Guest Editorial

Welfare-state change, the strengthening of economic principles, and new tensions in relation to care

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Outline of the concept of the special issue

Changes in family structures, a massive increase in labour-market participation of women, and an ageing population have led to changes in the traditional organization of care work. European governments are being forced to find new solutions for managing what is called ‘the emerging care deficit’. This volume of the NJSF addresses the new forms of care emerging across European countries.

Care work is still to a substantial degree provided in private households in unpaid or paid informal forms of care work, but many welfare states in Europe have extended financial support and public provisions in the field of childcare and elderly care, and have established new social rights for care recipients (Anttonen & Sipilä 2005; Kröger & Sipilä 2005; Rostgaard 2002). Pay for family care in the framework of parental-leave schemes and elderly care has been introduced (Pfau-Effinger 2007). This measure implies that care work produced within the private household by family members or relatives is to an increasing extent organized as semi-formal care. Such policies have contributed to diminishing the tensions between family and employment that had been developing as a consequence of the increase in labour-force participation rates of women. However, in many European countries, these tensions between care responsibility and employment still exist.

This restructuring of the organization of care work has overlapped with another major change in European welfare states, namely, the substantial modification of the main principle of the provision of care. As long as care was provided in the family, its production was based on principles of mutual support. However, this notion of family care was contested beginning in the 1970s. Feminists argued that care provided in the family excluded women – the main providers of family care – from the labour market and social security
As far as care was formalized, with the state taking the main responsibility, it was usually organized in the form of a broad public sector of social services. Care provision was based on social rights connected to needs. But state care based on public-sector social services was also contested, even in the Nordic countries. In the discourses of the early 2000s, people described it as rigid, uniform, and inhumane (Vabø 2006). The new type of welfare-state policies now in place following the reforms aim instead to empower people in need of care (or their relatives in the case of small children), and to give them the option to act as ‘consumers’ on the basis of ‘free choice’ between the different types of care provision on offer. According to Mia Vabø (2006), ‘consumerism’ was a major driving force behind the reforms of the Nordic welfare states. These reforms have been subject of a great deal of empirical research and a broad debate in the social sciences. However, these reforms have turned out to be even more far-reaching than many observers had expected and the introduction of ‘consumerism’ was part of a much larger phenomenon. In the new world of care provision, welfare states now tend to treat care as a good that people can sell and buy on markets under the conditions of competition between providers. Moreover, the organization of care on the basis of the principle of ‘need’ was to some extent substituted by the principle of ‘efficiency’, and it became legitimate for firms to use the production of care to make profits. We call this development the ‘strengthening of economic principles’ in relation to care.

The new policies include such elements as the introduction of Fordist principles into care work, the outsourcing of parts of what was formerly state-provided services to the market or the non-profit sector, the establishment of welfare markets and competition among the providing organizations, the introduction of cash-for-care schemes, the replacement of the concept of clients or patients holding rights with the concept ‘consumers’ making ‘free choices’ on the emerging social-care market (Bode 2005; Budäus 2003; Clarke & Fink 2008; Daly 2002; Knijn & Verhagen 2007; Kremer 2004; Lewis & al. 2008; Lundsgaard 2006; Rostgaard 2002; Ungerson 2005; Vabø 2006). These reforms have to a considerable degree been influenced by neoliberal ideas and principles (e.g., Esping-Andersen 1999; Jæger & Kvist 2003; Vabø 2006).

The introduction of these new policies has in part offered new solutions to budgetary problems and the lack of efficiency in care provision. However, it has also created substantial new tensions and contradictions in the care arrangements, because the new principles of care provision contradict other principles (Eichler & Pfau-Effinger 2009).

It is plausible to assume, however, that different welfare states have implemented these new principles to different degrees and in different forms. So far, there have been relatively few comparative studies on the strengthening of economic principles in care provision (for an exception, see for example Bode 2005; da Roit & Le Bihan 2011). There are also open questions concerning which cases such policies lead to tensions and which particular elements of these policies produce tensions.

Aims of the special issue

The aims of this special issue of the NJSR are 1) to analyse policies that strengthen economic principles and their outcomes in the field of childcare and elderly care in European welfare states; 2) to analyse tensions and...
contradictions which have emerged as a consequence of such policies; and 3) to contribute to the further development of the theoretical and conceptual frameworks for this line of research.

The authors analyse and explain the specific ways in which different welfare states have introduced and strengthened new economic principles in their care policies. Moreover, they analyse the outcomes of these policies, their potential tensions and contradictions, and the conditions under which such policies can lead to tensions in relation to care. In this regard, the volume will add new elements both to the debate and to the scientific analyses of the strengthening of economic principles in care policies of European welfare states.

The special issue is a mixture of comparative analyses from different welfare states in Europe, as well as case studies of single welfare states. The main bulk of the articles addresses the organization and policies of childcare and care of the elderly. Several of the articles analyse the change towards the client or user as a consumer in a service ‘market’, the new choice between ‘cash or care’, as with childcare, or between for-profit, non-profit or public-service delivery, as with care for the elderly.

The articles in this special issue are the result of the international research collaboration in the EU Network of Excellence ‘Reconciling Work and Welfare in European Societies’ (RECWOWE). The editors are the convenors of the task group, ‘Tensions in care between work and welfare’ under RECWOWE.

The contributions

As a central part of the strengthening of economic principles in the field of long-term care in European welfare states, the figure of the old person in need of care, who was previously regarded as the client or patient, has been replaced by the figure of a ‘consumer’ who makes ‘free choices’. In most countries these choices include offers by different providers of home care who compete on the care market and care performed by family members. The focus of the first article by Birgit Pfau-Effinger, Per H. Jensen, and Ralf Och is on the effects of these policies on caring family members. It aims to give an answer to two different research questions. First, how do different welfare states legally construct the work situation of caring family members and their relationship with the elderly ‘care consumers’? Secondly, to what degree does this construction cause tensions? To answer these questions, the authors compare the legal construction of the work conditions of family caregivers in Germany and Denmark, as well as the effects on their relationship with the older relatives who receive care.

The findings show that the degree to which ‘consumerism’ in long-term care causes tensions in the situation of the caring family member and in the care relationship depends on the ways in which it is embedded in a ‘family care regime’. In this regard, the tensions are clearly greater in the semi-formal family care regime of Germany compared to the formal family care regime in Denmark.

The following article by Barbara Fersch and Per H. Jensen investigates politics of ‘choice’ for senior citizens in the Danish welfare state. The strengthening of economic principles in elderly home care in Denmark has primarily taken the form of outsourcing public care provision. The content and quality of services have remained the same, but the providers of services have
changed. The welfare state has continued to bear the major responsibility for the provision of elderly care, while outsourcing has allowed clients to choose freely between a public and private provider of care. The major aim of outsourcing has been to empower the frail elderly by providing them with exiting and choice opportunities and to construct them as consumers of welfare-state provision. Though Denmark’s central government introduced the public service reform, the municipalities bear the administrative and financial responsibilities for the care of seniors. In other words, national policy-makers have imposed on the local authorities (municipalities) the duty to provide the opportunities for choice to individuals in need of care. Against this background and drawing on the case studies of two Danish municipalities, this article analyses how nationally imposed ideas and the ‘politics of choice’ have created tensions locally in the form of municipal resistance and blockages.

Ingela Naumann investigates the development of ‘childcare markets’ in both Great Britain and Sweden. The findings are that there are trends not only towards the marketization but also towards the universalization of childcare, which suggest a complex picture of competing policy logics and goals in the restructuring of welfare states. These similar ideas and trends have, however, played out differently in different national contexts. While market mechanisms have developed slowly over time and have so far had a limited effect in Sweden, in the UK ideas about universal early childhood education became influential as part of a new social-investment agenda in the 1990s, though their restricted implementation has not fundamentally altered the existing childcare market. The author finds that historical policy trajectories thus continue to matter; however, tensions and incoherencies among existing policies can open spaces for change.

With the article by Tine Rostgaard, we again investigate the case of free choice of home care in Denmark. The article discusses the overall premises underlying the introduction of the free choice in home care as a panacea to the crisis of the welfare state, and continues with a discussion of the assumptions behind the free choice with regard to the role and responsibilities of the home-care user, the older person. With free choice, the user is expected to become active in seeking information about providers and changing the home care they receive when the quality is poor. This emphasis on free choice overlooks the fact that care is not a commodity like others, for it requires trust and established relationships. In reality, most users do not desire the opportunity to change providers, but they do need continuity in care provision and care staff. Although users are generally appreciative of the opportunity to choose between providers, they do not rate the quality of the care to be any higher in the private sector than in the public. The article concludes that consumerism is now part of the logic of governance, and this has changed the relationship between the welfare state and its subjects. Consequently, new forms of risks, responsibility, and dependencies have been created.

Anneli Anttonen and Liisa Häikiö in their article scrutinize social care by investigating recent trends and changes towards marketization and market-like mechanisms within the social-policy field of social care in Finland. They find that public-sector service provision is being redefined and reorganized in such a way that the state and municipalities are taking less responsibility for producing care services-in-kind. Universalism, which the Nordic welfare states are so renowned for, is being challenged by neoliberalism, market-friendly social-policy doctrines, and demands for the development of user-friendly service systems that make choice possible. The authors find that the transformation of public administration into public management and the
influence of managerialism and New Public Management (NPM) on recent public-sector reforms have accelerated welfare-state change. As a result, a very extensive and deep reform of social-care service provision is taking place in Finland. These changes mean that the mixed governance mode will be reinforced and the earlier, state-centred welfare production mode is at least partly withering away. In this respect Finland is approaching the liberal welfare states. It is remarkable that there are today few critics of the new market-like mechanisms and operational practices.

The final article by Teppo Kröger investigates whether the introduction of market-based practices linked to NPM has affected the work satisfaction of care workers in care systems for the elderly in Denmark, Finland, Norway, and Sweden. This question is highly relevant because most countries are struggling to hire and retain workers in this sector. The work is often of low pay and of low status, and can be both mentally and physically strenuous. Using comparable survey data from Denmark, Finland, Norway, and Sweden, the author finds many variations between the four Nordic countries concerning both the adoption of market-inspired practices – which Denmark has been the most and Norway the least eager to introduce – and their implications. Employees of for-profit and public employers have similar levels of work satisfaction. In contrast, the implementation of a purchaser-provider model, whereby care assessment and care provision are separated administratively and physically, is associated with weaker levels of work satisfaction. The introduction of other NPM-based practices does not display similar negative associations. In particular, quality-control mechanisms are associated with higher levels of work satisfaction among care workers.

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References


Tensions between ‘consumerism’ in elderly care and the social rights of family carers: a German-Danish comparison

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Abstract
The focus of this article is on the effects of the strengthening of economic principles in the field of care that have taken place in many European welfare states since the 1990s, which are connected with new emphases on ‘choice’, on the role of the market in the provision of elderly care, and on efficiency as a new main welfare value. As a central part of this development, the figure of the elderly person in need of care, who was interpreted before these changes as the client or patient, has been replaced by the figure of a ‘consumer’ who makes ‘free choices’. In most countries the frail elderly can choose between offers by different providers of home care who compete on the care market and care performed by family members. The focus of this article is on the legal construction of the working conditions of the family care giver. It aims to give an answer to two different research questions: How do different welfare states legally construct the working conditions of caring family members and their relationship with the elderly ‘care consumers’? And to what degree does this cause tensions between the desire to care or not to care and actual care conditions and opportunities? In order to answer these questions, we compared the
legal construction of the work situation of family care givers in Germany and Denmark, as well as the resulting effects on their relationship with the older relatives who receive care. The findings show that the degree to which ‘consumerism’ in long-term care causes tensions in the situation of the caring family member and in the care relationship depends on the ways in which it is embedded in a family-care regime. In this regard, the tensions are clearly greater in the semi-formal family-care regime of Germany compared to the formal family-care regime in Denmark.

Keywords: consumerism, elderly care, social rights, family, Germany, Denmark

Introduction

The way social care is organized is crucial for the structuring of work in European welfare states. As a reaction to such changes as the ageing of society and the increase in women’s labour-force participation rates, many welfare states in Europe have extended financial support and public provision in the field of childcare and elderly care since the 1990s, and have introduced new social rights both for care recipients and for those who provide care in the family (Anttonen & Sipilä, 2005; Kröger & Sipilä, 2005). At the same time, a restructuring of policies towards elderly care has taken place. These were based on a fundamental shift towards the strengthening of economic principles and on new emphases on ‘choice’ and the role of the market in the provision of care for older people and on efficiency as a new main welfare value. Accordingly, the introduction of new welfare markets in which non-profit and market-based providers compete together with new elements of public management and new Fordist principles in professional care work have been the main elements of the restructuring process (Bode, 2007; Daly, 2002; Knijn & Verhagen, 2007; Rostgaard, 2006; Vabø, 2006; Pavolini & Ranci, 2008).

As a central part of this development, the figure of the old person in need of care, construed before these changes as a client or patient, has been replaced by the ‘consumer’ who makes ‘free choices’ (Rostgaard, 2006; Ungerson, 2004; Vabø, 2006). Older people who need care should now be able to choose between different offers. In most countries these include offers of different types of providers of home care who compete on the care market – public, for-profit, and non-profit providers. Family members are also included in part in the market competition, since the elderly person in need of care can also chose paid family care instead of home care in many programmes for long-term care in European welfare states (Ungerson, 2004). The introduction of these new policies towards care has in part created substantial new tensions and contradictions in the care arrangements in European welfare states, because the new principles of care provision contradict in part other principles like the need for a high quality of care. Germany provides a good example. Care work done by agencies on the basis of competition, as is allowed by the ‘Long-Term Care Insurance Act’, is strongly standardized and restricted to physical care activities, with the consequence that it often does not match the socially constructed expectations of care recipients and their relatives (Eichler & Pfau-Effinger, 2009).
This article aims to answer two different research questions. First, how do different welfare states legally frame the work conditions of caring family members and their relationship with the elderly ‘care consumers’? Secondly, to what degree does this cause tensions between a desire to care or not to care and actual care conditions and opportunities? In order to answer these questions, we compared the legal framing of the work situation of family care givers in Germany and Denmark, as well as the resulting effects on their relationships with the older relatives who receive care.

We used for this objective the approach of different ‘family-care regimes’, by which we mean the ways the institutions of the welfare state legally construct the work situation of the person who provides care for an older relative and the care relationship between care giver and care receiver. We assumed that the differences in the legal construction of the work situation of the family carer, the care relationship, and the social rights connected with family care all differ in different types of welfare states. We present a comparative analysis of the legal framework regulating the family-based care of senior citizens in the welfare states of Germany and Denmark. Both welfare states have distinctly different cultural and institutional traditions in relation to care for old people. In Germany, for a long time and up to the mid-1990s, the family mainly provided elderly care, which was unpaid and not defined as ‘work’ (Pfau-Effinger, Jensen & Flaquer, 2009). The Danish welfare state, in contrast, has had a longer tradition of state responsibility for the care of old people. Since the 1990s, these two different types of welfare states have further developed in regard to the ways in which they organize long-term care for older people. On the one hand, the sector of social services engaged in the care of old people has been extended in both societies. On the other hand, in both societies the field of care for old people has seen a strengthening of economic principles (Pfau-Effinger et al., 2009). Our analysis is an outcome of two research projects, one on Germany and the other on Denmark, led by the authors and funded by the German Research Council (DFG) and the Danish Research Council for the Social Sciences.

**Discussion of the State of the Art**

Most scholars would probably agree that care needs are increasing with the ageing of populations, and that change in the roles of care and care relationships is associated with changing institutions, cultures, policies, and processes. However, while some scholars employ a biographical approach for analysing the conditions of the ‘biographical continuity’ of care givers in the face of life-changing challenges (e.g., Chamberlayne & King, 2000), this study employs a state-centred or citizenship perspective; that is, we are interested in how welfare policies (and citizens’ rights) rather than biographical resources structure the organization of care. This article has as its starting point in the fact that many welfare states have introduced long-term care programmes based on allowances which give older people in need of care the choice of either hiring a paid care giver from the marketplace or paying caring family members. The idea is that older people in need of care can act as autonomous, self-reliant social citizens who have the ‘freedom of choice’ between different offers, which is epitomized as a right to receive care. Furthermore, these programmes also include new social rights from the point of view of the family care giver (see Knijn & Kremer, 1997). These include their right to receive some kind of pay for the care they provide, a social right to time off for care tasks (i.e., an exemption from the obligation to work), and in part elements of social security for the duration they provide long-term care (Pfau-Effinger, 2005).
These new policies of ‘freedom of choice’ represent ideas of consumerism, especially on the part on the person in need of care, as consumerism is based on ‘access, choice, information, redress and representation’ (Vabø, 2006:405). Whereas other concepts like empowerment, user-orientation or user-involvement treat the relationship between the person in need of care and the care provider as a trust relationship, this relationship of consumerism is one based on material interest and is mediated via the market. This means that the care receiver is viewed as an autonomous market participant who acts ‘with scepticism and distrust towards the provider, [is] always ready to take action if services fail, [is] always looking for the best buy (“value for money”)’ (Vabø, 2006:405, 413).

Consumerism in elderly care has been a common trend in European countries since the 1990s. Various factors have been identified in the literature to explain this common trend, such as the incapacity of the traditional welfare state to meet individuals’ needs and the trend towards marketization. In part, governments have justified the introduction of cash-for-care programmes with the need to empower those in need of care. Another reason is the trend towards the recognition of (formerly unpaid or cheaper) informal care work (Ungerson, 2005).

Thus far, little research exists about the consequences of consumerism on the ways in which the work relationship of the caring family member with the old person in need of care is legally constructed in different types of welfare states in a comparative perspective. Da Roit and Le Bihan (2011) have investigated the situation of women in cash-for-care arrangements of long-term elderly care in France and Italy. They were particularly interested in the ways these programmes shape informal care and family relations in these countries. They have analysed the situation of family care givers, mainly women, who combined employment and long-term care of an elderly family member, and have found that cash-for-care systems, differently from what is sometimes expected, do not in principle support a reintroduction of the family into care in these countries. Instead, people use them for outsourcing long-term care. However, unlike this present article, the main perspective of their study was on the work-family balance of caring women and less on the legal framework of family care.

Claire Ungerson (2004) has also conducted international comparative research into the ways that wages for the care work of caring family members are constructed. She has analysed how the ‘commodification of care’ has developed in five European countries: France, Great Britain, Italy, the Netherlands, and Austria. Her main focus is on the pay that caring family members receive and on how it is paid. She found that in several welfare states these payments have the character of what she calls ‘routed wages’, that is, ‘the method whereby people in need of care are given cash rather than (or in addition to) formal care services, and then encouraged to employ their own care labour directly with this cash’ (Ungerson, 2005:49). Ungerson, moreover, shows that the labour-market impact of the welfare-state policies towards work in long-term care is to some extent dependent on the funding regime of the specific welfare state. These regimes represent different combinations of the degree of regulation, on the one hand, and the degree of commodification of care work, on the other. According to Ungerson, funding regimes cover a spectrum between fully commodified informal care and care paid only by additional inflows into the household.

The results of the above-mentioned studies also show that long-term care provided by family members no longer fits the description of informal work.
Often it is paid in the context of welfare-state programs, and includes elements of social security. For this reason, Pfau-Effinger (2005) has introduced the term ‘semi-formal care’ for these kinds of family care. Comparative policy analyses of the legal framework of paid family care, how it constructs the work situation of those who provide care for elderly relatives, and their relationship with the elderly ‘care consumer’ have hitherto been relatively rare.

The conceptual approach of this article

We assumed that the family-care regimes in the welfare states of Germany and Denmark differ substantially, and therefore that the degree and nature of tensions which are connected with the care provided by family members for their frail elderly relatives also differ. By ‘family members’ we mean persons who belong by definition broadly to the same family as the persons in need of care, such as daughters and sons, spouses or partners. The indicators that we used to compare different family-care regimes in the field of long-term care include:

- the quality and degree of the elderly’s social right to receive care provided or organized and co-financed by the welfare state and how these relate to their ‘consumer’ role;
- the quality and degree of the family members’ legal rights connected with their care work in comparison with standard employment, such as:
  - the duration and amount of pay, as well as conditions of eligibility for pay;
  - the level of social-security rights to benefits for unemployment, pensions, sickness of caring persons;
  - the right to leave regular employment or to reduce the working time in employment, and the degree to which the job is protected in this situation;
  - the legal rights within the care relationship (e.g., protection against dismissal, etc.).

We shall analyse tensions that may be associated with the situation of the options that frail senior citizens have as ‘consumers’ of long-term care to ‘choose’, on the one hand, and the working conditions of caring relatives in the same legal context, on the other.

Main features of welfare-state policies towards long-term care in the context of the German Care Insurance Act (SGB XI)

Until the early 1990s, the care of elderly people in the former West German state had essentially been organized as unpaid family care, and for this reason the classification of the German welfare state in this respect as a ‘conservative welfare regime’ in Esping-Andersen (1999) and its description as a ‘political regime strongly oriented towards the male breadwinner’ in Lewis and Ostner (1994) were fully accurate. Care in residential homes played a secondary role by comparison (Alber & Schößkopf, 1999). In the former East German state, elderly care was also mainly based on unpaid family care.
despite the orientation towards a dual-earner family model (Heusinger & Klünder 2005: 69; Naegle & Dallinger 1993: 308).

