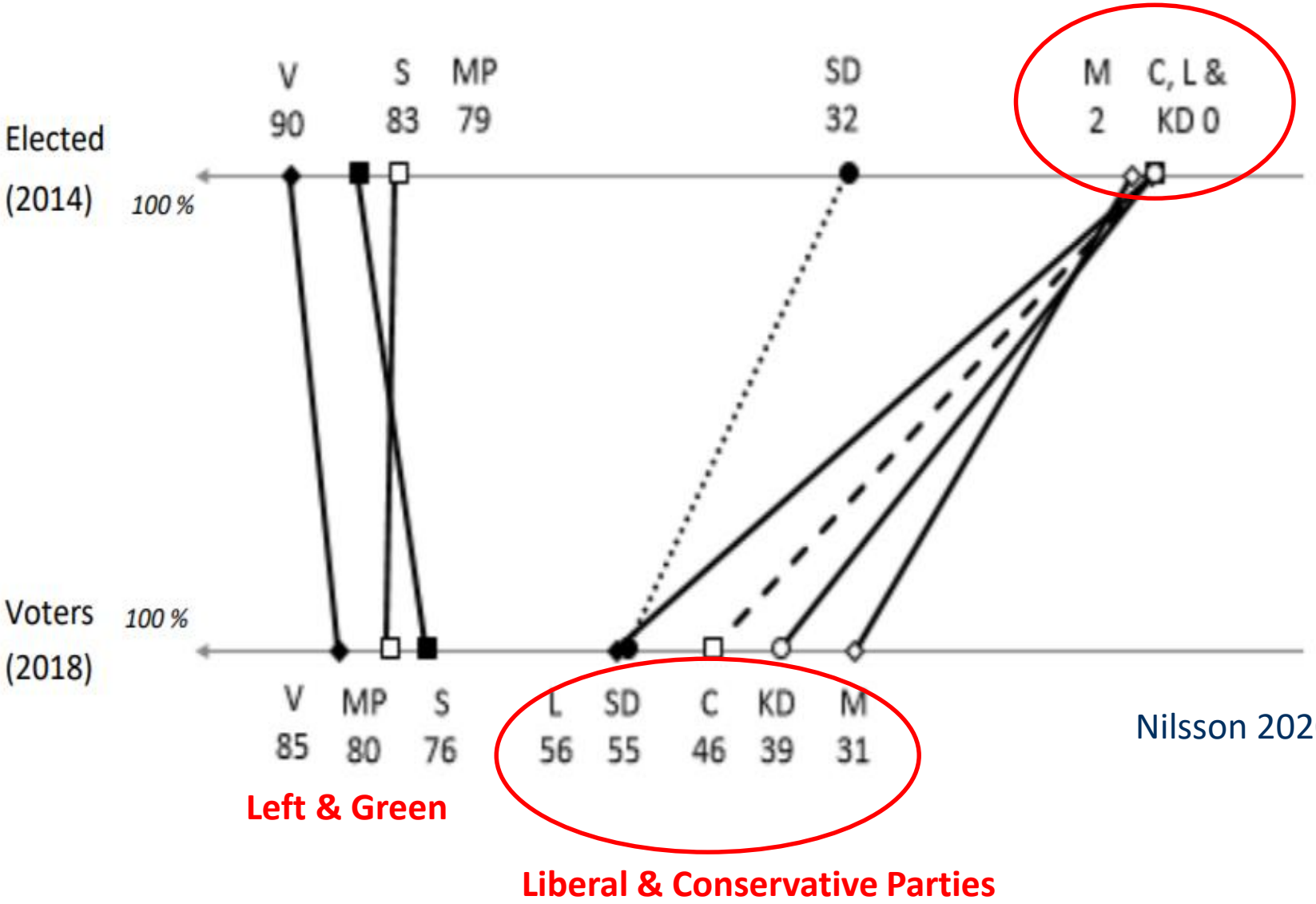
Different mix of public, non-profit and for-profit around the world (residential care)



Partly different, partly similar trends in the Nordic countries

- Similarities:
  - Profit-making in eldercare allowed in all Nordic countries
  - Lack of good statistics (non-profit and for-profit often merged)
  - Profit in welfare services is a contested issue but 2/3 of population is against – gap between politicians and electorate (Sweden)

Figure 6 **Attitudes to the proposal Profit distribution shall not be allowed in tax-funded healthcare, education, and social care among members of the Swedish Parliament in 2014 and the Swedish people in 2018 (percent good proposal)**



Nilsson 2020

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- Similarities:
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  - Lack of good statistics (non-profit and for-profit often merged)
  - Profit in welfare services is a contested issue but the majority is against – gap between politicians and electorate
  - Large local variations: urbanization, size and political majorities matter
    - In half of Swedish municipalities all care is public but in around 20 municipalities the majority is private

