





**Marketisation in Nordic eldercare:
four countries, four responses**
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- Funded by NordForsk and Swedish funder Forte (FAS) 2012-2014
- Convenors: Marta Szebehely, Gabrielle Meagher and Anneli Anttonen
- Aim: Encourage research about marketisation in eldercare by
 - Bringing together Nordic (and Anglo-Saxon) researchers from various disciplines
 - Making information more available for scholars and students
 - Publication of the report “Marketisation in Nordic Eldercare” important first step



- Presentation based on work carried out within *Normacare*
- New report: *Marketisation in Nordic eldercare*
- Contributions by 17 scholars from 7 countries + ‘the wisdom of the crowd’



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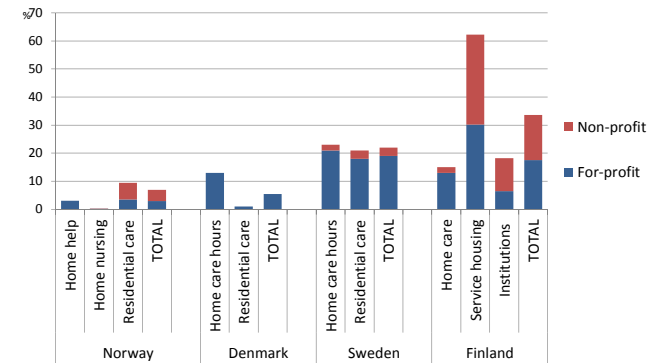
Contributors

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- Gabrielle Meagher, Albert Banerjee, Pat Armstrong, Charlene Harrington (**Australia, Canada, USA**)

The Nordic universal 'caring state' as an idea(I)

- Generous provision of publicly financed high quality services
- Highly independent local state (municipalities) collect taxes and organise the services
- Directed to and used by all social groups
- **Accessible, affordable** (also for the poor) and **attractive** (also for middle class)
- Mainly publicly provided

For-profit and non-profit provision of Nordic eldercare (2010-2012)



Still mainly publicly provided but...

- Increase of marketisation since early 1990s in all the Nordic countries
- Private provision is not new – but competition and profit is: virtually no for-profit companies before 1990
- Forms of marketisation:
 - Importation of market ideas into the public sector
 - Competitive tendering and outsourcing to for-profit providers
 - Choice models/vouchers
 - Financial incentives – tax rebate
- Finland and Sweden more affected than Denmark and Norway

Similar traits

- Lack of national statistics
- In contrast to schools – profit-making in eldercare allowed in all Nordic countries
- Large municipal variation – urbanisation and political majority matter
 - Sweden as an example:
 - In more than half of municipalities all eldercare publicly provided
 - Stockholm: 64% of residential care and 62% of homecare hours privately provided

Instruments of marketisation (1)
Outsourcing after competitive tendering
(mainly residential care)

	Finland	Sweden	Denmark	Norway
Legislation opening up for outsourcing	Social Welfare Act 1984; less state regulation 1993	Local Government Act 1992	?	No specific legislation that made outsourcing possible
Procurement legislation	Full implementation of EU procurement legislation 1992/2007		Exception for NP residential care	Exception for NP residential care
Use of competitive tendering	Relatively widely used	Relatively widely used (35% of municipalities)	Rarely used (4% of municipalities)	Rarely used (2-7% of municipalities)

- ### The market
- The bidding process favours large corporations
 - Increasingly concentrated market
 - Two largest corporations (Attendo and Carema), owned by private equity companies, each with 15,000 employees in the Nordic countries
 - A paradise for international capital: generous funding – little regulation (so far)

- ### Can differences in legislation explain the larger FP-sector in Finnish and Swedish residential care?
- Finland and Sweden: overimplementation of the EU competition directive
 - Denmark and Norway: protection for non-profit residential care
 - Same in Finland until 2001 (Slot machine association)
 - Timing matters? The recession in Finland and Sweden in the early 1990s – hopes that competition will save costs

Instruments of marketisation (2)
Consumer choice models (mainly for home care)

	Finland	Sweden	Denmark	Norway
Legislation on choice models	Vouchers legislated in 2004/2009 (not mandatory)	Act on System of Choice 2009 (not mandatory)	Free choice legislation 2003 (mandatory)	No specific legislation on choice
Use of choice models	Relatively widely used: Used in half of the municipalities	Relatively widely used: Used in 44% of municipalities; +14% decided to implement	Widely used: Choice of practical help in 95% of municipalities; personal care in 2/3.	Rarely used: <8% of municipalities

- Choice legislation: number of providers cannot be restricted - a home care user in Stockholm has to choose between 100 companies
- A fragmented home care market - many small companies, high turnover (at least in Sweden)
- Similar ideas behind choice models: older people as consumers who make informed choices and exit, if dissatisfied
 - Can frail older people act as consumers?
 - Care quality difficult to assess and measure
 - Continuity of care crucial → very few exit

- ### Interaction between tax rebate and (choice models of) home care
- Crucial for many small home care companies
 - Cheaper than needs-assessed home care (for some users)
 - To top up services: private providers of needs-assessed home care can offer 'extra services' – incentive to high income groups to choose private providers – affects the public sector?

Instruments of marketisation (3)
Tax rebate for household services
(outside the eldercare system)

	Finland	Sweden	Denmark	Norway
Legislation on tax rebate	1997	2007	1993 (several changes since)	No tax rebate available
Generosity	45% of the cost up to a rebate of €2,000 per person and year	50% of the cost up to a rebate of €5,700 per person and year	33% of the cost up to a rebate of €2,000 per person and year	
Uptake	Limited data: used by 10% of all households (home repairs and services combined)	Rapid increase; 8% of population 65+ on average € 350/year; Higher uptake in high income groups.	No current data on uptake, used by 14% of all households in 1999	

- ### 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
 - Increased costs for regulation and oversight?
 - Sweden: drastic increase of government activities to control and encourage competition and to produce guidelines for municipalities (more than 50 reports in 2 years)

Consequences of marketisation – what is known about quality?

- No evidence for improved quality
- Care research: time, continuity and flexibility crucial for users
- National data sets only in Sweden: Lower levels of staffing, training and permanent employment in for-profit eldercare
- Better 'process quality' in for-profit eldercare, e.g. assessment for risk for falls, pressure ulcers
- No data on actual falls, pressure ulcers etc; no difference in 'user satisfaction' between public/private or between municipalities with/without choice models.
- **Measures and findings contested**
- Demands for stricter regulation and control → threat to care quality?

Finally: What can be learnt from Nordic comparison?

- Contested issues – hopes, fears and economic interests
- Most (but limited) research on consequences in Sweden – no evidence for improved quality or reduced costs, but rapidly increasing control apparatus
- Learning from Norway's different route?
 - Stronger resistance
 - No choice legislation
 - No tax rebate
 - Protection of the non-profit sector
 - A union initiative based on collaboration: the 'Model Municipality Experiment' – innovation and empowerment without competition – a Nordic model?

Consequences for universalism: the distribution of welfare

- No empirical studies
- Winners and losers in choice models?
- Does the quality of care decline if 'the sharp elbows of the middle class' disappear?
- Risk for dual care systems – in contrast to the idea of universal services?