With the ‘Long-Term Care Insurance Act’ implemented in 1995 and 1996, the German welfare state for the first time defined care for senior citizens as a task for the central state, and established a new social insurance that finances a universal basic provision for those in need of care on the basis of contributions from everyone in gainful employment. An important goal of this act was to make it possible for elderly people in need of care to live a self-determined life in a private household. The Long-Term Care Insurance Act (SGB XI) also introduced such elements as the market and ‘consumer choice’ into the organization of care. Further, on the basis of the financing of ambulant professional care by the long-term care insurance fund, the act encouraged the emergence of a broad sector of publicly financed providers in the field of ambulant care (Schulz-Nieswandt, Mann & Sauer, 2010).

On the basis of these changes in the institutional framework of care, the autonomy of those in need of care has tended to be strengthened, since elderly people can release themselves from relationships of dependence on family care through opting for ambulant professional care. Nevertheless, in the largest proportion of cases family members exclusively still carry out the care of frail elderly people who live in private households. Among those people in old age who receive care allowance in the context of the Long-Term Care Insurance, 69.3 per cent live in their own household. In this group, the percentage of those who were cared for exclusively by a family member was 67 per cent in 2009 (Eichler & Pfau-Effinger, 2009; Motel-Klingebiel, 2002; Mischke & Meyer, 2008; Statistisches Bundesamt, 2009).

The role of the consumer principle and ‘free choice’ for old people in the German policies towards long-term care

Old people only have the right to receive paid care if they can prove that they have a physical need for it through illness or disability (§ 14 Abs. 1 SGB XI). Those who meet the rather tight selection criteria receive a care allowance that mainly covers only actual physical health care, and as long as they are not very seriously ill. They must themselves organize other items such as housework. Most recipients are thus still dependent on the additional support of family members if they want to live in their own households.

Old people who need care can choose between various providers of care: service agencies run by local authorities or non-profit organizations, as well as commercial providers. They also can claim care from family members such as spouses, partners, daughters and sons, and social networks. All these types of care are publicly paid to a certain degree. The care insurance makes the payment of the care allowance to the service agency if the care receiver has opted for care by an agency. The amount that the care insurance pays differs according to which of the three ‘care levels’ the person in need of care has been assigned to, that is, according to the extent of that person’s requirements. If a person in need of care opts for an ambulant care service, the long-term care insurance fund pays a lump sum to the care service. This sum should cover a particular period of time for care per day. A lump sum of

1 Elderly people who need care can also receive it from people outside the family, like neighbours or members of social networks, if these persons are willing to accept the conditions of care work done by family members. Currently, the share of persons belonging to such groups who provide care in this legal framework is relatively small (Statistisches Bundesamt 2009).
€ 420 (care level 1), € 980 (care level 2) or € 1,470 (care level 3) is guaranteed per month (Deutscher Bundestag, 2008 SGB XI).

However, if a family member provides the care, the care allowance is considerably lower, and it is not paid directly to the family care giver but to the person in need of care. This constitutes a system of ‘routed wages’ (Ungerson, 2005 ). Payments to family members involved in care are from € 225 per month (care level 1) to € 430 per month (care level 2) and € 685 per month (care level 3) (§ 37 Abs.1 SGB XI). Also, the elderly person who receives care has the freedom to decide to forward parts or all of these funds to the caring relative, or not at all.

The decision on agency care or family care – but not the choice of a specific family member – is binding for the person in need of care for a period of six months. This means that the person who receives care can dissolve at any time the care relationship with the relative. If a family member is providing care, an official inspection of the care situation and the person providing the care takes place once the care period starts. This is the only time an inspection of the specific care situation in the family takes place.

The construction of the role of the caring family member in the German policies towards long-term care

As we have mentioned above, caring family members can receive payment for their care work. This pay is defined as some ‘financial compensation for effort’ paid for certain categories of otherwise unpaid voluntary work (cf. Pfau-Effinger et al. 2009). This corresponds to a payment of between four and five Euros per hour for the average amount of time a caring family member spends on care. However, the caring relative does not have a legal right to payment for her or his care work. Instead, the care receiver is free to decide whether to keep the money or to forward it to the caring relative; there is no obligation to pay, and the way he or she uses is not monitored.

Family members who provide care at least 14 hours per week in the framework of the Care Insurance Law have the option to be included in the pension system for the periods in which they provide long-term care (§ 19 SGB XI). They are also covered by insurance against accidents at the workplace (§ 44 Abs. 1 Satz 4 SGB XI, Hervh). On the other hand, they have neither the right to be covered by public health insurance nor by unemployment insurance, even though the care relationship can end anytime when the care recipient moves into any kind of home, dies, or just decides on a different care giver. Even though the person in need of care is bound to the decision for family care or agency care for six months (§ 38 SGB XI), this does not mean that she or he is obliged to maintain the relationship with a specific person during this time.

Further, even though a family member who cares for an older relative who receives the care allowance enters into a legal relationship with the care recipient, the law explicitly mentions that caring family members do not have a position as ‘employees’, that their pay does not have the character of wages, and that their relationship with the care receiver who pays them does not have

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2 It is also possible for the person in need of care to transfer the benefits from the care insurance to a ‘personal budget’ account, from which he or she ‘buys’ care work (§ 35 a SGB XI). In practice, this solution is rather similar to the direct payments made by the care insurance.
the character of an employment relationship (§ 3 S 2 SGB VI; Krauskopf Soziale Krankenversicherung, Pflegeversicherung, 71 Ergänzungslieferung 2010 Randnummer 4 zu § 19 SGB XI). The care relationship is also not based on any written contract. This means that family members who care for a frail older relative do not have any of the rights usually connected with an employment contract, like protection against unfair dismissal. They do have a right to four weeks’ leave from the care situation in case they are sick or for holidays, but they do not receive pay for time off. During these four weeks, the Care Insurance pays for substitute care from another family member or a care agency (§ 39 SGB XI). The unpaid time for holidays of four weeks is reduced for each day the care giver is sick and cannot work. This means that only healthy family carers have the full right to four weeks’ unpaid holidays.

Independent of SGB XI, there is a state programme for elderly-care leave from regular jobs in firms. People who temporarily care for an older family member can take unpaid care leave from the firm where they are normally employed. During this leave the worker’s job is protected; dismissal is not possible. There are two different leave plans for persons who provide care for relatives: the ‘care holiday’ (Pflegeurlaub) and the ‘caring time’ (Pflegezeit). The ‘care holiday’ comprises a maximum of ten working days and can be paid time if this is permitted by collective bargaining agreements. The ‘caring time’ is unpaid and can last a maximum of six months. The option is limited to employees of firms with a size of more than 15 employees. During the leave the job is likewise protected (§ 5 and § 7 Pflegezeitgesetz). It is also possible for employed people to reduce their usual working hours over a longer period, maybe even over several years, if they have been employed at least six months in the firm, if the employer does not object for economic reasons, and if the firm has more than 15 employees (§ 11 Teilzeit- und Befristungsgesetz).

Main features of welfare-state policies towards long-term care in Denmark

Contrary to the case in Germany, where public long-term care was institutionalized as cash-for-care as soon as the welfare state started to take over the main responsibility for long-term care, public long-term care in Denmark has historically been delivered as a public in-kind service, in part as home care and in part as residential homes for older people in need of more extensive care. The coverage of in-kind care has grown constantly and rapidly (Finansministeriet, 1995:9) – already by 1996 about 30 per cent of the total population aged 65 and over was receiving some kind of long-term care (Rgeringen, 1999) – and so have public expenditures (Strukturkommissionen, 2004). In effect, almost all older people in need of care are offered publicly financed and organized in-kind care provision.

Public in-kind care has become a citizen’s right. The provision of in-kind services is regulated by the Social Service Law which stipulates that necessary services must be given in accordance with every individual recipient’s need (cf. Jensen, Larsen & Stoltenborg, 2004; Jensen & Lolle, 2010; Rostgaard in this issue). To relieve the pressure on the public-care sector, from 1996 public authorities have offered prophylactic visits to people over 80 years, and from 1998 to those over 75. The aim of these advice and support measures is to enable older people to look after themselves better.

In Denmark, family care by spouses and inter-generational family care and family carers has practically disappeared, which is in accordance with majority cultural orientations in Denmark. The vast majority of Danes have the opinion that frail elderly people should be taken care of by public in-kind care. The family has thus been emptied of elderly care functions (Christoffersen, 1997). This development does not mean, however, that children do not at all care for their frail elderly relatives. A time-use study conducted in 2001 shows that 40 per cent of all Danes had helped or eased the situation of their parents or parents-in-law within the last four weeks. Still, this sort of help remains optional. The welfare state first and foremost delivers personal help to frail elderly people.

The strengthening of economic principles in elderly care in the Danish welfare state has primarily taken the form of outsourcing public-care provision and of allowing clients to choose freely between different public and private providers of elderly care. Home care, and not residential care, has been subject to outsourcing, and outsourcing has not changed the content or quality of in-kind home care. Public authorities finance and define the quality of care provision, and the welfare state has remained the primary party responsible for ensuring the adequate offer of care. It is only the care providers who have changed with outsourcing. Thus the major aim of outsourcing has been to empower frail elderly people by giving them choices or exit-opportunities as 'consumers' of welfare-state provision. Only a relatively small proportion of old frail elderly, however, have actually chosen a private provider over a public provider of home care.

The role of the consumer principle and ‘free choice’ for old people in need of care in the Danish policies towards long-term care

Since January 1, 2003, recipients of home help have been free to choose from different providers of home care, both public and private. The advantages of choosing a private provider are that private providers are allowed to offer additional, non-care services such as gardening, walking the dog, and so forth. Becoming a for-profit private contractor, however, requires the certification of the company by the municipality, and to attain this certification the private contractor must provide the quality of services required by the municipality. There is, however, no real price competition in the care market. Private contractors receive the same amount from the municipalities as the municipality itself spends on home care. If a consumer of home care chooses a private contractor, then the municipality pays for the private services directly to the private contractor. This means that the users are not involved in any kind of economic transaction, except in cases where users have ordered additional services (such as dog-walking) from the private contractor. Such services are settled between the consumer and private contractor.

A ‘softer’ free-choice approach has been introduced in relation to residential care. Since July 1, 2002, elderly people who have been assigned a residence in a residential home can in principle choose from institutions within and across municipal borderlines. With this change, it is possible for older people to take up a residence that is more in accordance with their wishes. Previously, municipalities only assigned residences to ‘their own’ population. The idea underlying this change was that older people in need of care should be able to settle closer to the homes of their children or other relatives.
The construction of the role of the caring family member in the Danish policies towards long-term care

Home care is delivered as personal assistance or care or as practical work in the home, in the form of cleaning, and so on, or both. These services, however, are to some extent dependent on the household situation of the elderly person in need of care. If the elderly person in need of care shares his or her household with a physically capable person, that person is expected to do all the practical work in the home; in other words, payment for home care in the form of housework is not granted.

With respect to personal assistance and care, relatives may themselves substitute for the public or private care provider. In such cases people who care for their frail elderly relatives do not enter into any legal relationship with the person in need of care, which would make them dependent on this person. Instead, they can choose public employment as carers with a ‘normal’ employment contract. The ‘Law on Social Service’ allows the person who is entitled to help and support to appoint a person to do the task (e.g. a spouse or a relative) (§74). The municipality must, however, recognize the person appointed, and a contract that specifies the extent and content of services, security of delivery, costs, and so on, between the municipality and the appointed person must be made. In effect, the family care giver becomes a public employee. If the care receiver is granted, for example, seven hours home care per week, the municipality will employ the appointed person for seven hours per week at a wage rate of about 19 Euros per hour. Since those people who provide long-term care for their relatives in principle act as public employees, they are entitled to all types of social security and other legal rights of a standard employment relationship. This regulation is very rarely used, however.

Different from Germany, in Denmark there is no general state programme which gives family members who care for their frail older relatives the right to ‘care leave’ from their jobs. In Denmark, employees only have a right to unpaid care leave if they have to take care of a closely related dying, handicapped or seriously ill person. As far as people must take leave to care for a dying close relative, they are entitled to compensation amounting to 1.5 times sickness pay but not exceeding the wage that they have earned so far. In contrast, there are no legally based rights to absenteeism for ‘ordinary’ long-term care on a nearly daily basis.

The legal framework of family care and its contradictions in the German and Danish care policies

It has turned out that the legal framework of family care differs considerably between the German and the Danish welfare states (see also Table 1). These differences of legal framework regard the social rights of senior citizens as well as their role as ‘consumers’.
Table 1: Differences in the family-care regimes of the German and the Danish welfare state

<table>
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<th>German welfare state</th>
<th>Danish welfare state</th>
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<tbody>
<tr>
<td>Quality and degree of the elderly’s social right to receive care</td>
<td>medium</td>
<td>high</td>
</tr>
<tr>
<td>Quality and degree of the family members’ legal rights connected with their work situation, in comparison with standard employment</td>
<td>low to medium</td>
<td>high</td>
</tr>
<tr>
<td>• Duration and amount of pay to family carer, and conditions of eligibility for pay;</td>
<td>low to medium, clearly below level of standard employment</td>
<td>high – at level of standard employment relationship</td>
</tr>
<tr>
<td>• Level of social-security rights of the family carer</td>
<td>low to medium, clearly below level of standard employment</td>
<td>high – at level of standard employment relationship</td>
</tr>
<tr>
<td>• Family carer’s right to leave regular employment or to reduce the working time, and job protection</td>
<td>medium</td>
<td>Low</td>
</tr>
<tr>
<td>• Legal rights of family carer within the care relationship (e.g., protection against dismissal, etc.)</td>
<td>very low</td>
<td>high – at level of standard employment relationship</td>
</tr>
<tr>
<td>The magnitude of personal care performed by family members</td>
<td>high</td>
<td>very low</td>
</tr>
</tbody>
</table>

In Germany, the frail older person in need of care is considered a ‘consumer’ with ‘free choice’. Therefore, senior citizens who need care have various rights and options. They can decide between different types of care, which includes the option to choose the care of a relative. If she or he decides that care should be given by a relative, the person receives funds to pay the care work of the relative, but does not have any obligation to forward the whole amount, or any part of it, to the caring family member. This means that in principle the person in need of care also has the option to use the funds as desired, say, to improve his or her own lifestyle. However, the financing of agency care carried out in private households mainly only covers physical health care. This limits considerably the social rights that senior citizens have in relation to long-term care. If they are not very seriously ill, they do not have the right to get payment for household help or overnight care. Care policies, therefore, rely considerably on family support of the old persons who want to live in their own households.

This is different in Denmark, where the conceptualization of old people who need care as ‘consumers’ is embedded in a different type of family-care regime. Old people in need of care usually get comprehensive care by public agencies. Different from Germany, public care for the individual person in need of care is also comprehensive. It includes 24-hour care if needed, and support in housework like cleaning and shopping. The consequence is that people in need of care are much less dependent on a caring relative’s staying with them overnight and providing household work.

The differences in the legal framework of the caring family member are even greater. The other side of the relatively privileged situation of the care receiver...
in the German welfare state reveals that the situation of the care giver is relatively precarious. Care in the context of the SGB XI does not constitute an employment relationship, and does not even require any contract. It constitutes a relatively precarious, semi-formal form of care work paid in hourly wages clearly that is below market levels. The care giver does not even have a legal right to receive this pay. The social rights connected with the care situation of the family carer do include insurance against accidents and in part also pension insurance, but two fundamental social rights are absent, namely rights to health insurance and unemployment insurance. Free time off for sickness or holidays is guaranteed for up to four weeks but is unpaid, and it is possible for the care receiver to dissolve the care relationship at any time.

That the person in need of care can terminate the care relationship at any time means high income-loss risks particularly for those caring family members who may have given up or interrupted their regular jobs in the employment system in order to provide the family care. The care provider is, therefore, largely dependent on the good will of the person in need of care to maintain the care relationship and to receive the payments. Even if they do receive the full pay that the Care Insurance pays to the person in need of care, they may still be dependent on additional income sources, since the pay is below the poverty-line level. Given that family care, in 75 per cent of the cases, is provided by women, the law also contributes to maintaining gender inequality. The fact that family members who provide long-term care for a relative can take leave from their regular job which is then formally protected for the period, balances these risks to some degree. However, the leave is limited to six months.

The care policies of the German welfare state – the ways in which they construct the care situation of family care givers and their relationship to the person in need of care – therefore create particular tensions. The way the care relationship is legally framed causes distinctly contradictory interests within the family, that is, between the ‘consumer’ and the ‘worker’. The care receiver, on the one hand, has the option of a free choice between different types of care and care providers, and can decide how she or he uses the ‘care money’ in the cases where the care is provided by a family member. The care giver who provides care for a family member, on the other hand, is legally in a relatively weak and precarious position. The affective nature of the relationship can reinforce this vulnerability. A main motive for why people care for older family members is love or the feeling of moral obligation (Eichler & Pfau-Effinger, 2009).

The options of living autonomously in one’s own household and of choosing between different types of care provision, including family care, are not at the expense of the family-care provider in the Danish welfare state. Family members can take over the daily care of a relative under an employment contract with the municipality and thereby act as a public employee, albeit on a (short) part-time basis. This means that they receive wages at levels commonly paid in the care sector, and have all the social rights and job protection of standard employment relationships. Differently from Germany, they do not have any legally constructed, direct financial relationship with the care receiver, and thus there is no personal or financial dependence of one or both partners on the care relationship.

On the other hand, again differently from Germany, an option for leave during which the job of the person who temporarily provides family care is guaranteed, does not exist. This may mean a substantial risk of job loss or difficulties returning to regular employment for an employee who decides to
stay away for a longer time in order to care for an old relative in need of care. In this regard, the law creates a tension between the wish to take care of a family member temporarily, and the risk of losing one’s regular job in doing so. As shown in Table 1, Denmark and Germany differ in all dimensions of the two family-care regimes. Other things being equal, the Danish situation is more favourable for the care recipient as well as for the family care giver as compared to the German situation. Paradoxically, however, the amount of family care giving is much greater in Germany than in Denmark.

Conclusion

It has turned out that the family-care regimes of Germany and Denmark differ considerably. On the one hand, a common trait of the welfare states of Germany and Denmark is that they construe old people in need of care as ‘consumers’ who have free choice in the care market. Frail elderly people have the option to decide between different types of care provided by agencies and between the care of agencies and family care, and they can get the funds to pay for the type of care they choose. This also means that people in need of care have the option to be ‘freed’ from personal dependence on the family. However, this option is more consistently supported in the Danish welfare state, since care provision is comprehensive and covers different types of needs of the person. In Germany, by contrast, care policies still rely on the care given by family members.

On the other hand, the family-care regimes of the German and the Danish welfare states are clearly different in the ways in which the situation of the person who provides family care is legally construed in her or his relationship to the relative receiving care. The care work of the person who provides family care in Germany is constructed as semi-formal care. It is based on poor pay, only some rights to social security, and little protection for the care giver in the care relationship. In this context, some main tensions are substantive to the care work and the care relationship between the relatives. Tensions exist between their wish to give the care and the financial and social insecurity and risks connected with the care situation. Moreover, the legal framework constructs tensions between the interests of the person who receives care and the person who provides care, and between the affective and the financial dimensions of the relationship between the care giver and care receiver.

In Denmark, the degree of tensions connected with the care situation of somebody giving temporary care to an older relative is clearly lower. Since family care is formalized, care during the daytime instead of working at their normal workplace is an option. In that case, the caring family member has an employment contract and receives wages that usually are paid for long-term care. Also, she or he has rights to social security and job protection as in any standard employment relationship. Caring, however, is associated with a loss of income, in as much as care is given only part-time, and the carer is forced to give up his or her ordinary full-time job. It follows from this disadvantage that there is tension caused for people who decide to take over the daily care of a family member, since they risk a loss of income as well as of their job itself because only a very restricted leave-taking scheme exists.

Our findings show that the degree to which ‘consumerism’ in long-term care is associated with tensions in relation to the care situation of the caring family member and the care relationship depends on the ways in which it is embedded into a family-care regime. In this regard, the tensions are clearly
higher in the semi-formal family-care regime of Germany – compared to the formal family-care regime in Denmark.

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Experiences with the privatization of home care: evidence from Denmark

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Abstract
Processes of privatization in home care for the elderly in Denmark have primarily taken the form of outsourcing public-care provisions. The content and quality of services have in principle remained the same, but the providers of services have changed. The welfare state has continued to bear the major responsibility for the provision of elderly care, while outsourcing has allowed clients to choose between public and private providers of care. The major aim of outsourcing has been to empower the frail elderly by providing them with exit-opportunities through a construction of this group as consumers of welfare-state provisions. The central government in Denmark has produced the public-service reform, but the municipalities bear the administrative and financial responsibility for care for the elderly. Further, national policymakers have decided that local authorities (municipalities) must provide to individuals requiring care the opportunities to choose. With this background in mind, this article analyses how national, top-down ideas and the ‘politics of choice’ have created tensions locally in the form of municipal resistance and blockages. The article draws on case studies in two Danish municipalities, whereby central politicians and administrative leaders have been interviewed. We have identified four areas of tensions: 1) those between liberal and libertarian ideas and values versus local political orientations and practices; 2) new tensions and lines of demarcation among political actors, where old political conflicts no longer holds; 3) tensions between promises and actual delivery, due to insufficient control of private contractors; and 4) those between market principles and the professional ethics of care providers.