Sweden: Shift from public to private providers in three waves since early 1990s

- **Competitive tendering** and outsourcing (mainly residential care)
- **Customer choice** models (first mainly home care, increasingly also residential care)
- Financial incentives – **tax rebate** for care and household services

The first wave of marketisation: Outsourcing after competitive tendering

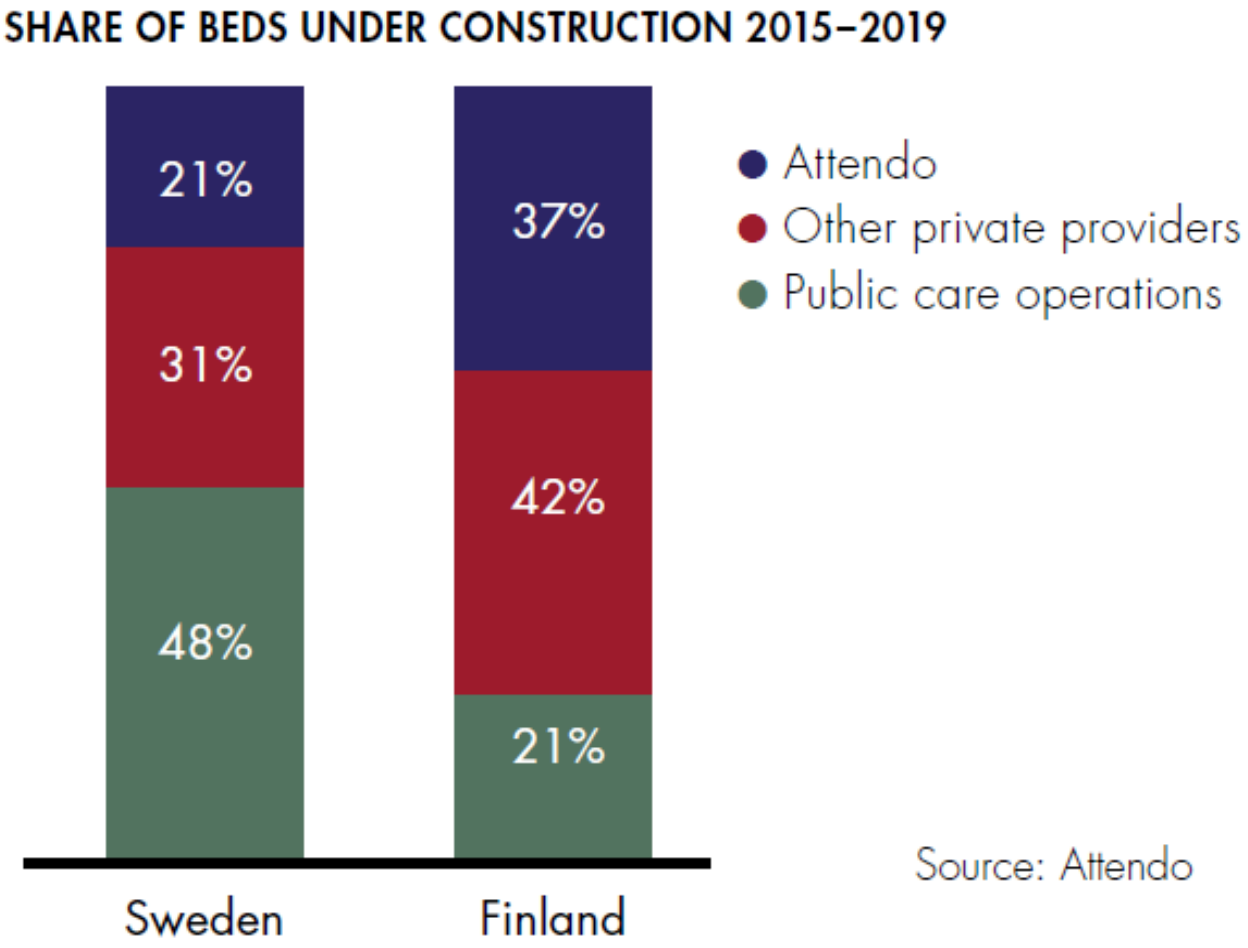
- The promise: improved quality, reduced costs; small companies and non-profit organisations will stimulate the public sector
- New **Local Government Act 1991**: municipalities free (but not forced) to outsource care services
- Municipalities invite private actors to compete in running a nursing home for 6-8 years
  - Initially **price competition**, rather the quality
- Favoured large corporations
  - Could underbid, had resources to write convincing bids

Structure of the private market today

- **Highly concentrated market** (in residential care)
- Big actors usually active in multiple areas
- Two largest corporations: **Attendo** and **Ambea** have together more than half of all private residential eldercare in Sweden.
- Higher concentration than in most countries
  - Attendo has 25,000 employees mainly in SE and FI
  - Ambea has 26,000 employees mainly in SE (and NO)
- New phenomenon: **80% of Attendo's and 71% of Ambea's net sales are "own operations"** – increasingly building new homes instead of running outsourced homes