Keywords: elderly care, home care, free choice, marketization, privatization, political conflicts, Denmark
Introduction

The organization of elderly care has changed dramatically in most Western countries in recent decades. Where care was previously provided within households and kin networks, it is now a public activity subsidized by the welfare state. This development has led to the marketization of intimacy and the commodification of care (Ungerson, 2000, p. 69). The trend towards the marketization of intimacy has assumed different forms in different countries or contexts. A distinction can be drawn between paid informal (black market work), semi-formal (cash for care) and formal (care provided by paid employees in the social services or a voluntary agency) forms of care (Ungerson, 1997; Geissler & Pfau-Effinger, 2005; Jensen & Møberg, 2011). In the Danish Social Democratic Welfare State, formal forms of care have become predominant (Andersen & Jensen, 2011, pp. 280ff). Care has become a universal citizen’s right, with the municipalities being responsible for operating the elderly-care sector, and services offered include housing and care facilities for the elderly, as well as personal and practical assistance in the form of home care. As formal forms of care are predominant in Denmark, care givers provide care to persons outside of their family, and care giving has become a profession-like occupation. Care givers are unionized, public salaried employees, and their wages and work conditions are regulated by the social partners, that is, unions and employers’ associations. In effect, care givers are paid wages equivalent to those that are paid to persons with similar qualifications, hours of work are regulated, and social rights, such as sick leave, are derived from employment in care. In 2005, roughly 100 000 persons – about 3.7 per cent of the total labour force (calculated as full-time employees) – were employed in the public elderly-care sector (cf. Jensen & Rathlev, 2009).

With home care, municipalities could freely choose until the early 2000s whether they wanted to make use of private (for-profit) contractors or whether all staff in the home-care sector should be municipally employed. However, municipalities were reluctant to make use of their outsourcing opportunities. By March 2002, only about 2.5 per cent of home care for those over 67 years was provided by private contractors (Strukturkommissionen, 2004). By January 1, 2003, however, a Liberal-led, right-of-centre government introduced public care service reform according to which the recipients of home care would be free to choose from different providers (public or private for-profit) of home care, meaning that municipalities became obliged to contract out the provision of home care if individual citizens so desired.

As in other European countries (e.g., Knijn, 2000; Pavolini & Ranci, 2004; Whitfield, 2006), the elderly-care reform in Denmark was inspired by liberal and libertarian values, epitomized as the ‘freedom to choose’, which was believed to empower seniors by providing them with opportunities to choose. This constructed them as the consumers of welfare services (cf. Morris, 1997) while at the same time reinforcing the superiority of the market as a decision-making mechanism. Clarke (2004) and Clarke et al. (2007) have strongly argued that ‘free choice’ is a proxy for deeper processes of privatization and that the introduction of ‘free choice’ is a vanguard of ‘direct’ forms of privatization, that is, the transfer of services, organizations, and resources to the private (for-profit) sector. However, the organizational design of the ‘free choice’ of elderly care in Denmark has thus far (only) taken the form of outsourcing as well as the creation of a new provider market by supporting the formation of for-profit service providers.
Free choice as a key organizing principle in elderly care was legislated at the national level. Neither the users nor the providers of care from below demanded the new policies. Rather, national politicians with neo-liberal convictions defined a new orientation with regard to the future of public services in the face of relatively autonomous municipalities, which are responsible for defining and financing policy outputs. Increased choice, or exit-opportunities, in the area of elderly care was thus imposed on autonomous local politicians and administration from above. Such top-down imposed policies might have contributed to new tensions and contradictions, not least because the local level is able to resist or block ‘politics of choice’. As will be shown, municipalities are in practice able to facilitate or hinder the entrance of private for-profit providers into the care market.

With this background in mind, this study has sought to shed light on the following questions. How do local municipal actors in politics and administration deal with the introduction of choice and market mechanisms in elderly care? How do they react to national politics of choice, and how do they obstruct or ease the process for private providers of entering the care market? How do they see and perceive the consequences of the introduction of choice for the quality of care work, on the one hand, and the working conditions among care givers (i.e., the staff), on the other? To do so, this article draws upon qualitative interviews held with local actors in the administration of two different municipalities, and aims to reach a conclusion on how privatization creates tensions between pervasive ideas and local orientation and practices. The two municipalities represent two different approaches and orientations regarding the ‘politics of choice’. Whereas one municipality was ‘enthusiastic’ about outsourcing and competition, the other was ‘sceptical’. In the conclusion, we reflect upon the tensions, contradictions, and local reactions that have emerged from the top-down reform of public home-care services for seniors.

The local system of elderly care in Denmark

It is important to understand the context in which the ‘politics of choice’ were introduced in Denmark. There are 98 municipalities in Denmark, and these municipalities play a central role in the provision of care to senior citizens. The relevant legislation, the Social Services Act, stipulates that the municipalities bear the responsibility for the care for senior citizens. Elderly care is a citizen’s right, and the municipalities must offer personal assistance and care together with help or support relating to necessary practical work in the home. Like other Scandinavian countries, the municipalities thus bear the main responsibility for running residential homes and nursing homes, and for providing staff and practical care in the form of home help (Szebehely, 2005; Trydegård & Thorslund, 2010). Still, contrasts in elderly care exist between the Scandinavian countries. While Denmark’s provision of elderly care complies with the image of the Scandinavian social-service model, Sweden’s deviates significantly from this image (Rauch, 2007).

The municipalities have considerable autonomy and room to manoeuvre when it comes to the actual extent and substance of the care, however, as well as the situations in which one is entitled to receive care (cf. Jensen et al., 2004).

1 Factors such as ageing populations (e.g., Ungerson, 2005), the overload of the welfare-state apparatus (e.g., Offe, 1982), and differentiation or individualization (e.g. Rostgaard, 2006) played a role to advancing the care reform, but these factors do not necessarily call for a liberal-inspired reforms.
This means that the municipal council has extensive authority to define the level of municipal services (quality, coverage, etc.) for seniors. Still, the municipalities are obliged to make their political priorities and level of services visible to the municipal residents. The municipalities have been required to establish quality standards for municipal services since 1999. These standards must indicate the level of service that the municipal council has set for the municipality, just as the municipalities are required to install particular control mechanisms aimed at ensuring the fulfilment of the quality standards.

The connection between policy and financial responsibilities is very close in the area of elderly care. The municipality defines the content of elderly-care services, and the municipalities finance elderly care entirely (municipal spending in Denmark accounts for approximately 55 per cent of the total public expenditures). Danish municipalities have the authority to tax income, which, in combination with user fees, is the most significant source of municipal revenue. Taxes and user fees accounted for 56 per cent of the combined revenues for municipalities in 2002. Other sources of revenue include operating and installation revenues, refunds, borrowing, and compensatory payments (from the state). Compensatory payments aim to level out the conditions between rich and poor municipalities with respect to spending needs, tax bases, and other factors (Strukturkommissionen, 2004).

Overall, there has been a strong tendency in Denmark towards the formalization of care for seniors and such care becoming a public responsibility. By the end of the 1980s, however, the public sector and formal care for seniors had been restructured. Denmark has been marked by a trend towards ‘de-institutionalization’. Home care and residential homes replaced senior housing, which led to an increase in home care (i.e., personal assistance, care, and assistance with practical tasks in the home). The most common type of home care is cleaning. Home care aims to keep seniors with reduced functional capacity (physical or mental) in their own home as long as possible.

This shift towards de-institutionalization has been accompanied by a trend towards flexible and private (free choice) care for seniors (Rostgaard, 2006). With regard to home care, municipalities could freely choose until January 1, 2003 whether they wanted to opt for a private contractor or whether all of the staff in the ‘home-care sector’ should be municipally employed. Since January 1, 2003, however, the care receiver has been free to choose from among different home care providers, that is, public or for-profit private providers.

Not just anyone can establish a private company and provide home care. The municipality must first recognize these companies, and this recognition is based on the quality and price requirements outlined by the municipality. The municipality must also control the compliance of private contractors with quality standards. The municipality – not the care receiver – must pay directly to the private contractor for services delivered, and the municipality is responsible for all of the paperwork associated with the delivery of for-profit private home care. In other words, the scheme is not based on cash-for-care principles. Private contractors cannot, therefore, compete on the price for care, but private contractors have some advantages in attracting customer’s vis-à-vis the public care provision. Private contractors are allowed to offer additional services such as gardening or dog-walking to the care receiver, and the care receivers themselves must pay for these additional services. Public providers of care are only allowed to offer personal assistance and help for domestic tasks. All the same, the overall responsibility of providing care remains with the municipality. If a private contractor were to choose to stop
delivering care to a specific individual, the municipality is obliged to assume the provision of care.  

Cases and methods

The data used in this article originates from case studies of Danish municipal governance structure in the area of elderly care, and two cases have been selected and compared. The two cases have been selected on the basis of ‘most similar’ design criteria (e.g., Lijphart, 1975). The two municipalities resemble each other with regard to numerous structural characteristics, including the tax base, debt, degree of urbanization, and the percentage of elderly, frail individuals who have chosen a private home care provider (cf. Indenrigs- og Sundhedsministeriet, 2011). The two municipalities differ from each other, however, regarding population size and how much money the municipalities spend per senior per year on elderly care. Furthermore, the two municipalities differ markedly when it comes to local policies, organizational structures, and practices concerning the introduction of privatization and choice. These marked differences are mirrored in different cultural orientations towards the ‘politics of choice’. In Municipality A, the central actors appeared to be quite ‘enthusiastic’ about the introduction of economic principles, whereas in Municipality B they seemed quite ‘sceptical’.

Both municipalities have a lengthy historical tradition of electing a Social Democratic (local) government. It is peculiar, then, that in the last election in 2010, the sceptical municipality, B, produced a Liberal majority, whereas the enthusiastic municipality, A, continued under a Social Democratic banner. Municipality A is not only characterized by political stability, but it is also marked by administrative stability and continuity. The seniority among the interviewed administrative staff is much greater in Municipality A (7-11 years) as compared with the seniority in Municipality B (1-4 years). The same pattern of continuity and discontinuity can even be found with regard to the person chairing the municipal seniors committee, which is responsible for all questions relating to the elderly before the municipal council. In Municipality A, the chair celebrates his 40-year anniversary in this position, while the chair in Municipality B was a newly elected municipal council member.

The different orientations in the two municipalities have had an impact on the magnitude of private providers. The number of private providers is much larger in Municipality A, where individuals requiring care can choose between 18 providers (13 private and five public providers), whereas only five providers (four private and one public) can be found in Municipality B (Servicestyrelsen, 2011).

The ‘core’ of the empirical material consists of qualitative interviews with the central actors involved in the formulation and implementation of local care policies. In 2010 we interviewed the most important political and administrative actors in relation to local elderly care. In each municipality, we have interviewed one elected politician, that is, the chair of the municipal senior committee. Moreover, we have interviewed persons in key positions within the local administrations, including: (1) the chief executive in the social administration (including elderly care) and overall head of all of the administrative staff interviewed; (2) the head of the care-assessment unit. The care-assessment unit serves a dual role of assessing care needs and grants

2 According to the legislation, private contractors can not refuse their services to citizens, and they cannot terminate a contract (§ 15). In practice, however, they can.
care while and at the same time of controlling the quality of services delivered by private and public home-care providers; (3) the head of the municipal elderly-care unit, who is the overall head of all municipal providers of elderly care; and (4) the municipal elderly-care unit is subdivided into sections (district organizations) and we have interviewed the head of a district organization. Additional information has been taken from official municipal documents, such as the official quality standard in the municipality.

Not all interviewees spoke unequivocally. The interviewed actors expressed quite different (or even opposing) approaches regarding the introduction of economic and market principles into the organization of elderly care. Our criterion for distinguishing between ‘enthusiastic’ and ‘sceptical’ municipalities is, however, that most interviewed actors in Municipality A were in favour of the introduction of market mechanisms, whereas the vast majority of those interviewed in Municipality B appeared to be rather sceptical towards the phenomenon.

Local policies, municipal service organizations, and forms of competition

All Danish municipalities have an elderly care unit responsible for the overall provision of elderly care within the municipality. The care unit is sub-divided into districts covering different geographical areas within the municipality. The districts are responsible for the delivery of public home care to the client or user. At the time of the interviews, there were five districts and 13 private providers of care in Municipality A, and four districts and four private providers in Municipality B. In the latter, the older person could choose between the municipal provider (home help will be delivered from the district in which the senior lives) or from one of four private providers. Quite unusually, it is not only possible in Municipality A to choose between public or private provisions, but also between the five municipal service units.

We have chosen an organizational structure in which the municipal providers compete with each other, because the user can also choose between the municipal provider and private providers. But here we’ve chosen to go one step further… (The chief executive in the social administration in Municipality A)

The reason for this ‘dual’ competition, that is, internal as well as external, is that the chief executive in the social administration in Municipality A is able to influence the competition. The chief executive believed that competition would improve the quality of municipal services:

Well, I am committed to competition. And I am committed to the idea that we in the public sector should be exposed to competition all of the time in order to be forced to be cutting-edge. Without any question. (The chief executive in social administration, Municipality A)

Another interviewee from the administration, however, the head of the care assessment unit in Municipality A, was more critical about the chosen ‘one-step-further’ competitive structure. She states:

Instead of installing free choice between private and public, we’ve installed free choice between five municipal providers. And then you don’t have the time for the private providers… Well, we absolutely don’t

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3 All interview quotations have been translated from Danish to English by the authors.
have the time to have meetings with them, to inform them, to check on them, and to keep them at bay and to say to them, ‘Now you have to document things’, and things like that... (Head of care assessment unit, Municipality A)

This interviewee indicated that ‘dual’ competition may become an obstacle for efficiency and cause negligence in the control of private providers. This was not a critique of private provisions; rather, it referred mainly to the enhanced competitive structures in Municipality A. Her experience and interpretation of the situation are based on her position as the head of the care-assessment unit in charge of controlling both the private and public providers of care.

Conversely, Municipality B has employed a less competitive organizational structure, and clients or users have fewer opportunities to choose compared to Municipality A. They can choose between three private providers and the public offerings. If the client or user chooses the public option, services will be delivered from the district unit covering the receiver’s place of residence. In Municipality B, the atmosphere that stifles competition is even supported by practices of blockage:

We don't have any private providers for meals on wheels. The political system is against that... I almost said... they are of course not against it, but they make demands that don't make it easy for the private providers to access the market. ... The word is – at least in our department – that it's because they demand skilled kitchen staff – even for the delivery of food. Everywhere else, it's just a driver who can read an address and run the meal upstairs. (Head of care assessment unit, Municipality B)

As can be seen, the special demands set by Municipality B restrict the access to the care market for private contractors. These restrictions are not informal practices, since they are clearly spelled out in the quality standards for municipal services. Under the item ‘delivery’ in the quality standards regarding ‘meals on wheels’ in Municipality B, it is stated:

The meal ought to be delivered by skilled staff so that the citizen receives adequate instructions concerning the meal and answers to any questions. (Quality standards Municipality B; cf. National Board of Social Services, 2011)

The quality standards for the delivery of ‘meals on wheels’ in Municipality A are quite different. Here, the following requirements must be fulfilled:

The drivers must understand and speak Danish. The drivers must be familiar with the pensioners’ possible special problems, and they must meet them with understanding and flexibility. (Quality standards Municipality A, Source: National Board of Social Services 2011)

The drivers in Municipality B must clearly be skilled staff, whereas this is not the case in Municipality A. This possibly helps to explain why there is no private provider of meals on wheels in Municipality B, whereas there is one in Municipality A.

The interviewed head of a district organization in Municipality B seems to describe these tendencies in more general terms:

But I think it [the choice between private and public providers] did not receive as much importance as it possibly could have gotten. And I’m not

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4 The authors have translated the quotes from the quality standards of municipalities A and B from Danish to English.
surprised, because there are no equal market conditions. ... This might be a little hypocritical. But it probably depends on what kinds of politicians you have in the municipality. There are some other municipalities ... which have privatized their senior centres and that kind of thing... So it’s possible one way or another (Head of district organization, Municipality B).

This quotation demonstrates how municipalities within the same legislative framework can create different environmental conditions from which private providers can emerge. Municipalities may support the formation of private providers by creating ‘equal market conditions’ for public and private providers, or they might resist or block the formation of private providers in the face of the ideas and intentions of national policymakers.

The comparison between municipalities A and B outlines two distinct patterns in the organizational structure and practices. In Municipality A, most of the interviewed actors were positive or enthusiastic about competition and ‘politics of choice’. Municipality A had even taken competition a step further than was envisaged, by introducing competition between the municipal district units in addition to the competition between public and private providers. This structure, however, has been criticized from within for being inefficient and undermining the control mechanisms. In Municipality B, on the other hand, the introduction of economic principles appears to have been delayed and impeded by various forms of resistance. Local policymakers can restrict the market for private providers, as seen in the case of the obstructive quality standards set on the meals-on-wheels service.

Patterns of interpretation

It is often argued that competition enhances the quality of services, and the chief executives in the social administration in both municipalities appear to support such basic ideas. Even the chief executive in the social administration in sceptical Municipality B made the following statement:

I think it’s really fine that the user can choose between public and private home care services. ... And our quality awareness and cost-consciousness and so on clearly got sharpened by the fact that we have competition. So it’s really fine. I would be sad if they were not there anymore. (The chief executive in the social administration, Municipality B)

However, competition can also have a negative effect on the quality of care. As described above, the head of the care assessment unit in Municipality A believed that complex and competitive structures drain the resources for controlling private providers, which in turn threaten the quality of care:

They [the private providers] do allow themselves ... not to document anything about the individual citizen, even though they have to. Well, because they just have to work profitably and to earn money with that, they don’t get it done, even though it’s actually a requirement for them... And until now, there was no case in which they have been reprimanded for not doing so. (Head of care assessment unit, Municipality A)

The interviewee’s colleague in Municipality B, a clear ‘sceptic’, thinks that the private competitors actually do provide a lower quality of care:

The private firm is usually able to have more unskilled staff than the municipal home care. What they have to provide is the same – the same services. And well, to be completely honest ... I think it’s a somewhat
poor alternative to municipal home care. And so the question is where to give the money that one uses for these services; if one thinks that it is really fantastic to give it to private providers or if one rather lets it circulate in the public system... (Head of care assessment unit, Municipality B)

This interviewee drew a connection between the educational backgrounds of the care givers and the quality of the care: a lower proportion of skilled staff is expected to mean lower quality care.

Some anticipated that the introduction of market mechanisms would have an effect on the staff’s and care givers’ professional self-understanding and work ethics. One head of district in Municipality A emphasized the positive consequences of market mechanisms and cost-benefit thinking:

Well, in any case, the fact that the private providers came in did mean that we had to look at our own tasks with different eyes. And that we also had to look at what we’re doing today. And all of a sudden, we had to put time and a price on everything we do. That was a good experience for a lot of the employees – that they all of a sudden found out, well it isn’t something we just do... ... So for many of our employees, it meant that they felt that they were growing a little professionally by focusing on what they’re doing. And all of a sudden what they were doing became very visible. And suddenly, what they did had a value (Head of district organization, Municipality A)

In line with this argument is the notion that the introduction of economic thinking casts light on the economic value of caring and fosters the recognition of care work and care workers. Standardization in the sense of ‘putting’ a time and price on every task may actually support the processes of professionalization. Hanne Marlene Dahl (2009), who has analysed how care workers handle the implementation of New Public Management (NPM) within home care in two Danish municipalities, has argued that NPM reforms may lead to increased recognition of care work. NPM can also lead to increased misrecognition, however, depending on how NPM reforms are translated into work practices. ‘The different translations of NPM ... matter a great deal for their impact on recognition and misrecognition’ (Dahl, 2009, p. 649). Similarly, we find different interpretations in municipalities A and B regarding how the fortification of economic principles affects the ethics and quality of care work:

For me, welfare services depend on relations. In reality, I don’t like the word ‘services’ – for me it’s not the right word when it comes to relations. Because services are something more tangible, concrete that you give to a customer. The term ‘service’ also comes from a different world. So all of this terminology we have about it ... also ‘level of service’, for example. Service is something we provide to a citizen. One tends to forget that, in reality, one is cooperating and establishing a relationship [with the senior]. And here, I do see a risk when it comes to the perspective that the citizen is a customer ... it becomes a business transaction instead of saying that it is actually the establishment of a relationship. And it is really very much about finding out what kind of needs the individual actually has. (Head of elderly care unit, Municipality B)

Here, the interviewee points to care as a reciprocal relationship based on responsibility and relatedness, a topic which has also a focus in the academic discussion of care (see also Daly & Lewis, 2000). Later on, when asked about her individual definition of good elderly care, the same interviewee again emphasizes ‘basic values’ such as ‘responsibility’ and ‘respect’. In her view,
the specific character of care work makes any ‘privatization’ efforts difficult. This leads her to being one of the ‘sceptics’ in Municipality B:

One must be very aware that it [elderly care] is not just some... some... some thing, or something you can just do to someone ... And here I do see some risks. But it’s not like I’m completely against it – you can’t say that. I just think that you shouldn’t go into it in a starry-eyed manner. I think you should be very aware about who does what in such situations. (Head of elderly care unit, Municipality B)

Another aspect that is criticized by nearly all of the interviewed actors – although, as we shall see later on, with different motives and diverse conclusions – is the fact that no real privatization took place, in other words, that the privatization in the context of Danish elderly care was actually outsourcing. Home care was not understood as a ‘real’ market. The social-administration chief executive in Municipality A (a competition enthusiast) was really annoyed about the fact that there were no genuine market conditions in the field of home care:

I disagree strongly with how it is today – that there’s no competition over price. I just don’t get it … Because without competition over price, what’s left from the private sector? At the end of the day, isn’t it what the private sector is grounded in? That there should be competition over price? But I would also like to have marketization in the sense … that the users should pay much more themselves. So that seniors could buy from the private providers what they miss from the level of service that we provide – as some kind of base … I think that would be really fine. But here again, I think something is wrong today. (Head of social administration, Municipality A)

Earlier on, the same interviewee made it clear that she saw competition as a means of enhancing quality and of enforcing development in municipal elderly care. In this context, we can see how she criticizes the Danish ‘imperfect’ form of marketization as a hindrance to the unfolding of what would have otherwise been proclaimed to be the great effects of market competition. She criticized two main aspects. First, that there was no competition over price, and secondly, that seniors did not pay at least part of the services themselves, because that is how a market usually works. Earlier in the interview, she already made it clear that she only sees the provision of personal care as a public responsibility and that she would embrace making practical help like cleaning as services which seniors must pay out of their own pockets.

A common point made by many of the interviewees was the claim that private and municipal providers do not compete on an equal footing:

The municipalities are challenged by the fact that we must always be ready to overtake the citizen again and that we have to provide 24-hour coverage. And that’s costly. So as a firm you can opt out of these tasks but you can’t do it as a municipality. That challenges the municipalities in this competitive world through unequal conditions. (Head of elderly care unit, Municipality A)

This interviewee emphasizes that the private providers have some advantages within the market, since the municipality must act as a ‘last resort’ and is responsible for assuming the costly and non-profitable tasks. One of the district heads in Municipality B underlined an additional aspect of the unequal market participation:

What I think isn’t okay is that one ... isn’t equal. For example, the private providers can provide extra cleaning for extra payment. We can’t. ... We
don’t have equal conditions ... There are things we are not allowed to do. And we have to take over. If a citizen is tired of the private firm, we have to take over. Whereas the private providers can ... say ‘no thanks’, and they can pick and choose. And then it’s the municipality that takes over. (Head of district organization, Municipality B)

Hence, the last two actors criticized the policy of privatization in Denmark for favouring private providers and leaving the more costly, less attractive tasks to the municipalities. Whereas the ‘enthusiastic’ head of social administration in Municipality A criticized the ‘imperfect’ privatization for hindering the ‘blessings’ of market principles and competition, the other two interviewees criticized how the home care market is constructed, which benefits private providers vis-à-vis municipalities.

As can be seen, different interviewees and actors assigned privatization to different meanings and consequences. Some of the interviewees saw a positive impact on the quality of care from competition and the market mechanism, while others saw the introduction of a market and private competitors as a threat. When it comes to the impact on care work and care workers (the staff), we again see opposed interpretations of the consequences of privatization. One interviewee believed that market mechanisms strengthen the recognition of care work; another saw it as a threat to care-work ethics. There were also different interpretations regarding the actual functioning of the market mechanisms. Some argued that the ‘market’ is constructed in such a manner (i.e., outsourcing) that the rewards from privatization are suppressed; others believed that private providers are privileged.

Conclusion

Since the early 2000s, the Danish right-of-centre government has supported the establishment of private home-care providers in order to help to shift the provision of care and resources from the public to the private sector. This endeavour has been imposed on autonomous local municipalities from above, even though municipalities already had the opportunity to contract out service provisions prior to the service reform in 2003 if they wanted to do so. As of 2003, however, the free choice of local political communities has only been tolerated as long as it is exercised in the right direction.

Nevertheless, the abstract values of free choice have never become a reality. The municipalities still define which services clients are entitled to receive. It is not like a supermarket, where clients can choose between different products. Rather, clients will be offered a product or service defined by the public authorities. Accordingly, the ‘politics of choice’ only allow clients to choose whether the municipality or a for-profit private contractor delivers a pre-defined commodity (or service).

A genuine ‘politics of choice’ in Denmark is also undermined because of the neutralization of market or price mechanisms. Because there is no real competition over price, the only incentives for care receivers to choose a private instead of a public provider are, first, that clients feel more comfortable with a private rather than a public provider of care, and, secondly, that private providers, contrary to public providers, are allowed to offer additional services. Even though a relatively small proportion of total care is provided by private contractors, privatization policies in elderly home care in Denmark have created several layers of tensions.
In Denmark, municipalities bear the responsibility for providing care for senior citizens, and municipalities control how quality standards in public and private (for-profit) care are defined locally. These standards can be defined in ways that tend to exclude private contractors. In one of the municipalities examined in this article, we have found that this municipality demands that the provision of meals on wheels can only be delivered by skilled kitchen staff, which makes it difficult (i.e., expensive) for private contractors to access the care market. This creates tension between the overall idea of choice as a political value versus local political orientations and practices.

Different municipalities and different actors within municipalities are oriented differently towards the ‘politics of choice’. On the basis of our case study, we draw a distinction between ‘enthusiastic’ and ‘sceptical’ municipalities and actors, which indicates that the same phenomenon is interpreted quite differently by different actors. This causes local political struggles and conflicts. However, the demarcation between the ‘enthusiastic’ and the ‘sceptical’ does not follow conventional political thinking. It was a Liberal-led government that introduced ‘politics of choice’, but our case studies show how the Social Democratic municipality is ‘enthusiastic’, whereas the Liberal municipality is ‘sceptical’. The ‘politics of choice’ thus gives rise to new kinds of tensions and lines of division among political actors.

In addition, we have found a tension between what is promised and what is actually delivered. The municipality defines the quality standards, and these quality standards may deviate from what is actually delivered by private contractors, who tend to deprive older people of what they are actually entitled to get. Such tensions may occur owing to the insufficient control of private contractors. The municipalities are responsible for controlling the quality of services delivered by private providers, but the control can be inadequate. In our case study, we have found examples showing a lack of resources to control private providers. A similar tension between promises and delivery arises because private contractors are inclined to use unskilled staff to maximize profits.

Finally, tensions between professional ethics and market principles may arise, since cost-benefit thinking tends to pose a threat to the ethics of the profession-like occupation of care. This tension, however, is not clear-cut. At least administrative leaders in the two municipalities report that outsourcing and the introduction of market mechanisms have also led to the increased recognition of care workers because the introduction of private contractors has led to a self-reflexive process regarding the distinctive qualities of care work.

References


Towards the marketization of early childhood education and care? Recent developments in Sweden and the United Kingdom

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Abstract

Extensive public debate is being waged across mature welfare states as to whether social services are best provided by the state or the market. This article examines developments in Early Childhood Education and Care (ECEC) policy in Sweden and the United Kingdom, identifying trends towards marketization and universalization of ECEC that suggest a complex picture of competing policy logics and goals in the restructuring of welfare states. This article first discusses two models of early-years provision, the market model, and the universal model, outlining underlying assumptions, tensions, and implications of market and state provision of ECEC. A comparison of recent reforms in Sweden and the UK highlights how similar ideas and trends play out differently in different national contexts. In Sweden an integrated public ‘educare’ programme gradually developed over time, and market mechanisms introduced in the 1990s have so far had limited effect on the system overall. In the UK ideas about universal early childhood education became influential as part of a new social-investment agenda in the 1990s but have, owing to their restricted implementation, not fundamentally altered the existing childcare market. Historical policy trajectories continue to matter, yet tensions and incoherencies between policies can open spaces for change.

Keywords: Early childhood education and care, marketization, universalism, Sweden, United Kingdom, social investment

Introduction

The strengthening of economic principles in the organization and delivery of social services has been a recurrent theme in recent public-sector reform throughout mature welfare states (Pollitt & Bouckaert, 2000). This article examines changes in Early Childhood Education and Care (ECEC) policy in Sweden and the United Kingdom since the 1990s, and asks to what extent these developments reflect general trends of marketization. Sweden and the UK are commonly characterized as ‘universalist’ and ‘residual' welfare states,
respectively, which reflects their markedly different welfare-state designs (see e.g., Sainsbury, 1991; Wincott, 2006). The generous public ECEC system in Sweden and the historical marginalization of childcare policy in the UK fit the picture well. Comparing developments around ECEC in these two contrasting cases helps highlight how similar trends and ideas play out differently in different national contexts. In both countries the marketization of early-years services has taken place with competition and for-profit provision playing a new or enhanced role. However, this is not the only trend in ECEC reform: in the same period public responsibility for and universal access to early-years services have been extended.

Such state-led service expansion may seem surprising in a general climate of financial austerity and retrenchment, and stands in tension with the neo-liberal underpinnings of the ideas of New Public Management that have influenced both countries (Blomqvist, 2004; Naumann & Crouch, forthcoming). A number of scholars have linked developments around ECEC to the broader restructuring of welfare states towards a new ‘paradigm’ of ‘social investment’ (Taylor-Gooby, 2008; Jenson & Saint-Martin, 2006). In this concept, early-years services play a central role in making parents and children productive workers in the present and future, which implies increased state involvement as a means for ultimately economic ends. It is important to note, however, that the various policy initiatives around ECEC in recent years cannot all be reduced to economic intentions. The trends of marketization and universalization in ECEC services do not add up to a coherent new welfare-state design, but present a contradictory mixture of policy goals and solutions. By disentangling the various developments around ECEC, this article suggests that, rather than a move from an ‘old’ towards a ‘new’ welfare state, what we may be witnessing is the maturation of ‘old’ policies alongside the pursuit of new agendas. Recent ECEC reforms in Sweden and the UK indicate some change in policy principles, while remaining enmeshed in the historical policy legacies of each country.

The first part of the article provides an analytical discussion of two contrasting approaches to ECEC services – the market model and the universal model – as a framework for understanding the tensions and contradictions underlying ECEC reform. Thereafter, developments in ECEC policy in Sweden and the UK are examined. First, the two post-war ECEC systems are briefly outlined to help identify continuity and change in ECEC policy since the 1990s in the analysis that follows. The subsequent comparative discussion highlights tensions inherent in different reforms and the extent to which they have altered the pattern of national ECEC provision. The last section draws some lessons from the comparison of ECEC reforms with respect to welfare-state change in general.

**Competing models of early-years provision**

Recent academic debate about welfare-state reform in Sweden has revolved around the question of whether the introduction of market mechanisms in social services has led to the abandoning of universalism as guiding principle of the Swedish welfare regime (Blomqvist, 2004; Bergh, 2004). In the British case marketization trends are seen to be more in line with the traditionally restrained and targeted nature of state involvement in people’s welfare in this ‘liberal’ or ‘residual’ welfare state (Wincott, 2006). Here, new commitments to universal provision, such as in preschool education, have been dubbed a ‘quiet revolution’ (Smith, 2007). It is noteworthy, however, that the principle of universalism has always been part of the Beveridgian post-WWII welfare
state, for example, in National Health Insurance or the national pension. Such observations invite a focus on the dimensions of ‘selectivity’ and ‘universalism’ when assessing changes in ECEC policy in Sweden and the UK. The discussion about ‘market’ versus ‘state’ in social-service delivery can be cast within these specific dimensions. However, this debate also has broader scope, because it considers not only the type of policy instruments chosen and level of generosity, but also different perspectives on the types of relations social services do, or should, entail.

The market model

The ECEC market is constituted by the exchange relationship between individual purchasers (parents) and private, commercial providers (firms or corporations). Both purchasers and providers are assumed to behave as self-interested actors: parents by seeking the best ECEC solutions and providers by seeking profit-maximization. The ‘pure’ childcare market is also assumed to be self-regulatory: the size of the childcare sector, the available types of services, the prices and the quality will reflect demand; consumer choice and competition produce an incentivizing mechanism in that providers offering unsatisfactory services will be squeezed out of the market. The expected outcome is an ECEC sector that both displays a high degree of diversity, which reflects parents’ differing preferences, and delivers high-quality, cost-effective ECEC services.

The appeal of the market model to pressure groups (parents) and policymakers lies in its responsiveness to consumers and its promises of efficiency. It also allows governments to refrain from explicit normative decisions about who should be using ECEC services because the market is supposed to be demand-driven. A core assumption on which the market is premised is that ‘buyers’ are well-informed about the ‘product’ they purchase and are free to enter or exit a transaction. In practice, however, there are various constraints on parental choice, constraints which are implicated in dysfunctional market developments (see also Ball & Vincent, 2005). First, since the cost of ECEC services is borne by the parent-purchasers, access to services is determined by parents’ resources. Some parents will be unable to afford ECEC services altogether, and others will have to content themselves with inadequate solutions. Secondly, parents tend to be logistically and geographically constrained. Since commercial providers are likely to target buyers with the highest purchasing power, geographical service imbalances may be the result, with good and varied availability in affluent urban areas and scarce or unsatisfactory provision in disadvantaged or remote areas. ‘Need’ – foremost parents’ need for childcare in order to hold down a job – is the most immediate limitation to ‘free choice’. If the need is strong, providers may become less responsive to demands and expectations, and might, for example, trade quality for efficiency because they will get their customers anyway. Lastly, not all parents hold the necessary expert knowledge that enables them to assess the suitability and quality of early-years services. The ECEC market can, therefore, be seen as being highly selective, where affordability, availability, and the advertisement power of firms directly influence parental choice, and in practice these factors leave many with little choice at all.

1 While the market model is grounded in normative assumptions about social relations, public debate has tended to focus on its instrumental aspects. This is beneficial for governments since the declining stability in voter-alignments have made value statements politically more risky.
No such ‘pure’ ECEC market seems to exist anywhere. No welfare state dares to leave the provision of early-years services fully to market forces because children are considered a particularly vulnerable group in society in need of special protection. Thus, even in countries such as the US or the UK, where ‘childcare markets’ are said to exist, these are in fact strongly state-regulated (Penn 2010). Secondly, children are not only the ‘private pleasure’ of their parents but carry certain ‘public-good’ characteristics. Welfare states have always had an interest in influencing the ‘quantity’ and ‘quality’ of the future generation of citizens, workers, and soldiers via a range of social policies (see e.g., Myrdal, 1945; SOU, 1972; HMT, 2001). In some countries such as France and Sweden, the potential of early-years services to impact on children’s health and socialization, as well as on family and fertility behaviour, has received attention already in the early twentieth century (Naumann, 2006); in other countries such as the UK this focus has more recent origins (Lloyd, 2008; Smith, 2007). Broader goals such as poverty alleviation or the reconciliation of family and work cannot easily be achieved through the market owing to its selection effects, and this difficulty has led states to intervene in ECEC provision. Thirdly, the increasing recognition of young children’s right to educational opportunities, as reflected in Article 28 of the UN convention of the Rights of the Child (UNCRC), has galvanized governmental action (UN, 1989). For these reasons, welfare states are involved in the regulation, funding, and provision of early-years’ services, albeit to varying degrees. In some countries such as Sweden, state involvement in ECEC has approached a ‘universal model’, as outlined below.

The universal model

In the universal model, provision and funding of all ECEC services are public. ECEC in this model is understood as a social right – a right that extends to both parents and children as actual users of ECEC services – meaning that access is open to all children irrespective of socio-economic background and, in a pure model, free at point of delivery (see also Bergh, 2004). The social-rights character implies that social risks associated with the early years – such as parents’ need for extra-familial childcare, children’s special or general needs for good care, and learning environments – are covered collectively via citizens’ tax contributions. The public responsibility for ECEC in turn implies a public interest, and public interest thus entails public debate over the content and aims of ECEC services, which connects with broader societal goals that are most likely guided by dominant cultural norms.

The appeal of this model to pressure groups (children's advocates, educational specialists, women’s movements) is its emphasis on citizenship, that is, the manner in which ECEC extends to wider society and can be claimed as inalienable right. Its appeal to governments is state control and its integrative potential. The possibility of pursuing broader goals through ECEC services directly influence the behaviour of families and foster social cohesion. But the universal model also has shortcomings because the principle of universalism may produce highly standardized services to ensure equal access and availability across a country. In ‘real-world’ contexts this may imply an unsatisfactory fit between available services and local or individual needs. The focus on children and their rights implies an obligation to certain quality standards of service provision. Depending on how ‘quality’ is socially defined

2 In the market model the children’s position is more ambivalent. While they are users of ECEC services, they are also the ‘product’ of the transaction between parents and service providers. Further, the main focus in the market model rests on parents as service-purchasers.
this can be very costly for welfare states. Under conditions of economic constraint, tensions may arise between ‘universal access’ and ‘quality’ where the latter may be traded for the former. Furthermore, by reproducing dominant norms and ideals about children and social relations (e.g., about gender roles) in the types of services offered, certain understandings and forms of ECEC will be marginalized or excluded. There is thus an inbuilt tension in the universal model between universalism and citizen’s individual needs and preferences, a tension that has intensified over last decades as advanced societies have become more pluralist and diverse.

To sum up, both the ‘market model’ and the ‘universal model’ of ECEC provision carry theoretical appeal while also leading to inadequacies in practice. The market is expected to produce responsive, diverse, and efficient ECEC services, but is highly selective; the universal system is expected to provide equal access and opportunities for all children, yet may become uniform and unresponsive. ‘Quality’ of services can in practice become a problem with both models. When examining recent national ECEC reforms we should thus not expect unidirectional developments towards either market or state provision, but policy responses that attempt to cater to an array of goals by combining diverse policy instruments and logics.

An increased policy orientation towards the ECEC market model, termed ‘marketization’ in the discussion below, could happen along one or more of the following dimensions:

- A decrease in state regulation, such as the relaxation of inspection regimes or standardized quality requirements (e.g., staff-to-child ratios, health, and safety).
- A decrease in state funding and subsidies to suppliers or service users.
- A decline in the proportion of public or publicly funded services in favour of for-profit providers.
- The introduction of market mechanisms such as choice and competition, and a strengthened focus on efficiency and economic goals.

Not all developments of privatization necessarily imply marketization: independent charities and other non-profit organizations may also provide private services. Privatization is linked to marketization whenever it involves an increase in individual risk and costs to service users (i.e., reduction in state funding) and where non-profit providers are encouraged to act like firms.

The ‘universalization’ of ECEC means extended access to good-quality services independent of service users’ socio-economic background. It can also include a strengthened framework for public funding and regulation and the recognition of public responsibility for children’s upbringing. Yet not every increase in state involvement necessarily equals a development towards the universal model. Targeted measures are likely to underscore socio-economically stratified access to services; differentiated parental fees, on the other hand, may support the principle of universalism. Nor does ‘universal access’ of itself imply programme generosity or comprehensiveness, even though these aspects are commonly associated with each other in characterizations of Nordic welfare states (Bergh, 2004), for it does not define the extent of membership. In practice universal ECEC policies may be of quite limited character, guaranteeing access only to certain age groups of children (e.g. three- to five-year-olds) and for certain times (e.g., part-time).
There is thus no simple trade-off between market provision and universal ECEC – more ‘market’ does not necessarily mean less ‘state’ – and no linear relationship exists between the two. Rather, both models are outlined here to highlight the shaping of ECEC systems by different and competing logics and mechanisms: parental preferences versus citizenship; competition versus public planning; individual interests versus collective interest. The ways in which trends of ‘marketization’ and ‘universalization’ have manifested themselves in Swedish and British ECEC will be examined next.

ECEC policy developments in Sweden and the UK

Historical Background

During the post-WWII decades ECEC services were equally scarce in Sweden and the UK, the male breadwinner model was dominant in both countries, and small children were seen to be best cared for by their biological mother. In Sweden in 1968, two per cent of children aged four, 11 per cent of the five-year-olds, and 43 per cent of six-year-olds were in childcare and preschool programs (Naumann, 2006). In the UK in 1965, two per cent of three to four-year-olds had access to state-provided childcare and 11 per cent of children had some kind of out-of-home care (Penn, 2009, p.117). In the following decades ECEC services in Sweden expanded dramatically on the basis of strong demand by working parents, radically changing social norms about gender roles and children’s place in society, and a high welfare-state commitment. In the UK, on the other hand, state involvement in ECEC service provision remained minimal, where the raising of children was defined as a private family matter and the norm of the male breadwinner remained dominant.

Sweden

In Sweden, a unitary public ECEC system for children aged one to six was established in the early 1970s. Designed as a collective full-day service, modern Swedish ECEC was intended to fulfil a wide range of functions: to provide good-quality day care while also offering pedagogically sound learning spaces; to enhance gender equality by supporting the reconciliation of work and family life; to mitigate class differences by offering children equal educational opportunities from an early age; and to support economic growth and welfare-state sustainability by bringing as many parents as possible into the labour market. The foundations for this public ECEC system were laid in 1972 by an extensive state investigation that detailed major aspects of these services, drawing on psychological child development research, sociological, and economic theory, and by synthesizing political goals with feminist thinking on childcare that had been debated since the 1920s (SOU, 1972; Naumann, 2006). Universal availability of public ECEC grew to become a central political promise of the Swedish Social Democratic government (Naumann, 2006).