An ageing population in generous welfare states – an attractive market

Care homes for older people – majority of new homes are built by private companies:



A second wave of marketisation

Partly as a response to oligopoly tendencies (but hand in hand with "own operations"): choice models

- The promise: the possibility to 'choose and choose again' will empower users, increase quality + facilitate for small companies to enter the business
- Sweden: **Choice legislation (LOV) in 2009**.
- **Free establishment**: The municipality must accept all providers that meet 'reasonable demands' – cannot limit the number of providers → many small homecare companies
- Private residential care providers need a permit from the Health and Social Care Inspectorate - since 2019 also homecare providers

A fragmented homecare market, in particular in Stockholm

- From **56** companies in 2006 to **180** companies in 2016 to **72** companies in 2021
- 2018 sharpened local demands on ’collective agreement’ + demands on permit since 2019
- Still many small companies
  - Difficult for companies to survive → forced ”exit” for users
  - Difficult to choose between many companies
  - Difficult for the city to control many providers
  - Several cases of fraud

A third form of marketisation –

Tax rebate for care and household services

- Legislation (RUT) in 2007: 50% of the cost for home services up to a rebate of SEK 50,000 (€5,000) per person and year
- Popular among older people, especially with high income
- Outside the needs assessed eldercare system but interacts with choice models:
  - Private providers of needs assessed homecare can offer 'extra services' – incentive for high income groups to choose private providers of tax-funded home care and 'top up' → leave the public sector to the poor?
  - Possible to 'top up' also in private nursing homes (in 'own management')

Consequences of marketisation – what is known about costs?

- Some evidence for **cost saving** of first generation outsourcing (price competition)
- Some evidence for **higher costs** in municipalities with choice models
- **Today no discussion on cost saving** and no data is reported
- Increased costs for regulation and oversight?

Consequences of marketisation – what is known about quality?

- No evidence for improved quality
- Care research: **time**, **continuity** and **flexibility** crucial for users
- National data: Lower levels of staffing, training and permanent employment in for-profit eldercare (less **time**, less **continuity**)
- Better self-reported 'process quality' in for-profit eldercare, eg. risk assessment
- No data whether more risks are avoided; no difference in 'user satisfaction' between public/private or between municipalities with/without choice models.
- **Measures and findings contested**
- More market, more detailed regulation → less **flexibility**?

Should we expect that choice models improve quality?

- **Economic theory: Choice can increase quality**
  - If it is easy to assess quality beforehand
  - If information on quality is easily accessible
  - If it is easy to exit (to change provider)
- **Not the case in eldercare**
  - Care quality is relational – difficult to assess beforehand and difficult to measure
  - Is needed in a vulnerable and often acute situation
  - The information provided is difficult to grasp
  - The consequences of making the wrong decision are serious
  - Continuity is a central aspect of quality: makes exit difficult – very few change provider

Is marketisation a threat to universalism?

- Large actors have strong voices – can affect public policy
- Change of discourse: eldercare users are seen as consumers with wants, not citizens with rights
- Winners and losers: user choice favours those with more resources – can find the best options → increased inequality?
- Choice + topping-up →risk for dual care systems
  - The new trend of ”own management”: some private companies build fancy homes with high rent and offer topping-up services → increased inequality? (+ more difficult to step back to public)

Finally: why more for-profit in Finland and Sweden than in Denmark and Norway?

- **Legislation matters?**
  - Finland and Sweden overimplemented the EU competition directive; Denmark and Norway protected non-profit care
  - Norway today: demands for choice legislation but also trends of de-privatisation
- **Timing matters?**
  - The recession in Finland and Sweden in the early 1990s – hopes that competition would save costs made price competition popular among local politicians
- **Resistance matters?**
  - Stronger resistance to marketisation in Danish and Norwegian Social Democracy and unions; in Norway also strong lobby organisation "For the welfare state" (For velferdsstaten)
  - Stronger interest organisation for private providers in Sweden and Finland?
- **Scandals matter?**
  - Tax evasion, bonus systems, fraud, maltreatment…

Further reading?

Anttonen A & Karsio O (2017) How marketization is changing the Nordic model of care for older people. In Martinelli, Anttonen & Mätzke, eds: *Social service disrupted*.

Lloyd L et al (2014) It's a scandal! Comparing the causes and consequences of nursing home media scandals in five countries, *International Journal of Sociology and Social Policy*

Meagher & Szebehely, eds (2013) *Marketisation in Nordic eldercare,* Stockholm University

Meagher & Szebehely (2019) The politics of profit in Swedish welfare services: Four decades of Social Democratic ambivalence, *Critical Social Policy*

Moberg L (2017) Marketisation of Nordic Eldercare – Is the Model Still Universal? *Journal of Social Policy*

Nilsson L (2020) *Strong public support for the traditional Swedish welfare state during restructuring and marketization*.

Szebehely M & Meagher G (2018) Nordic eldercare – weak universalism becoming weaker? *Journal of European Social Policy*