3 Children in Britain normally enter school at the age of five, while their Swedish counterparts do so at the age of seven.
The universalization of ECEC services in Sweden was a gradual process that took shape over several decades. In 1973 the state for the first time formalized its responsibility for ECEC by obliging municipalities to provide free early-years services to preschool children, albeit at that point only for six-year-olds. In 1976 a bill was passed with the ambitious plan to expand ECEC with 100 000 new day-care places and 50 000 after-school places (Antman, 1996). In 1980 the provision of ECEC services was legally placed under municipal responsibility, but with substantial financial contributions by the central state. In 1985 a new expansion programme was passed with the aim to provide by 1991 ECEC for all children aged one-and-a-half to six years whose parents were gainfully employed (Antman, 1996). The state’s financial commitment to its expansion plans was considerable: social expenditure for ECEC rose from 0.15 per cent in 1963-1964 to 2.75 per cent in 1987-1988 (Hinfors, 1990, p.49). Between 1975 and 1990 ECEC services expanded from a coverage of 17 per cent to 52 per cent of children aged one to six (Bergqvist & Nyberg, 2001, p.243). Despite this massive expansion, the demand for places grew faster in line with women’s mass-entry into the labour market; childcare queues were long, and places were generally reserved for children of working parents or for children with special needs (Naumann, 2006).

**United Kingdom**

In the UK ECEC services developed slowly in the absence of an explicit childcare policy in a mixed economy with an administrative bifurcation into care and nursery education. The Department of Health (DHSS) was responsible for childcare, mainly developing targeted programmes aimed at children at risk, and the Department for Education (DfEE) was in charge of preschool education. The implementation of programmes and the levels of day-care and nursery-school provision were left to local authorities (LAs), but limited financial support from central government meant that LAs' actions were restricted. During the 1970s the national government started to take greater interest in ECEC, especially in preschool education, and a gradual increase in public nursery schools took place. In 1972, the then education minister, Margaret Thatcher, announced expansion plans for preschools to provide sufficient places for all three- and four-year-olds according to demand by 1982. However, these plans were quickly scrapped when the Conservatives returned to power under Thatcher in 1979 (Randall, 2002). Owing to lack of available ECEC services and the growing need, parents started to organize play-groups and parent co-operatives, and private day care and childminding, both in registered and unregistered forms, expanded considerably (Penn, 2009).

Contrary to feminist pressure in the 1980s to open the childcare system to all children, the Thatcher and Major governments focused on preschool education as part of a broader agenda to reform the educational system along the lines of marketization and centralization (Ruggie, 1984; Naumann/Crouch, forthcoming). Nursery schools did not have to be organized through the state educational system, but a new voucher scheme led many primary schools to set up ‘reception classes’ for four-year-olds to claim the voucher money (Penn, 2009, p.120). The government also initiated a series of ‘Under-Fives Initiatives’ in which it worked directly with voluntary providers, therewith bypassing the LAs (Randall, 2002, p.225). The responsibility for the organization of day care was left to LAs, mainly as a measure for families in need, and the 1989 Childcare Act set out an inspection and standards regime under which private childcare providers had to be registered and inspected at local governmental level. As a consequence of these policy developments, public childcare places remained very scarce for children under the age of
three, with a coverage of two per cent in 1993, while (part-time) nursery schools for three- to four-year-olds expanded considerably to cover 60 per cent of this age group (Bahle & Pfenning, 2001). Private ECEC services increased more than threefold, and ECEC service provision fragmented, resulting in considerable regional and local variations in the availability and the quality of services (Randall, 2002).

By the beginning of the 1990s Sweden had an extensive public ECEC system with a broad remit, while in the UK a mixed economy of ECEC services existed with a clear distinction between care and preschool education alongside an increasingly dominant role for private providers. Albeit with some delay, both ECEC systems had developed in line with the general welfare-state trajectories of the two countries: generous public-service provision in Sweden based on the principles of equality and universalism and the dual-earner family norm; and limited state involvement in day care in the UK, reflecting a preference for means-testing and low de-commodification, along with an ambivalence towards mothers’ employment characteristic of the British welfare state. Part-time preschool education had been recognized as desirable; however, at the same time as preschool services received more attention by the state, they became part of new marketization trends within the educational system. Since the 1990s changes have taken place in the Swedish and the British ECEC system that both strengthen and challenge these earlier developments.

**ECEC reforms in the 1990s and 2000s**

**Sweden**

Criticisms concerning the legitimacy and efficiency of large, uniform and centrally led public services had mounted during the 1970s and 1980s. These concerns, together with the spreading of New Public Management (NPM) ideas, led in the 1990s to the decentralization of public-sector governance and the opening up of the welfare system to private providers of every kind (with non-profit and for-profit orientations) (Blomqvist, 2004). In 1991 the newly elected centre-right government promised a ‘choice revolution’ that would increase diversity and economic efficiency in public services. The old top-down, regulation-heavy relationship between the central state and municipalities was replaced by a system of governance by objectives for key social services, and detailed earmarked state funding to municipalities was replaced by block grants. Deregulation and decentralization gave the municipalities considerable freedom to decide over the organization and delivery of social services, including ECEC.

Until the 1990s, private ECEC services hardly existed beyond a few facilities with specific pedagogical traditions (e.g., Montessori, Rudolf Steiner) or facilities set up by parent co-operatives owing to a lack of available public childcare. In 1984 the Social Democrats passed a law prohibiting commercial childcare services in response to one large corporation's attempts to develop such nurseries. However, in 1991 the then conservative government removed most of the restrictions on the establishment of non-municipal, private ECEC services, and from 1992 onward even for-profit providers were given access to public funding (Strandbrink & Pestoff, 2006, p.43). Following these developments, the number of non-municipal ECEC facilities increased from 500 in 1988 to 3113 in 2002, providing ten per cent of places for children aged one to six. The number of for-profit providers on all private facilities was low throughout the 1990s but increased during the 2000s; by 2008 the proportion
of privately provided places had increased to 14.2 per cent (SOS, 2009). Today, for-profit ECEC makes up a bit less than ten per cent of Swedish ECEC places overall, but large differences exist between municipalities, with commercial ECEC being hardly existent in some whilst being widespread in others (Skolverket 2010).

In the mid-1990s, Sweden was hit by a severe economic crisis. Nevertheless, state funding of ECEC remained constant in this period: public expenditure for ECEC and after-school care was 3.78 billion euros in 1990, 3.67 in 1995, and 3.81 billion euros in 1997. However, the demand for childcare also rose sharply in the 1990s, leading to renewed massive service expansion, from around 330 000 places in 1990 to over 700 000 places in 2000. This expansion that took place without additional funding raised public concern about a potential reduction of quality of early-years services, as indicated in the deteriorating child-staff ratio from 4.4 in 1990 to 5.7 in 1998. However, this trend was reversed through earmarked state grants to increase staff numbers in preschools in the 2000s; in 2006 the staff-child ratio was 5.1 (Skolverket, 2008, p.39). It has also been noted that changes in quality are difficult to assess due to other developments (Bergqvist & Nyberg, 2001). In the same period a professionalization of ECEC staff took place, with an increase in the proportion of staff holding university degrees, rising to 54 per cent in 2000 (Skolverket, 2000, p.49). Furthermore, service integration on the municipal level between school education, ECEC, and after-school care intensified in ways that allowed for more efficient use of resources, such as the sharing of facilities and activities (Cohen et al., 2004). In 1998 a preschool class for six-year-olds was introduced as part of the school system, and consequently this age group was removed from the ECEC system’s planning and costing. Many municipalities also responded to financial constraints by off-loading costs to parents. In 1990 parental fees covered ten per cent of total ECEC costs; by 1999 this figure had increased to 18 per cent (Bergqvist & Nyberg, 2001, p.265).

These changes – decentralization, deregulation, and privatization – led to considerable differences between municipalities with respect to variety, availability, parental fees, and quality of ECEC services (Strandbrink & Pestoff, 2006, p.44; Cohen et al. 2004). However, policy reforms implemented during the latter part of the 1990s and the early 2000s display attempts to reverse some of these developments, along with a renewed emphasis on universalism and a retrieval of central state control. The pedagogical focus of early-years services was strengthened by transferring the responsibility for these services from the Social Department to the Education Department. In 2001 a new system of integrated teacher training for school teachers, preschool, and after-school pedagogues further augmented the educational standing of preschool staff (Cohen et al., 2004). In 1998 a national curriculum for children aged one to five was introduced that not only outlined the pedagogical remit of early-years services (which is broader than the understanding of ‘education’ in the UK), but also pointed to their societal mission of transmitting democratic values and practices (Lpfö, 1998). Following this educational logic, in 1999 a statutory right to early childhood education was extended to all children, including children of unemployed and non-working parents. The 1999 bill obliged municipalities to provide a place for every child from one year of age within three months of application. In addition, preschool for four- to five-year-olds was made free of charge. And in 2000 the national government set upper limits to municipal parental fees, the so-called ‘max tax’, to ensure affordability for all parents: parental fees are differentiated according to income, but do not exceed three per cent of family income for the first child and two per cent for the second child (Skolverket,
By the beginning of 2000, the Swedish ECEC system had become fully universal. Today, almost half of one-year-olds, 91.3 per cent of two-year-olds and 97 per cent of three- to five-year-olds attend ECEC services (SOS, 2010).

United Kingdom

When the Labour Party came to power in 1997, it announced radical changes in the direction of childcare policy, committing itself to providing sufficient and affordable ECEC services. The then Chancellor of the Exchequer, Gordon Brown, declared in his budgetary speech that childcare would be an integral part of New Labour’s economic policy, and in 1998 the government produced the first National Childcare Strategy (DfES, 1998). Its aims were to combat child poverty and social exclusion by bringing parents into paid work and supporting children’s ‘early learning’. Linking ECEC explicitly to the reconciliation of work and family life also meant a new direction in family policy because it promoted the dual-earner family (Lewis, 2003; Lloyd, 2008). In addition a ‘Sure Start’ programme was introduced in 1999 to provide public early-years services in disadvantaged neighbourhoods. Declaring the desirability of collective childcare was indeed a radical shift from previous governmental policy. But with the central focus on low-income parents and their children, the New Labour government remained committed to their Conservative predecessor’s focus on reducing welfare dependency, albeit with a more active role for the state.

In its 2001 manifesto the Labour party promised to create 1.6 million new childcare places and in 2004 the government presented a Ten-Year Strategy (HMT, 2004) that set up an extensive policy framework for the development of ECEC services; it became formalized in the 2006 Childcare Act (applicable to England). With their expansion plans, New Labour continued and reinforced the trends of marketization in the ECEC sector that had taken place earlier. While the Childcare Act set out how local LAs were to assess, coordinate, and inspect public and private ECEC services, it also made explicit that LAs were only to provide services themselves if there were no private alternatives available (HMT, 2004). The government initiated various supply-side measures of ‘pump priming’ and start-up funding, which encouraged private providers to establish ECEC services, but it did not increase state funding for LAs to fulfil their obligations. State expenditure on ECEC increased moderately from a low 0.2 per cent of GDP in 1998-1999 to 0.4 per cent in 2003 (OECD, 2005, pp.109f.). A new system of Childcare Tax Credits was introduced to help working parents with childcare costs. These demand-side subsidies covered up to 80 per cent of childcare costs for low-income families, but quickly decreased with growing income to ten per cent or less for middle-income families. With these policies New Labour continued the commitment to restrict public-service provision and to strengthen parental choice and service plurality via market mechanisms.

However, other aspects of the Childcare Act and further initiatives in the 2000s did not follow this market logic but instead emphasized the importance of early-years provision for all children’s education and well-being, placing these services in a wider community context. With the 2006 Act, the state for the first time announced its legal responsibility to provide ECEC. It obliged LAs to offer a free preschool place to every child aged 3-4 for 2.5 hours a day, as well as sufficient childcare and after-school care for children of all ages whose parents were at work or in training. A preschool curriculum for three- to four-year-olds was introduced, partly to improve educational standards in preschool settings, and in addition to integrate care and education, since the national curriculum
was also intended for facilities offering day care for this age group. The creation of a new Department for Children, Schools, and Families responsible for all child- and family-related services further emphasized this more holistic view of the child that linked care, education, and wider aspects. In England the state-run Sure Start centres were expanded to become Children’s Centres comprising, besides ECEC, a wide range of family and community services such as parenting classes, health care, citizen’s advice, and employment bureaus. The Children’s Centres were to be located primarily in disadvantaged areas, but were to expand gradually to every ‘local community’ in England (Ball & Vincent, 2005; Lloyd, 2008).

Following these initiatives, ECEC services expanded considerably in the UK. In 2004 35 per cent of children aged zero to two years and 86 per cent three- to five-year-olds had an ECEC place (Plantenga et al., 2008, p.30); among four-year-olds there is today almost full coverage. The expansion of places for three-year-olds took place mainly in the private service sector, and, as a consequence, the proportion of publicly provided places decreased from 85 per cent in 2000 to 47 per cent in 2004 in England and Wales. The majority (81 per cent) of four-year-olds attended public settings, mainly through reception classes in primary schools (Brewer et al., 2005, p.166). Devolution in the UK at the end of the 1990s meant that ECEC services became the responsibility of the respective nations, and differences in policy orientation do exist, particularly between England and Scotland (Wincott, 2006; Cohen et al., 2004). From the standpoint of comparisons between countries, however, the similarities in the structure of the ECEC sector prevail, not least because important subsidies such as Tax Credits are operated by the central government.

New Labour have described their targeted approach as ‘progressive universalism’ (HMT, 2001) – a definition that is notably not based on ideas of public-service provision for all, irrespective of socio-economic background. The Labour government’s expansion efforts underscore the aim of a gradual universalization of the ECEC system. However, a clear tension exists between these intentions and the chosen policy instruments: Sure Start and Children Centres target geographical areas rather than granting a right to every child, and thus actual access to ECEC services is not guaranteed. Nor do these Centres necessarily reach every child at risk or from a low-income background, since locations of disadvantage and individual circumstances of disadvantage do not neatly match. The very part-time nature of free preschool for three- to four-year-olds also hampers attempts to support the reconciliation of family and work. Most working parents need alternative care arrangements beyond the nursery school, and many are logistically not able to use preschools at all but rely on predominantly private and expensive day care. Parents in the UK spend on average a third of their income on childcare costs, the highest among OECD countries (OECD, 2007), and for many families the financial burden is even heavier. In London the average weekly cost for 25 hours of nursery care for a child under two is currently £118.54 (Daycare Trust, 2011). The affordability of childcare thus remains a significant problem for many families, in practice hindering many mothers of small children from entering the labour market (Ball/Vincent, 2005, p.561). Informal care remains the dominant form of extra-familial childcare; in the early 2000s 70 per cent of employed mothers relied on informal childcare (Lewis, 2003, p.232). The quality of ECEC services is another problematic area. In nursery schools for three- to four-year-olds there are trained teachers, yet the children

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4 Tunstall and Lupton (2003) have even found that most poor children did not live in disadvantaged areas.
are subjected to high teacher-to-pupil ratios and have to adapt to school education-oriented classroom settings. For day-care staff, training requirements as well as pay are minimal, and this leads to high rates of turnover in these settings and leaves the question open as to whether there is sufficient competence to implement the national early-years curricula. These tensions are expected to increase as the newly elected coalition government in 2010 has announced their intention to reduce the scope of public Sure Start Centres, providing mainly part-time preschool education, and a refocusing of childcare policy targeting disadvantaged children.

Discussion: ECEC services between marketization and universalization

Over the last twenty-years the Swedish and British ECEC systems have undergone fundamental changes with respect to the quantity of available places, underlying rationale, and governance structure. Do these changes also reflect general welfare-state trends towards increased marketization? The answer is both yes and no: market mechanisms have been introduced in both ECEC systems but only within certain dimensions and to varying degrees. At the same time, early-years provision has been universalized following a very different 'public-good' logic, again to varying degrees in the two countries, that has older roots than the recent market-drive in social-services reform.

In the UK during the 1980s and in Sweden somewhat later in the 1990s a new focus on private-service provision appeared in ECEC policy with the aim to increase parental choice, diversity, and efficiency in the system. Particularly in Sweden, the space for market processes has, however, remained limited. Strict fee regulations and public funding of ECEC services, whether public or private, make price competition impossible, and high quality standards concerning staff training, ECEC activities, and facilities curb profit margins even further. Some commentators have even pointed to tendencies towards self-exploitation among small private providers to keep their businesses running (Bergqvist & Nyberg, 2001). Nor did marketization imply decreased state involvement: public funding for ECEC has remained high, among the highest in the OECD (2007). Furthermore, while the number of commercial providers has increased continuously, the expansion of public places was greater. The changes in Swedish early-years provision with respect to marketization were thus incremental and did not lead to the dismantling of the public ECEC system. Should the number of for-profit providers increase to a more substantial proportion, this could eventually challenge the public organization and underlying social-rights logic of Swedish ECEC services.

In the UK, the trends of marketization in ECEC provision were more pronounced. While the development of a childcare market for children of working parents was of a more unplanned nature during the 1970s, NPM ideas introduced under the Conservative government in the 1980s paved the way for the marketization of ECEC governance, which also occurred in other parts of the public sector at that time. It was, however, first under New Labour in the 1990s when the rise of social-investment discourse made ECEC service expansion part of an economically oriented policy agenda. ECEC services in this model play an important role for welfare-state sustainability and economic growth by bringing parents into employment, lifting families out of poverty, and by giving children a good educational foundation so that they become productive workers in an internationally competitive knowledge economy. Nevertheless, despite the strong preference for the market model, the UK government did not retreat from the scene. To the contrary, a pronounced
increase in state involvement can be observed since the 1980s. On the one hand, the childcare market did not grow by itself (Lloyd, 2008), but service expansion had to be promoted by the state by means of various measures. Secondly, the state had to mitigate negative market effects with respect to availability, affordability, and quality via targeted measures, demand-side subsidies to parents – who nevertheless shouldered the bulk of childcare costs – and standards and inspection regimes. An unexpected side effect of the market approach has been the increase in state regulation and centralization, which is evident in the very detailed and prescriptive English preschool curriculum (DfCSF, 2008).

In Sweden, we find a contrary development since the 1990s with the decentralization of ECEC governance and the relaxing of state regulations. For example, the Swedish preschool curriculum is only a few pages long, comprising mainly mission statements and broad objectives (Lpfö, 1998). Indeed, many municipalities do not even set requirements for ECEC providers concerning staff-to-children ratios or the like (Skolverket, 2008). Yet these reforms cannot be associated with a ‘free-market’ logic because they were attempts to strengthen local self-administration. The state is still the central player, albeit with a much enhanced role for local governments. Marketization and decentralization have led to greater variations in the ECEC system, and have therewith challenged its universalism. Nevertheless, Swedish ECEC stands out as displaying a high degree of equality from an international perspective (OECD, 2006). This may be a result of the strong and long-established normative underpinnings of a system that emphasizes ‘public good’ and the social-rights aspects of early-years services.

The most dominant trend in Sweden dating back to the 1970s has consequently been the universalization of early-years services that followed the concept of integrated ‘educare’ which combines the aims of supporting the reconciliation of family and work with children’s early education. This model has not been abandoned but reinforced in recent years, with massive increases in public ECEC services and the extension of a statutory right to a place for all children aged one to six. The underlying logic since the 1970s has been the gradual expansion of citizenship rights, including women’s rights to equal access to employment and children’s rights to a good upbringing and equal educational opportunities (Naumann, 2006). Developments in this direction have also taken place in the UK, though much more recently and relatively modest in extent, with universal part-time preschool for three- to four-year-olds, and particularly with the broader orientation towards universal ‘educare’ in Children’s Centres.

Some scholars have interpreted the limited nature of universal preschool education in the UK as an incoherent implementation of the governments’ social-investment agenda, because it ensures neither education for all children nor adequate support for employed parents (Jenson & Saint-Denis, 2006; Lewis, 2003). However, while limited implementation may hamper the yielding of expected returns, the ‘social-investment’ logic in itself does not lead to universal social rights. From an instrumental-investment orientation it might be neither economically nor politically sound to provide universal ECEC for all children: post-industrial societies are not only knowledge economies but display large low-skill and low-pay service sectors. Providing all children with good ECEC would raise expectations, and could potentially create political tensions and demands for social and economic change should the economy prove unable to provide adequate employment for all well-educated children. My point here is that the introduction of universal preschool education and universal Children’s Centres were driven by a different older, social-rights
logic. Claims around gender equality and children’s well-being and education had been around for a long time in the UK, just as in Sweden, but without their transformation into policy. The social-investment discourse then opened the opportunities for feminists and children’s rights advocates to influence ECEC policy and to broaden its remit in areas where they had been unsuccessful in the past (Wincott, 2006).

Also, in the Swedish case we could argue that ‘social-investment’ ideas created opportunities for ECEC services to develop, but long before the 1990s. The link between ECEC services and ‘productivist’ welfare-state goals (i.e., raising children to become productive citizen-workers) goes a long way back to conceptions of ‘preventive social policy’ that were constitutive of the Swedish welfare state in the 1930s (Myrdal, 1945). Swedish ECEC service expansion in the 1970s and 1990s was also motivated by the government’s interest in increasing employment rates and state revenue (Naumann, 2006). The Swedish approach to social investment has, however, always been integrated with a redistributive-citizenship conception of service provision (see Esping-Andersen, 2002).

**Conclusion**

This examination of recent policy developments in the field of early-years services in Sweden and the UK has revealed that marketization is not the only trend common to such provisions in both countries. Another important driver for reform has been the extension of children’s rights to early childhood education. Further developments include shifts in the relation between central and local governments in ECEC governance that cannot easily be attributed to either marketization or universalization trends. Thus, a general summation is that service-sector reforms are more complex than the controversy between ‘state’ and ‘market’ in policy debates may suggest. A second, more specific finding stands out: while both economic and rights-based ideas have shaped policy goals in Sweden and the UK, it matters which policy reforms came first. In Sweden, on the one hand, market mechanisms were introduced into a well-established, fairly universal public ECEC system, with limited effects on the overall system; in the UK, on the other hand, ideas about universal access to ECEC became prominent after a ‘childcare market’ had already been created, and the instruments chosen to support this market (i.e., demand-side subsidies) limited the possibility to expand public-service provision. Universal preschool access in the UK is thus of a rather limited nature. The tensions between political promises to ‘invest in children’, all children, and actual policy implementation may, however, produce pressures for further change towards a more universal model.

Central to this article, therefore, is the observation that policy developments in welfare states continue to be shaped by historical trajectories, but not in a steady and linear fashion; nor do they evolve neatly from one ‘paradigm’ or ‘regime’ to another, but may include the maturation of ‘old’ welfare-state promises alongside the exploration of new paths. An investigation of the interplay between different underlying logics and goals of policy reform and the resultant dynamics of change may be a fruitful focus for future research on the restructuring of welfare states.
References


Care as you like it: the construction of a consumer approach in home care in Denmark

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Abstract

The free choice of a home-care provider was introduced in Danish home care in 2001. This article discusses the overall premises for the introduction of free choice in home care and how it constitutes an overarching response to the crisis of the welfare state. The government at that time intended free choice to lead to more user-led services, more cost-efficient services, and the development of a care market, all in line with its ideology. The article argues that to achieve these ambitions, the government introduced many new but implicit assumptions about the role and the responsibilities of the user of care. On the basis of qualitative interviews with elderly users, care workers, and care assessors, the article examines these assumptions and their implications for the user. The findings show that most users desire continuity in care more than the opportunity to ‘exit’ a care relationship. Moreover, users do not rate quality any higher in the private for-profit sector than in the public. The article concludes that consumerism is in Denmark now part of the logic of governance, thereby changing the conditionality of the welfare state and its subjects, and creating new forms of risks, responsibilities, and dependencies.

Keywords: choice, home help, Denmark, consumerism, elderly

Introduction

In 2003, a Liberal-Conservative government introduced the free choice of provider in Danish home care in order to improve user autonomy and care quality, to cut costs, and more implicitly to encourage the development of a market in care. From this point onwards, local authorities had to ensure that private for-profit providers of home care operate along side municipal
providers. Elderly (and other users of home care) can in most municipalities today choose between the two types of provider once an assessor employed in the municipality has evaluated their needs. The service has continued to be free of charge and the number of care hours remains the same, regardless of which provider is chosen.

The Minister of Social Affairs at that time claimed the following:

The introduction of free choice has given dignity of the elderly pride of place, simply because from now on they will be able to exercise a choice, rather than merely use the municipal standard service offer. For the government it is simply how we view human nature. (Henriette Kjær, former Minister of Social Affairs; author’s translation)

This statement illustrates that the policy of introducing a consumer choice between public and private for-profit providers of home care in Denmark intended to constitute a change of governance, which reflected a perspective of human nature that coupled human dignity with the possibility of exercising choice. However, as this article argues, the introduction of choice is a logic of governance that appears to be multi-functional and goes well beyond concerns about individual human dignity. The introduction of choice acts as an overarching policy strategy in the wake of overall criticisms of the failures of the welfare state and seeks this regime's modernization. This is not restricted to Denmark. ‘Choice’ has in many European countries become a major buzzword in political rhetoric, along with others such as ‘user-involvement’, ‘participation’, ‘empowerment’, and ‘active welfare citizenship’ (Evers, 2003). Along with competition, contracts, and cost control, free choice is an important component of the institutional and organizational reforms inspired by New Public Management (NPM), which have affected the public sector in many countries in recent years (Vabø, 2009; Pollitt & Bouckaert, 2000). The search both for more diversity and pluralism in service orientation and practice and for greater efficiency and effectiveness works surprisingly well with the governmental desire to confer more power on users. Thus, at least on the surface, no disparity or conflict between these goals appears to exist.

Choice has in Denmark been an element of reforms of various policy areas since the late 1990s, particularly within care for the elderly. The focus of this article, home help for the elderly, has been the political test case of the introduction of the Danish version of choice. The elderly have been provided with what is called a ‘free choice’ between a public and a private for-profit home help provider(s). While other countries have introduced the choice of provider of home help as a voluntary option for the municipalities in recent years (see e.g., Blomberg et al., 2000; Blomqvist, 2004; Edelbalk & Svensson, 2004; Renning, 2004; Stevens et al., 2011), Denmark has gone further and made it obligatory for the municipalities to enter into contracts with for-profit providers, and almost all municipalities today offer this choice. In Denmark, the government has framed the choice as being directly related to gains of efficiency and improvement of quality, while toning down its more political and ideological preference for privatization. By focusing on the user of care services, this new policy promised to introduce more empowerment and more individualized services. Little, however, was said about whether increased user-involvement would change the care relationship between care recipient and care provider, and if change were to occur, what might be the results.

This article aims to investigate both the reasons for the government’s introduction of free choice of home-care provider and its description of the shape it was to take. The aim is first, on a more theoretical level, to
understand how the introduction of free choice is situated in the overall modernization of the welfare state. Secondly, the aim is to investigate after the introduction of free choice the expectations attached to roles and relationships that were communicated to the elderly as recipients of home care. This aspect is illustrated by statements of users of home care, care workers, and care assessors. The article thus examines the implicit assumptions about the elderly as users in the consumerist model in regard to the identification of need, quality, and possibilities for expressing satisfaction through the exit or entry into provider organizations.

This article is based on qualitative interviews with users of private for-profit and public home care, care workers working in public or private for-profit home-care sectors, and care assessors employed with the municipality. Interviews were conducted in four Danish municipalities (Bogense, Kalundborg, Søllerød, and Århus) in 2007. In all, 18 individual interviews and 14 focus-group interviews were carried out. Observational studies were also applied.

This article argues that the initial notions of welfare-state failure have given way to a new regime of consumerism in Denmark. Free choice was the all-embracing answer to many of the paradoxes of the welfare-state crisis: it was supposed to result in better user-led quality of care, and to provide more cost-efficient services, and it was intended to develop a care market, in line with the ideology of the present government. Free choice seems to introduce new rights of equality, making everyone entitled to choice and giving the user a new active role. The argument presented here, however, is that the elderly themselves desire continuity in care, not the possibility of exiting and thus ending care relationships. Moreover, free choice in care overlooks the crucial point, that care work involves relationships, trust, and dependency, and thus care cannot be viewed as simply another commodity.

The crisis of the professionalized welfare state – where to go from here?

The introduction of free choice in Danish social policy is part of a strategy to respond to criticisms of the welfarist approach, with its standardized products, top-down decision-making, and the automatic acceptance of the judgment of professionals (Evers, 2003). Free choice, however, has also been part of a Danish political and ideological project to introduce more market mechanisms into the public welfare sector. One important factor contributing to the demands for more free choice has been the underlying assumption that the welfare state in its present form has failed. A look at the internal challenges to the welfare state reveals at least three general explanations for this welfare-state failure of legitimacy and governance, all of which are also consistent with the criticisms of the Danish welfare approach.

First, some scholars invoke the theory of systemic overload, as social problems have become increasingly politicized and made public, and demands are often contradictory and of both economic and political concern (e.g., the lack of producer efficiency, the failure to meet user demands, and the lack of service innovation) (Clarke & Newman, 1997). The theory of systemic overload has also been a driving factor behind Danish modernization reforms,

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which have focused on increased professionalization, accountability, control, equity, cost-efficiency, and more (Melander, 2008).

Secondly, there are researchers who note a conflict between equality that is a political promise of the universal welfare state and the actual welfare outcome (Højlund, 2002), especially as decentralization is very pronounced in the Scandinavian welfare states. This phenomenon has led Kröger (2009), amongst others, to argue that the Scandinavian countries have ‘welfare municipalities’ rather than a welfare state, with a single and uniform welfare approach. Until 2007, in Denmark alone, 275 local municipalities were in charge of social care; after a re-structuring reform they are now down to ‘only’ 98. The local approach is especially pronounced within social-care services, where local politics result in different welfare policies, provisions, and outcomes, which is exemplified, for example, in the variation in public spending for elderly care across municipalities (Lolle, 1999). The social-care services are also policy areas in which needs are very individual and therefore difficult to generalize. The same care need may result in different welfare responses across local areas, and the need for social care for two people, despite their having similar social problems, may also be perceived differently. Although the Danish welfare system is based on this decentralized approach, the welfare state is nevertheless not able to deliver uniform, equal outcomes.

Thirdly, some scholars see a conflict between ensuring autonomy and legitimizing public intervention in private affairs for a higher social purpose. This is a classic clash between social-liberalist assumptions about the legitimacy of intervention in matters of lifestyles, family formation, choice of education and work, and more, and a more liberal assumption of the sovereignty of the individual (Højlund, 2002) – where the latter has been especially successful in advocating for choice, while emerging individualization has been a driving factor favouring the individualist approach. Other forces have also fostered this development, through the increasing dominance of bureaucratic logic and consumer-market logic (Kremer, 2006). The consumerist approach obviously breaks with previous assumptions that only professionals should define need. The accommodation of participation and empowerment of the user has thus gone hand in hand with increasing criticism of the previously unchallenged dominance of professionalism. Not only should users have a stronger voice in the decision-making, but there should be better political control and accountability of the work done by professionals, and it should be paid by the public (Foster & Wilding, 2000). Dybbroe (2008, p. 44) notes that this increasing political and institutional control in the care sector has in fact led to a standardization and manualization of the care work. According to her, this development results in a de-qualification of care workers since work is now ‘less dependent on the learning and development of the care worker and more dependent on political and institutionally directed constructions of caring practices’. The increased participation and empowerment of the user has, however, been of more concern, and the Liberal-Conservative government that took office in 2003 saw free choice as a way of accommodating such individual preferences. The following statement exemplifies this view:

> With the free choice, the individual can better influence his/her own life, and at the same time citizens will experience a more attentive public sector, with a focus on individual wishes and needs. (Regeringen, 2002, author’s translation)
Welfare reform in a social-democratic welfare regime: entering free choice

Free choice is an appealing strategy as it appears to offer the possibilities of both introducing more user empowerment and signalling political innovation and responses to criticisms of a lack of equality and individualism. In Denmark free choice between a public and private for-profit provider has, therefore, been a central element of many reform strategies since the late 1990s. Initially, launched by the Conservative government in 1991 in the health-care sector as part of a strategy of marketization and privatization, the free choice of public and private for-profit providers was a response to critics who claimed that the health system was both ineffective and too costly, claims that were by then universal in most welfare states.

The notion of free choice soon proved persistent in the Danish political rhetoric, including with the Social-Democratic government that came to power in 1992. However, the party backbenchers demanded stronger opposition to privatization and outsourcing, viewing both as antithetical to the very essence of social-democracy. The government decided, therefore, that basic services such as home help were to remain within the public sphere. Thus in contrast to the Swedish reforms in the early 1990s that allowed the privatization of home help as part of the economic-crisis package, Denmark continued its public provision of home care into the new millennium.

The form of free choice in home help

However, when a Liberal-Conservative government came into office in 2001, free choice was placed on the agenda as part of its overall NPM strategies. Since then, the choice option has spread to other policy areas, as a fundamental element in the modernization of the welfare state (Greve, 2004). For the elderly who live in their own home, the introduction in 2002 of free choice initially encompassed only practical care assistance, such as help with cleaning, shopping, and doing the laundry. Personal care, such as help with bathing and getting dressed, was not included, and continued to be provided by the public home-help providers. This distinction in the free choice clearly reflected the legacy of Social-Democratic welfare ideas, that the privatization of these kinds of intimate services as personal care was inappropriate.

In 2003, however, the Liberal-Conservative government decided to include personal care in the drive for free choice. Private for-profit providers thus today offer the same services as public providers and also provide services around-the-clock. In addition to basic personal care and assistance with practical tasks, private for-profit providers can also offer what is called additional services, such as gardening, window polishing, snow clearing, or simply time to sit and chat, as is shown in one of the illustrations from the interviews with private home-help providers below. All of these services are charged.

In order to increase the number of private for-profit providers, local councils are now obliged by law to ensure that these providers operate in the municipalities. In turn, municipalities must enter into contracts with private for-profit companies, along with the municipal home-help services, so that the

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2 See also Rostgaard, 2006 for a more extensive account of the introduction of free choice in home care.
3 Lov nr. 399 af 6. juni 2002 Frit valg af leverandør af personlig og praktisk hjælp [Free choice of provider of personal and practical help].
elderly can choose between one or more private and public providers. While the provision of home help remained free of charge, regardless of who provides the care or how many hours were provided, private for-profit companies can charge for extra services such as window cleaning. The process for receiving help has remained the same. The elderly are still assessed by a care assessor who is employed in the municipality according to the same needs-assessment criteria as before. However, with the introduction of a purchaser-provider split these assessors today no longer operate from the same premises as the public home-help provider.

By 2010, 611 private for-profit home care companies were operating in Denmark, and only four out of 98 municipalities had no private for-profit provision of home help. Excluding Copenhagen, which has 57 private for-profit companies, on average six companies operated in each municipality offering free choice, with urban areas having the highest concentration of providers (Danmarks statistik, n.d). In the spring of 2011, in order to stimulate the privatization of social care, the government debated whether in some municipalities the implementation of free choice should also exclude public providers, so that in those municipalities only private for-profit providers would operate.

Construction of a consumer approach – what are the assumptions?

Several political arguments support the decision to introduce more choice for users. First of all, free choice constitutes a timely answer to the requests for more individualized welfare solutions in that it can accommodate what the Ministry of Finance sees as 'the citizen who increasingly views her/himself as set free from both the close and the larger communities, and therefore places more individual and critical demands to society, including to the public services' (Finansministeriet, 2002, author's translation). Secondly, free choice breaks with the former public monopoly of service provision, thereby ensuring a more efficient and improved care provision. According to traditional assumptions about the market mechanism, the quality of care should improve as providers compete and as users gain influence through their choices. Nonetheless, the question remains of what implicit assumptions there might be in the drive for free choice with regard to the role and responsibilities of the user and the purpose of care provision, as viewed from the perspective of elderly users, care workers, and care assessors.

A new focus – the active user

At the heart of free choice lies the assumption of the autonomous user. The ageing population is expected to be increasingly more diverse and individualized, and presumably will require more diversified welfare solutions that give the user more say in the organization of care. This assumption underpins the views that proponents of free choice hold, even though users in most Danish user surveys pre-dating the introduction of free choice expressed satisfaction with the public provision of welfare. Such satisfaction is in contrast to the introduction of choice in other countries, where powerful organizations representing people with disabilities demanded more choice (e.g., Stevens et al., 2011). Still, the government believed that free choice would make the citizen more satisfied and more autonomous, whether he or she actually exercised this option (Kommunernes Landsforening, 2004; Finansministeriet, 2002).
Thus, care now has a new function: the organization of care must not only ensure that the cared-for receives what they need, but it must also contribute to the users’ autonomy. As care provision becomes user-led, not provider-led, the needs of the user are to lie at the centre, requiring the user to become more active. Users need to identify what – for them as individuals – is the best organization of care and they must express this decision through the choice of provider. The new care regime thus assumes that the user is no longer a passive care recipient but an active one.

Easy exit

The user in this way becomes a consumer with the possibility of ‘shopping elsewhere’ if he or she so desires. The choice itself provides him or her with influence and ensures that the care organization listens to him or her. There are in principle no constraints on the individual’s exercise of consumer power, and he or she is obliged to make a choice of provider, but can choose a new provider as often as he or she pleases. As Jon, a care assessor, expresses it, the ‘choice technology’ is easy to operate. It only involves contacting the municipality if one wishes to change provider:

And now there is a free choice, and many calls us – and they just need to call and say that they would like to change provider, and then we help them. (Jon, care assessor, author’s translation)

The introduction of choice thus presumes the existence of an easy and real opportunity for exiting, a choice that enables users to express dissatisfaction in a new way.

Less complex identification of quality

In the municipalities, users are then observed how they exercise the choice, as a way of understanding users’ preferences for the organization of care. In this way, municipal home-care organizations, local politicians, and administrators find it less complex to observe how specific users wish to see care provided. The administration statistics on the share of users using for-profit providers and municipal providers, and more importantly, any changes in this distribution, the municipality uses as a guideline of user preferences, pinpointing which provider has provided good-quality care.

In this way, the choice option also serves as a complexity reducing technology. From a political and administrative perspective, the identification and determination of how well the home-care organization is performing becomes less complex with respect to the offering of services in accordance with user preferences. Previously, such information was difficult to obtain because it required, for example, user-satisfaction surveys. Now, the municipality simply interprets users’ patterns of entry into and exiting from public and private services as an important indicator of whether various home-care providers are doing their job properly.

Consequently, users need to understand that choice is something that is observed and interpreted. The ‘competent’ consumer would, therefore, act differently from Michael, who says: ‘I think it is a rather big company, but it was purely accidental that we chose them. Or perhaps we asked the care assessor in the municipality, that might be it (Michael, user of private for-profit home care, author’s translation).
Common learning

The implicit expectation is that choice not only implies a movement between some constant alternatives (the private for-profit or the municipal provider), but choice should also help develop the quality of care, in that the various providers will learn from one another. The user is expected to choose the best alternative, and the provider is expected to consider why it was chosen or not. Providers are in this way expected to gain the opportunity to learn from one another by being inspired, thereby contributing to a general upgrading of the quality of care. As Anne, who works as a home helper in a private for-profit home care organization, expresses it:

I have experienced that those who receive municipal care, they also receive better municipal care after we entered the market. Now they [the municipality] suddenly need to deliver better services, and that must in the end benefit the elderly. So, things being equal, I think...that it is a good idea, because we need some competition. (Anne, private home helper, author's translation)

Choice thus not only ensures that the user has an opportunity help weed out poor quality providers, but also demands that care organizations that are not chosen learn and develop according to user preferences.

Setting the user free – but obliged to choose

Although free choice allows the user to choose his or her own provider, the user is also obligated to make a choice. In other words, the user has the right to choose but no right not to choose. All users must make a choice when the care assessor comes to visit:

What I do, when I visit an older person, is to bring three booklets explaining the free choice option. I take them out, when I sit with the citizen, and I say ‘You have received these by mail. Have you thought about what you want to answer? (Kirsten, care assessor, author’s translation)

Cathrine, a care recipient, says that the municipality involved in communicating free choice to her suggests that it is legitimate to choose a provider other than the public one:

You see, I received this form where you could choose. So in a way, it is the municipality that appreciated it that we can choose between a public and a private provider. (Cathrine, municipal care recipient, author’s translation)

While in principle the care assessor must not make the choice for the user, many users are highly reliant on the care assessor to make the choice, as in Michael’s case. NPM-remodelling strategies also imply a change in the daily organization of care and a pre-condition for the outsourcing of care is often that the organization of care assessment and care provision is split (Trydegård, forthcoming). Following the introduction of this purchaser-provider split, care assessors in Denmark today also operate from office facilities separate from those of the public home-help providers, and in principle should favour any providers. Little, however, is known about whether care assessors assist the elderly in making the choice of provider, and if they do, how.
Moreover, making the choice can be difficult. As Anja, a care assessor, noted:

I often experience that [older citizens] think that it is difficult to choose. 'Can't you do it?', they say. But then...then I leave [the brochures] in their home, and then they can have a look and call me when they have...maybe they call round and see whether they [the providers] can cater to some special needs which they [the older citizens] may have...

(Anja, care assessor, author’s translation)

The elderly in this way are expected to take action and to seek more information, perhaps by contacting other providers and asking about what they offer. Essential for the proper functioning of the choice option as a complex-reducing technology is that choices are not made randomly, but on the basis of careful considerations of where the best quality lies. As an autonomous user, the elderly individual is, therefore, expected to seek information that allows him or her to differentiate between the different service providers and to make a choice based on an assumption about which provider is best.

The new expert of needs and quality

Users are now the ones who decide what is best for them; if they find that the care is not according to their liking or if they disagree with the care worker’s approach, they can choose another provider organization. This user power makes the user the expert, as with the principles of consumerism, and transfers some of the identification of need and of the right form of care to the user, which is formally the last link in the care chain. In contrast, the professional care worker loses some say and can be challenged about his or her opinions. Hanne and Sanne, who both work as privately employed home helpers, commented on these changes:

It is sort of, when they are with the municipality, they are assigned something, but when they are with us, they are the ones to decide. It’s the mentality. (Hanne, author’s translation)

They become sort of the employer. Yeah, that’s the right word, I will use. Masters in their own house. ‘I’m the one living here’, right? ‘I’m the boss’, right? (Sanne, author’s translation)

Nonetheless, even with free choice, the service must be offered according to what is permitted in the care assessment; no one can receive more help than what the care assessor has written in the care plan. As Anne, a municipal home helper, comments:

I’ve talked with one of those users that I visit regularly and she says ‘I don’t care who does the cleaning, ’cause in the end I don’t get more time. I get the same service, no matter who I choose’ so she stayed with us. And she is right, you know. (Anne-Mette, municipal home helper, author’s translation)

Even so, free choice entails new assumptions about user-influence and responsibility, thereby also stretching the role of the elderly as the one who must identify and assess quality. The expectation that competition between public and private providers will lead to better quality includes the user’s choosing the ‘best’ provider. Thus, the user now has part of the responsibility for developing quality. If the user believes that the quality of his or her care is
insufficient, that user is entitled – but also expected – to change provider. The user must then also answer for the consequences of his or her choices: if the users remain with a provider who continues to provide care, it is partly a consequence of her own actions, because the user could have chosen differently. Thus, the discourse of freedom does not acknowledge the new risks which are created, namely, the freedom to make bad or wrong choices.

*Equal choice for all – but not equal outcomes*

The choice option also includes an assumption that choice is equal for all. In this way choice is in line with the universalist notion of the welfare state whereby everyone, regardless of age, gender or social class, is entitled to exercise choice. In reality, however, how choice is made differs considerably amongst users. It is primarily new users who choose private for-profit providers, presumably because they must exercise choice when entering the system whereas users already in the system may be offered the choice, but do not have to do so – and this difference matters:

I would say that most of those who have received services prior [to the free choice], and whom we call, are typically those who decide to stay where they are. There are few who decide to move. The new ones, on the other hand, who might need temporary care following a surgical procedure or something else, very often, once they take a look at it, chooses a private provider just as often as a municipal one. (Kirsten, care assessor, author’s translation)

New users not only arrive with no prior attachment to a particular provider, but are often also less frail and therefore less risk-adverse. The outcome of choice is in this way not equal; the choice is made on the basis of care needs, where care dependency also influences the choice:

There is this tendency of those who are most frail and least self-reliant to choose the municipal provider. While those who do well and manage somewhat on their own primarily choose the private. It’s like: ‘Well, I am in safe, municipal hands if something should go wrong’. (Josephine, care assessor, author’s translation)

In the early days of free choice, then, mainly new users chose a private for-profit provider. Often these users received only practical assistance. As expected, however, this practice changed over time: in 2004, two per cent of users receiving personal care and 22 per cent of users receiving practical assistance received help from a private for-profit provider (Den Sociale Ankestyrelse, 2004). In 2009, 31 per cent of recipients of practical assistance used a private for-profit provider, compared to only five per cent of recipients of personal care (Danmarks statistik, n.d.).

Part of the reason for the increase in the use of private for-profit provision of care may be that users today are more acquainted with the free-choice option and the local companies operating in their area. Nonetheless, many users remain unaware of the possibility of choosing between providers, and a survey in 2009 has shown that only 65 per cent of users know that they can exercise this right (Capacent, 2009). Presumably these users are mainly those who have received services for many years and therefore have not had to choose.
Exiting a care relation

However, even if users know about the possibility of choosing, exercising choice may not be a straightforward matter. The user can choose as many providers (and as often) as he or she likes, but changing a care provider constitutes stating that the quality of the present provider is insufficient. However, the consequences of using their option to exit may not be clear to the user, as Mille, who works as a care assessor, explains: ‘I also experience that they then ask: What if I need personal care? Will you be mad at me for choosing [a private for-profit provider]?” (author’s translation)

Moreover, for most users of care, their major concern is not whether they are entitled to exit or to end a care relationship, but rather to maintain one, as Cathrine, a user of municipal home help, says: ‘I think it would be good if we could have the same home helper more than once’ (Author’s translation). Often what is at stake is that during the day or week the elderly will be visited by many different care workers. Continuity in staff is rare, not only for those elderly who receive services several times a day, for whom care is often provided by more than one care worker. A recent nationally representative survey of home-help users has shown that one in five users of home help (18.2 per cent) is either very dissatisfied or dissatisfied with the number of care workers (Capacent, 2009).

Dissatisfaction is more pronounced amongst users who receive both personal and practical care, and these recipients of care are thus more likely to receive a visit from the home helper several times a day. Here 22.4 per cent of users express dissatisfaction, in comparison to users of practical care only, where 17.1 per cent are dissatisfied. As we have seen, most users (95 per cent) of personal care use a public provider and a higher proportion of users of municipal services are dissatisfied with the continuity of staff (21.0 per cent) compared to users of private for-profit providers (10.2 per cent).

Even if free choice is associated with the possibility of exiting and of maintaining a care relationship, private for-profit providers are nevertheless gaining ground because they are able to deliver continuity in care and to promote their services on the basis of that activity. Staff continuity is found in other studies to be the most desired attribute of quality from both older persons and care workers (Edebalk et al., 1995; Rostgaard & Thorgaard 2007). According to Monica, a care assessor, users do appreciate the same person coming to visit: ‘This is something the elderly appreciates. That is, that it is the same person’ (author’s translation). Monica states that it is not only the same person but also a person with certain characteristics that private for-profit providers can guarantee. ‘Some of the private ones also promote themselves by saying that the care workers working with them are mature ladies, instead of the young lasses that the municipality sends. What they mainly emphasize is that it is the same person and that you yourself can decide whether you want a man or a woman’ (author’s translation).

But the choice of a certain person or a person with certain characteristics, such as experience with care work, is not part of the assumptions underlying free choice of home-help provider. Although some private for-profit providers seem also to guarantee a choice of staff member, this certainly seems not to be practised amongst municipal home-help providers. As Gitte and Elsebeth, both municipal home helpers, explain:
Well, I have a funny story: When free choice was introduced, one of our users thought you could choose which home help you'd want to come and help you from the municipal provider [everyone laughs]. Because it was ‘free choice’, so we let him, but we normally don’t. It depends on who has time and so on.” (Gitte, author’s translation)

Yes, I experienced the same. And then she said: ‘I would like to hire you.’ Yes, yes. [they laugh] They misunderstand it, yes, they do. (Elisabeth, author’s translation)

Care in the name of freedom

A final implicit assumption when autonomy is communicated as a precondition of quality of care is that care is a commodity like any other, which the user decides to make use of. With several providers offering services, the user must from the beginning act as a critical consumer who is sceptical about the ‘commodity’ which she is offered, that is the kind of care which the provider can offer. This assumption, therefore, rests on the belief that the user must pay attention to whether he or she has received the best quality. Rather than a relationship build on trust, the market relationship assumes that the consumer keeps a certain distance and continuously reflects on whether another commodity might be better.

However, elderly care entails a very personal and often very intimate relationship between user and care giver. Care takes place in the individual’s private home and involves very private and intimate activities. This situation requires that a certain trust be in place between care user and care giver and that the care giver understands and respects the elderly’s dignity, vulnerability, and frailty, and such a relationship often requires time to develop.

As Rønning (2004) states, however, it seems as if a battle of the very soul of care has been taking place these past years. This battle stands between the view of care as a commodity, where the issues concern cost-efficiency, the standardization of care needs, and the price-setting of care, and the view that considers care as an encounter between care recipient and care provider, which is based in a social relationship between the two. As the assumption behind free choice is that the care relationship can be terminated and replaced, it ignores the process involved in establishing such a relationship.

It also overlooks entirely the fact that care needs cannot be postponed until something better is within reach. It is not possible, as with other commodities, for the elderly to ‘shop around’ until something better comes along. Nevertheless, the assumption that care can be treated as a commodity is gaining ground, as this conversation between Albert, who receives private for-profit home help, and three private home helpers illustrates:

Albert: ‘When you are at my age, one doesn’t have much family, and then one might need someone to talk to. There isn’t much of that.’

Sidsel (private home helper): ‘But have you ever considered that when you receive care from a private provider, you can buy extra time? Have you thought about that?’

Albert: ‘I know that, but that’s not it. I can’t buy time to have someone sit and chat over a cup of coffee.’

Astrid (private home helper): ‘Oh yes. You certainly can.’
Mette-Marie (private home helper): ‘You decide yourself what you want us to spend time on. You decide what we should do during the extra time that you purchase. It is not we who decide what to do. It’s your money. So it is only you who has to decide what is done.’

**Better quality?**

Has the introduction of private for-profit providers of home care led to the expected increase in quality? According to one care assessor, private for-profit providers provide more stable services and a difference in the approach to the user in that private for-profit providers appreciate to a higher degree that they are deliberately chosen:

> And the municipality is not service minded or provide stability well enough. We are not good enough at this either. And we are not good at getting out there and selling ourselves. Well, the private providers in our municipality, they come visiting, every time they have a new user, and say: Thank you for choosing us’. Well, you know, the municipality would never dream of doing this. (Mille, care assessor)

Users themselves acknowledge the possibility of choosing a provider: 57 per cent thus responded that having a choice of provider is either very important or important to them (Capacent, 2009). Nevertheless, ratings of quality show little difference between how users rate the care from the two provider types. Amongst users receiving practical assistance, 85.8 per cent of users of municipal home care are either satisfied overall or very satisfied with the services overall, whereas the share is only 86.5 per cent for users of private for-profit home care. Amongst users of personal care, 92.2 per cent of users of municipal home care are satisfied overall or very satisfied, compared to 85.7 per cent of users of private for-profit home care (Capacent, 2009).

**Conclusion**

The introduction of consumerism in social policy in Denmark, exemplified by the introduction of free choice in home care, appears to be part of an overall agenda of re-shifting the problematics of the traditional welfare state and, in particular, of overcoming ideological resistance to privatization. Initially, notions of welfare-state failure gave way to the new notion of consumerism in Denmark. The criticism aimed at the welfare state has come about because various paradoxes have been created over time and the welfare state has become increasingly complex. Paradoxes have arisen 1) because the welfare state at one and the same time has increased the politicization of problems while being accused of public welfare inefficiency and bureaucracy; 2) because both the political goal of unity and the goal of producing differentiated and individualized welfare solutions exist; and 3) because the welfare state has had difficulty finding its footing in the search for legitimacy of public intervention while also trying to secure individual autonomy and involvement.

This article has described how the choice was seen to be the ‘overarching’ answer to these three paradoxes. It was supposed to solve the paradox of how to empower the disempowered user of care (through active involvement); it was supposed to result in better user-led quality of care; it was supposed to provide more cost-efficient services (through the introduction of the market
principle); and lastly it was to help develop a care market, which would match with the ideology of the present government (privatization).

Inherent in the principle of the free choice are a number of assumptions about the role of the elderly as users and the responsibilities they are assigned in the consumerist model. This article has described how elderly users, despite their frailty, are expected to become actively involved in the identification of their needs and of the provider that can best meet these needs. The consumerist approach also gives these users room for expression of satisfaction through changing providers. Users are now ‘equal’, because the state guarantees that choice will be available for all across gender, ethnicity, income, class, and local authority, and the user is also made the co-producer of what care relationships are worth continuing (and in this way becomes the quality assurer).

This article argues that the consequences of introducing free choice are that users are given an opportunity to express themselves through choosing or rejecting a provider. However, the elderly themselves most want to choose the person who provides care and to obtain some continuity in this care relationship. They are much less concerned with their ‘ownership’ of the provider. Users also rate quality of care to be more or less the same, regardless of whether the care comes from a private for-profit or public provider.

It has also been argued that there is no consideration about the specific nature of care and dependency in the consumerist approach. Care is treated just like any other commodity and the elderly just like any other consumer. Yet for any market to be efficient it requires that the user exercises critical judgement about the purchased good. Mutual distrust is necessary for the market to operate most rationally, and consumers must always be on the lookout for a better or cheaper product if the market terms are to be fulfilled. But care, in contrast, also entails crucial issues of relationships, trust, and dependency.

Overall, the consumerist way of thinking also changes the conditionality of the welfare state and its subjects because this way of thinking creates new forms of responsibility and dependencies. While the regime of choice was intended to empower the disempowered individual, it also conditions the individual as a self-responsible agent, that is, responsible for his and her own welfare. Greater autonomy also implies the risk of choosing poorly or choosing too often, thereby becoming a bad risk that providers seek to avoid. Thus the discourse of freedom disregards new risks: the freedom to make bad or wrong choices.

References


Care ‘going market’: Finnish elderly-care policies in transition

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Abstract
The article evaluates marketization and its effects on elderly-care policies in Finland, where the welfare state has been the most important mechanism in mitigating failures caused by the functioning of market. In addition, since the 1960s the public sector has been regarded as the guarantee for citizens’ social rights and the common good. Therefore, marketization, denoting to market logics intervened with social-care practices that construct care as a commodity and the individual in need of care as a consumer, is a critical juncture for an evaluation of the underlying pattern change. To evaluate the change this article employs a framework of institutional policy analysis. By focusing on institutional framing of care policies, institutionalized responsibilities, policy discourses, and policy outcomes and by using textual and statistical data, this article aims to reach a detailed but comprehensive picture on marketization and its influence in the Finnish social-care regime. All institutional aspects analysed in the study show a clear transition from universal social policies based on public responsibility to market-friendly policies and the marketization of social care. However, they also imply that marketization is regulated by public authorities. On the basis of these results, we argue that Finnish elderly-care policies is going through a profound change, in magnitude similar to what occurred 30-40 years ago when the politics of universalism was breaking through. The new direction points to the market and a deep-going reform of social-care service provision is taking place, and the earlier state-centred welfare production mode is at least partly withering away. In this respect the pattern of social-care service provision is turning into something else. In all, Finland seems to be approaching the form of a liberal welfare state.

Keywords: marketization, elderly care, institutional policy analysis, Finland
Introduction

The feminization of labour-market participation, the attempts to raise the retirement age, and the overall individualization of lifestyles have reduced the informal care that even today is the main source of adult social care. Informal, unpaid care done mainly by women has to be complemented and substituted by formal arrangements more extensively than ever before owing to the ageing of societies. Researchers and politicians in various countries are searching for socially and economically sustainable solutions to meet the increasing care needs of aged persons. As Daly and Lewis (2000) wrote about ten years ago, social care is today one of the most important social-policy issues in Europe. This is also the case in Finland (Anttonen, Valokivi & Zechner, 2009). This article scrutinizes social care by analysing the marketization in the social-policy field of elderly care in Finland.

We use the concept of mixed-care production to refer to the multiple ways of providing care in post-industrial societies (Sipilä, Anttonen, & Kröger, 2009). The concept of mixed-care production comprises care provision both in the private sphere of households and the public spheres of the state, market, and civil society. Marketization, in turn, is a context-bound concept used in a number of different ways. In this study marketization refers to market logics intervening in social-care practices that construct both care as a commodity and the individual in need of care as a consumer. Marketization refers first to the increased presence of for-profit providers in providing social care, and, secondly, to the institutionalization of market-like mechanisms in providing care services within the public and third sectors (or civil society). Promotion and implementation of market and quasi-market mechanisms have created space for new operational practices such as ‘vouchers’, ‘personal or independent budgets’, and ‘payments for informal care’, often together with the introduction of purchaser-provider models (Anttonen & Sointu, 2006; Clarke, 2006; Newman, Glendinning & Hughes, 2008; Stevens et al., 2011). Reforms have aimed at targeting society’s resources in a more effective way, building up social-care markets, promoting choice, and giving citizens a voice.

Since the early 1990s, researchers have emphasized that innovations within social care often represent mixed-care production or new welfare mixes, where the clear demarcation between public and private provision is withering away (Evers & Sevetlik, 1991). This is true even in Finland with its fairly strong tradition of tax-funded service provision and fairly universal social-care policies. Marketization is related to the promotion of new welfare mix (or mixed welfare governance as we later show) in producing welfare and social care for citizens but also the overall regime or pattern change taking place in Western welfare states. To understand better the meaning and processes of marketization for social policy and social-care practices, this article employs a framework of institutional policy analysis. This approach analyses marketization as a critical juncture in which to evaluate the underlying pattern change by focusing on the institutional framing of social care, institutionalized responsibilities, elderly-care policy discourses, and some policy outcomes in the field of social-care provision. According to historical institutionalists, it is important to pay attention to incremental changes that may in the longer run lead to pattern or regime change in Western democracies that rely more heavily on market-based solutions in their public policies (Streeck and Thelen, 2005). There has been a move from ‘against market’ or anti-market welfare positions to ‘pro-market’ views that emphasize the public sector’s inability to
mobilize a significant amount of new resources for any welfare purposes (Sipilä & Anttonen, 2008).

**Market-friendly welfare production**

The timing of adopting market-based or market-like mechanisms and practices varies across countries as does the extent of realized reforms. While there are profound changes now taking place, we speak here about the ‘new politics of social care’ (cf. Pierson, 2001; Julkunen, 2006) leading to a new type of regime or national pattern in the production of social care. In Europe, the United Kingdom was among the first countries to reform its public-service model thoroughly (Clarke, 2006). Since the 1990s, a number of countries, including Finland, have followed the British route, at least to some extent. International organizations such as the Organization for Economic Cooperation and Development (OECD) and the European Union have paved the way for the ‘new politics of social care’ by recommendations and rules structured with market logics (Jenson, 2009). The governance of social welfare is changing owing to the stronger emphasis on issues such as consumer choice, user-friendliness, social-care markets, commissioning, externalization, commercialization, and contracting-out of care services (Clarke, 2006; Newman & Tonkens, 2011; Vabø, 2006).

Countries in the first wave of marketization that adopted new mechanisms to reform public-sector service production represent the liberal welfare regime (Newman, 2001; Stevens et al., 2011; Streek & Thelen, 2005). However, in the second wave the market-related reform movement also reached the Nordic countries, where the state traditionally assumed a wide responsibility for producing and financing social care for its residents. There are reasons to look more closely at one Nordic country, Finland, and its market-related reforms in social care. For two or more decades the phrase of ‘care going public’ has captured, first, the politicization and increased societal recognition of unpaid care work; and, secondly, it has referred to the processes through which an increasing proportion of care has moved from being solely in the private domestic sphere of the household and now falls in the spheres of the state, the formal economy of the market, and the voluntary and third sectors (Anttonen, Baldock & Sipilä, 2003). Because of the importance of the process of ‘care going public’ and the metaphoric strength of the phrase, we instead use here the expression ‘care going private’.

Since the 1950s, in the Nordic countries care has increasingly ‘gone public’ in the sense that the public sector has assumed much of responsibility for producing care services for both children and adults. By using the expression of ‘care going private’, we do not claim that a considerable part of ‘public care’ has now gone back to the private domestic sphere of the household; rather, it refers to a number of developments taking place within social-care policies and practices. Many Nordic scholars – without using the phrase – have made reference to the informalization of care (Rostgaard, 2004; Szebehely, 2005), the privatization of the management and provision of public-care services (Szebehely, 2004; Vabø, 2006), and the marketization of service provision (Trydegård, 2000). Care is ‘going private’ in the sense that one part of social care is now removed from the public sphere of welfare states and now to a

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1 The expression of ‘reproduction going public’ was coined by Helga Maria Hernes in the mid-1980s. With this slogan she implied that the division of reproductive work between the family and the rest of society radically changed in the course of the twentieth century (Hernes, 1987).
great extent overlaps with the formal economy of market, third sector, and the private domestic sphere of households. Yet it is equally important to recognize that market-like mechanisms have gained more importance within the public sector.

Marketization is one important developmental path framing and shaping Finnish elder-care policies. In this article, we start from the general assumption that care is now rather going private than public, and that the marketization of care and the strengthening of market or economic principles in social-care production is part of this process. The marketization of care includes, as already mentioned, different but intersecting processes (e.g., contracting out, the use of vouchers, tax credits) through which social care as a public good becomes a ‘commodity’ purchased in (social-care) markets. Overall marketization and the adoption of market-like mechanisms shape social-care institutions, care-related responsibilities, and the production of care both in the public sphere of the state and local administrations and in households (Szebehely, 2005). In addition, the sphere of third- and voluntary-sector service provision is similarly affected by the logic of market.

Anttonen and Häikiö (2011) have recently shown that marketization is present both in policy discourses and in the actual policies of social care for the elderly. Thus there is good reason to take a closer look to different sides of the phenomenon of ‘care going market’. Our aim is to ascertain whether there is a major market-related change taking place in Finland. Secondly, we ask how intensively and extensively ‘care is going market’. Thirdly, it is important to ask if the whole pattern of producing care and care services is changing in Finland into something different than that based on the Nordic social-care regime, with its foundational principle of universalism (Anttonen and Sipilä, 2010)

These questions are studied, as we call it, in the framework of institutional policy analysis. With a focus on institutional framing, institutionalized responsibilities, policy discourses, and policy outcomes we aim at to achieve a detailed but comprehensive picture of marketization and its influence in the Finnish social-care regime. First, we are concerned about how legal reforms frame and shape social-care production and particularly social-care markets. We follow changes from the major social welfare legislative reform of 1984 to the most recent reforms by paying attention to the ways that national legislation opens (or speeds) up and structures processes of marketization. Secondly, a more detailed analysis concentrates on diverse institutional aspects of marketization in the field of social care. We use the available statistical data mainly concerning coverage of social-care services to analyse shifts in public and private responsibilities in meeting care needs. Thirdly, national and local policy documents that determine elderly-care policies provide material for interpreting policy discourses and the ways these discourses are structured with market logic. Policy outcomes are measured using statistical data on the share of public and for-profit social-care service providers in social services.

The Nordic social-care regime and market failures

In contextualizing current processes of marketization of the Finnish social-care regime, it is worth noting that social policies and the universalist welfare state have been the most important mechanisms in mitigating failures caused by the functioning of the market in the Nordic countries. Citizens and decision-makers have viewed the state and the public sector as the guarantors of citizens’ social rights and the common good. This is why the welfare state has
been considered as a mechanism functioning against rather than for the market (Esping-Andersen, 1985). In every society rich people can purchase the assistance and care they need from the market by employing nurses and care workers. However, the great majority of people do not have this option. This has been one of the main reasons for extending social rights to cover such needs as social care – to simplify the complex reasons behind universal social-care policies.

Care practices are always and everywhere an integral part of the wider order and structure of a society. The norms and assumptions that govern care policies are products of gendered, political, cultural and religious norms, values, and habits (Pfau-Effinger, 1998; Pfau-Effinger & Rostgaard, 2011). International comparisons (Anttonen, Baldock & Sipilä, 2003; Bettio and Plantenga, 2004; Rostgaard and Fridberg, 1998) show that there are surprisingly large national differences in the scale, scope, and targeting of formal care services as well as in the operational practices used and justifications adopted. One and the same function may be arranged through services provided by central or local government, by private businesses, by welfare organizations or through various combinations of public and private sources. For example, carers and care recipients in some welfare systems may be offered cash benefits or tax concessions instead of services. Alternatively, a whole system may rely largely on social care being provided by relatives, friends, and partners or on care provided by immigrant care workers working in private households (Williams, 1995 and 2009).

In the comparative welfare-state literature the Nordic countries constitute one of the most distinctive welfare and social-care models. It is legitimate to speak about a Nordic social-care regime (Anttonen & Sipilä, 1996; Bettio & Plantenga, 2004) and universalism as a guiding principle behind its care policies and service provision. In the field of care policies there are (or at least have been) many important similarities between Finland, Sweden, Norway, and Denmark (Sipilä et al., 1997, 39-40). First of all, services are available to all citizens, irrespective of their economic status; secondly, the system offers fairly uniform services all over the country. Thirdly, a majority of citizens actually use these services when in need. Fourthly, universalism may also include the idea that citizens have rights to services. Fifthly, municipalities or regional administrative bodies are responsible for service provision.

The grand idea of universal social services was brought into public political discourse by the Swedish social democrats as early as in the 1920s (‘society as people’s home’). It was closely connected to the promotion of gender equality and a work society for all. Since the 1950s, universalist solutions often enjoyed strong support in social policy reforms. This was also the case with social-care services. In aged care two main instruments were used.

In Finland until the 1960s institutional care was the main mechanism for meeting the care needs of elderly people and the rate of institutionalization among the elderly remained high until 1980s (Noro, 1998). The municipal home-help service was greatly expanded in the 1960s and 1970s. Developments in municipal home-help serve as a very good example of universalist social policies. In 1966 the home-help service was made available to all those who needed them, irrespective of age and financial position, and the municipalities were required by law to provide these services (Rauhala, 1996). Municipal home help was the first truly universal social service in Finland. In 1970, around seven per cent of the population (65+) received home help, and in 1990 Finland was in the top position internationally with a coverage of 24 per cent (OECD 1996: Table 3.6; according to the national
statistics the corresponding figure is slightly lower, 19 per cent). In the 1980s and early 1990s Finland as one of the Nordic countries had the most advanced systems for safeguarding citizens’ and also aged citizens’ rights to social care. In this sense, it is possible to argue that the universalist social policies peaked in the early 1990s.

**Legal reforms paving the way for marketization**

In Finland, universal principles in the field of social-care policies were challenged during the economic recession of the early 1990s. The recession of 1990-94 was unparalleled in Western economic history, with unemployment rising up to the level of 20 per cent. This particularly unbalanced the central government budget, which again resulted in drastic cuts. One of the main objects of cost containment was state subsidies to local governments, which hit municipal social-service provision severely. Being less protected by social rights, services for the elderly were among the main victims of the cuts.

The economic recession together with the growth of a liberalist market ideology have led to a profound restructuration of social-service policy. It is interesting to note that even before the collapse politicians had opened up some important doors for promoting diversity in service provision. The major reform of the social-welfare legislation in 1984 permitted the use of state subsidies for purchasing social services produced not only by the municipal authorities but also by voluntary and private organizations, as well as payments for informal caring. The Social Welfare Act of 1984 obliged municipalities to provide services according to need, but it also gave them freedom to decide how these needs would be met. This was the beginning for the new politics of social care based on marketization and thus increasingly on mixed-care production.

Since the 1984 reform, the system of home-care allowances (HCA) has constituted the third instrument in providing care for the aged along with institutional and home-care services. The system of HCA brought into being new mechanisms and operational practices in making social-care policies. Instead of providing services for aged and disabled persons, relatives and other laypersons are paid to take care of those who need regular help and attendance. In Finland, cash benefits like HCA are primarily seen as an alternative to social-care services (Anttonen & Sointu, 2006). Payments for care schemes are a crucial part in the process where the government tries to reduce the costs of social-care services financed by tax revenues and provided with high professional standards that have also characterized public-care service provision in the Nordic countries.

Another major legal change that opened up space for marketization took place in 1993, when the system of earmarked state subsidies for social welfare was dismantled. This legal reform strengthened the idea that municipalities are in charge of arranging services, but they have the freedom to decide how these services are arranged and produced (following the Danish model of that time). These two legislative reforms paved the way not only for marketization but also for the informalization of social care by making it possible for local governments to purchase services from private (for- and non-profit) providers and to substitute some part of care service provision by supporting informal care given at home. All this has led to increased diversity in the social-care production for the elderly and mixed practices of governance in managing social-care systems at the local level of municipalities.
Further steps towards mixed governance that involved the market logic were taken when the tax credit for domestic help was introduced in 2001. This credit can be used for employing assisting personnel, including domestic and care workers, for instance, at an aged person's home. The tax credit for domestic help clearly represents a market-friendly policy alternative to publicly funded service provision. In principle, this reform allows people to purchase care services (with the exception of childcare) directly from private providers or to employ care workers, but in practice the use of this credit for purchasing care has been very limited (Finnish Tax Administration, 2011).

The introduction of the voucher system has strengthened market-like mechanisms in social-care production. Since 2004 municipalities have been able to provide some care services by means of service vouchers. The services provided for aged people most often include home help and cleaning services as well as services to support informal carers' legally defined right to some time off. In 2009, the Law on Health and Social Service Vouchers was passed to regulate better the diversity in local practices adopted in the Finnish municipalities. Thus it is only very recently that the system of service vouchers has started to gather more momentum within health and social-care policies in Finland.

**Diminishing public responsibility on social care**

Social care for the elderly is going through major changes with respect to the principles behind the legal reforms and mechanisms used in care policies. A working group set up by the Ministry of Social Affairs and Health suggested in February 2011 that long-term care given in old age homes and long-term health-care wards in hospitals should be reorganized so that all aged people needing 24-hour care should be living in sheltered housing (service housing) instead of institutions by 2020 (Working Group Ikähoiva, 2011). One motivation behind this reform is to speed up marketization by building up sheltered and extra-care housing for the elderly. Through the latter mechanism service users have to pay more for 'residential' care because services, medication, and housing are separate packages. This is also an avenue to move one part of the financial responsibility from the municipalities to the state. Finally, for private companies sheltered housing is a much more attractive care commodity than the traditional institutional care given in old-age homes and other similar institutions.

This major reform was to be accompanied by increases in home help, home nursing, and other home-based services, but in fact the trend has been quite the opposite since the early 1990s. For instance, the home-help service provision has been declining since the heyday of universalism. In 1999, home-help services covered only 11 per cent of the 65+ population compared to 19 per cent in 1990 (Table 1).
Table 1: Coverage of municipal home-help services, 1990-2009, Finland

<table>
<thead>
<tr>
<th>Year</th>
<th>Recipients</th>
<th>65+ %</th>
<th>75+ %</th>
<th>85+ %</th>
<th>65+</th>
<th>65+ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>125 571</td>
<td>18,7</td>
<td>31,5</td>
<td>42,4</td>
<td>103 096</td>
<td>15,3</td>
</tr>
<tr>
<td>1995</td>
<td>86 748</td>
<td>11,8</td>
<td>22,1</td>
<td>35,7</td>
<td>97 967</td>
<td>13,4</td>
</tr>
<tr>
<td>2005</td>
<td>85 604</td>
<td>10,2</td>
<td>18,3</td>
<td>34,4</td>
<td>108 249</td>
<td>12,9</td>
</tr>
<tr>
<td>2009</td>
<td>103 863</td>
<td>11,4</td>
<td>20,4</td>
<td>37,3</td>
<td>116 347</td>
<td>12,8</td>
</tr>
</tbody>
</table>

* Number of households receiving home-help services.
** Individuals receiving support services (meals-on-wheels etc.)
Source: SOTKAnet 2011.

Table 1 reveals a major change in care service provision. In addition, the decrease in home-help service provision has not been accompanied by an increase in support services such as meals-on-wheels and bathing services. On the contrary, the coverage of these services has also in fact decreased. The system of HCA has been designed to compensate some of the losses in municipal home help provision as seen in Table 2.

Table 2: Recipients of home-care allowance (HCA) 1990-2009, Finland

<table>
<thead>
<tr>
<th>Year</th>
<th>Recipients 65+</th>
<th>65+</th>
<th>75+</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>13 196</td>
<td>2,0</td>
<td>3,3</td>
<td>6,6</td>
</tr>
<tr>
<td>1995</td>
<td>11 294</td>
<td>1,5</td>
<td>2,7</td>
<td>5,0</td>
</tr>
<tr>
<td>2000</td>
<td>14 355</td>
<td>1,8</td>
<td>3,0</td>
<td>5,3</td>
</tr>
<tr>
<td>2005</td>
<td>19 796</td>
<td>2,4</td>
<td>3,7</td>
<td>6,0</td>
</tr>
<tr>
<td>2009</td>
<td>23 548</td>
<td>2,6</td>
<td>4,1</td>
<td>5,9</td>
</tr>
</tbody>
</table>

Source: SOTKAnet 2011.

Declining figures in home-help coverage and the increasing significance of HCA suggest that ‘care is going private’ at least in the sense that aged persons receive fewer home-help services. This loss has been compensated only partly by paying HCAs for relatives and spouses of aged persons needing care. Compared to other Nordic countries, the development of home-help service provision in Finland resembles most closely the situation in Sweden (Figure 1).
Figure 1: People living at institutions or in service housing and people receiving home help in the Nordic countries, as percentages of the age group 65 years or more, 1995-2008

Source: NOSOSCO, Social Protection in the Nordic Countries 2007/2008, Figure 6.2.3.

Figure 1 shows that in Finland and Sweden the governments have carried out reforms that have shrunk the scope of public-service provision and have limited aged citizens’ access to core social-care services by tightening the eligibility rules (Anttonen et al., 2009; Palme et al., 2002). In Finland, this has been done without any major changes in the social-welfare legislation. The law makes it possible to meet the needs of aged persons in very different ways. Even if there are national laws on social-care services, the social-care rights of aged persons are rather weak compared, for instance, to childcare rights (Kröger, Anttonen & Sipilä, 2003). This is also largely the case with home help that has turned into a municipal service. Today central-government grants cover only a minor part of local-government expenses in social and health care. The financing of public-care services is based primarily on taxation: the share of national tax-based financing is less than 20 per cent of total costs. The reminder is covered by local taxes and user fees. Customer fees vary to some extent, being in 2007 on average 16 per cent of nursing home-service expenses and 14 per cent of home-care expenses (Sjöholm, 2009).

In this section we have shown that public responsibility for social-care service provision is diminishing. As there are fewer services available than before and new mechanisms have not compensated these losses, new solutions are badly needed. The only elderly-care service that has increased since early 1990s is sheltered housing and extra-care housing. These services, however, compensate shortages in institutional rather than in home-help services. All these changes have paved the way for marketization as well as for the informalization of care.

**Marketization in public policy discourse**

Even today municipalities carry the main responsibility for financing and providing of social services. The introduction of legislative reforms coupled with limited financial resources since the early 1990s have contributed to the
development of new forms of governance in Finnish municipalities (Häikiö, 2010; Haveri, 2006). The municipalities have created structures based on the separation of purchasers and providers and have enabled for-profit or non-profit services, or both, to replace public services. The language of social-care policies is changing to include words such as choice, customer orientation, partnership, contracts, and the market.

Finland is, however, a ‘latecomer’ in the league of countries favouring market-friendly social policies. Some municipalities, like the City of Tampere, have adopted an extensive purchaser-provider model (Häikiö, 2010), with a steadily increasing presence of market mechanisms and market providers. In this section we trace market-related change from policy documents. The data used comprises 14 documents published between 2001 and 2008. Half of these documents were national ones, including those produced by the government and the Ministry of Social Affairs and Health. The other half comprised local policy documents produced by the City of Tampere. We do not present a detailed analysis of the policy documents here, since this has been done elsewhere (Anttonen & Häikiö, 2011). We briefly illustrate the role of elderly-care policy discourse in introducing markets as a policy alternative in providing elderly care.

The documents analysed confirm that the language of social-care policy is increasingly giving way to an elderly-care discourse that emphasizes personal responsibility, choice, and social-care markets (Anttonen & Häikiö, 2011; Häikiö & Anttonen, 2011). The documents of 2001-2004 referred clearly to the Constitution as the foundation of social citizenship and social security and public responsibility for social care. One cornerstone of the Finnish social policies is that the social rights of residents are guaranteed by the Constitution. Social protection is intended to support equal opportunities for all citizens. Section 19 of the new Constitution of Finland, which came into effect on March 1, 2000, guarantees the right to indispensable subsistence and care for those who cannot themselves obtain the means necessary for a life of dignity. The section develops this theme by guaranteeing the right to basic subsistence in the event of unemployment, illness, disability, old age, at the birth of a child or in the event of the loss of a provider. This is a general right to be provided in detail under separate legislation. The public authorities are also obliged to guarantee adequate social, health care and medical services for all and to promote the health of the population. (Strategies for social protection 2010, 2001.)

The discourse constructed with reference to the Constitution underlines that public authorities have the main responsibility for meeting citizens’ basic needs and that citizens are entitled to social and health care as well to education and income protection. However, since 2004, policy documents make fewer and fewer references to the Constitution, citizens’ rights, and public responsibilities. Instead, these documents emphasize the active position of older people themselves to take responsibility for their personal well-being. In addition, there are increasingly references to the issue of choice. It is particularly the ‘freedom of choice’ through which care is framed by market logic. In the documents elderly-care services were increasingly seen as commodities produced in the emerging social-care markets:

Securing the provision of services calls for a sound financial basis and new ways of organizing and producing services. The Government promotes partnerships between the public, private and third sector in the provision of services. The adoption of the purchaser provider model will
be encouraged. The applicability of social service vouchers and the domestic help credit will be expanded which will contribute to the emergence of working service markets. (The Government Programme. Prime Minister Matti Vanhanen's Second Cabinet, 2007)

The purchaser-provider model, social-service vouchers, and domestic-help credit are all public-policy measures designed to promote social-care markets. Care markets are constructed as means for securing universal access to services. The discourse underlines the public responsibility for creating functioning care markets and the individual’s responsibility for meeting care needs (Häikiö & Anttonen, 2011). The municipality retains the legal responsibility for meeting the care needs of aged citizens and carries the responsibility for quality control of private services, but in practice most of these new market mechanisms shift these responsibilities to individuals. For example, by using tax-funded service vouchers citizens become consumers with consumer rights, and they use care services according to consumer rules and legislation (Huhtanen, 2011). Public authorities are in most cases not responsible for consumer failures or choices (Vabø, 2006). In the social-care markets individuals also act as true consumers because they bear the financial responsibility for the care and cannot make demands with reference to universal social rights.

Consumerist positions were most visible in the local policy documents where inhabitants of the municipality are framed as clients and customers with individual needs and expectations (Häikiö, 2010). Whether the aim is to create new markets for social services or to create market-like mechanisms within public-service provision, individuals were positioned as choice-makers.

The Kotitori (“homemarket”) programme also makes it possible for old people to be both clients and patrons. As clients they use the services arranged by the city administration and as patrons they use services paid for with their own money. (Homemarket planning and decision documents 2.6.2008)

This extract demonstrates that the City of Tampere was planning to start in 2009 the so-called Homemarket project, which is based on the idea of the citizen as a conscious consumer, whose care needs are negotiated together with care integrators (or care managers). The project started in 2009, and interestingly Homemarket is run by a private company. From this it follows that these managers first assess the social-care needs for aged persons is first assessed and then make decisions concerning the help and services needed, including publicly produced services. The project does not yet cover the whole city, but the firm aims is to extend its authority in the coming years. Thus, care managers are responsible for setting up a service package for each consumer according to their needs and personal financial resources. They will also provide access to information covering all service provision within the municipality and beyond.

An analysis of the most recent policy discourse on social care for the elderly reveals that there is a major change in the vocabulary used by politicians and administrators. Market-related change is fairly obvious when reading official policy documents produced between 2001 and 2008. A longer period would have given much more information of the change from universal social protection to mixed welfare governance. Both a change in fundamental views and a change in political vocabulary are necessary preconditions for the new politics of social care to be implemented at the local level of municipalities.
The analysis (see also Anttonen & Häikiö, 2011; Häikiö & Anttonen, 2011) supports the argument that ‘old’ universalist politics founded on strong centralized institutions (hierarchies), universal treatment of ‘clients’ or ‘patients’, and the professional interpretation of needs is changing towards a politics of mixed governance, including in Finland. The state-centred service production relied heavily on steering mechanisms embedded in bureaucracy, paternalism, and professionalism (Langan, 1998). The concept of mixed (welfare) governance emphasizes that local authorities are to mix different organizing principles, governing methods, and coordination mechanisms to promote diversity instead of universalism. According to Jessop (1999) the new governance of welfare is characterized by changes in the definition of welfare, changes in the institutions responsible for delivering services, and changes in the practices of service delivery. Social care has always been produced by individuals, families, third-sector organizations, and private companies, besides public authorities, but within the mixed-governance structure, the relations and power positions of these providers are altered (Burau, Theobald & Blank 2007).

Table 3. Forms of mixed welfare governance.

<table>
<thead>
<tr>
<th>Organizing principle</th>
<th>Governing method</th>
<th>Coordination mechanisms</th>
<th>Position of service user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hierarchies</td>
<td>Administrative and political power</td>
<td>Command and control</td>
<td>Client, patient</td>
</tr>
<tr>
<td>Networks</td>
<td>Norms</td>
<td>Trust and support</td>
<td>Service user, co-producer</td>
</tr>
<tr>
<td>Markets</td>
<td>Money</td>
<td>Competition and choice</td>
<td>Consumer</td>
</tr>
</tbody>
</table>

Source: Häikiö & Anttonen 2011.

According to Table 3 market-based service provision is based primarily on competition and choice. Competition is a new steering mechanism used by public authorities, and choice is attached to the behaviour and rights of service users. A number of European scholars have argued that at the centre of the new politics of social care lies the figure of the ‘consumer’ making ‘free choices’ on the social- and health-service market (Clarke, 2006; Kremer, 2006; Vabø, 2006).

Anttonen and Häikiö (2011) have argued that the transition from government to mixed welfare governance shapes and frames both policy discourses and operational practices taken into use in Finnish social-care policies. It is too early to speak about a major shift in fundamental views from state-friendly to market-friendly social policies. Yet the public political debate encourages municipalities to adjust their welfare systems to the new mental, economic, and social situations. In Finland, citizens or residents even today give strong support to universalism and tax-funded social and health-care service provision (Kallio, 2010). This means that the new politics of social care is favoured and promoted primarily by elites. Surprisingly, the new market-friendly social-care politics has been implemented without any extensive public debate or opposition.

**Marketization of social-care service provision**

Although we have paid much attention to mixed welfare governance, it is worth noting that in Finland there has always existed some kind of welfare mix in social-care service provision for aged persons (Kröger et al., 2003). Most
particularlly sheltered housing has for decades been in the hands of welfare organizations extensively supported by public financing. Figure 2 presents the situation in 2008. However, in the field of sheltered housing, non-profit providers have had much influence for decades.

![Figure 2: Public, non-profit and for profit service provision: old-age homes, service housing and intensive service housing, 2008, Finland.](image)

However, for first time in the history of Finnish social policies, public goods such as home help services have been transformed extensively into products that one can purchase in the emerging social- and health-service market with public money involved. At the same time it is estimated that elderly populations can afford to use more care services purchased from market with their own money. First, we shall look at the market orientation of aged persons as purchasers of purely private-care services, and, secondly, we shall consider some outcomes of the process of marketization within local governance structures.

The introduction of tax credit for domestic help in itself reflects a market-related change in social policies. According to the tax-credit system all Finnish residents with taxable income can deduct a certain amount of wage (30 per cent) and work compensation (60 per cent) when purchasing home services including, for instance, household repairs, gardening, and cleaning services. The maximum amount of deduction was €3000 in 2011. While the deduction is granted on an individual basis it favours households with two adults. The system has existed since 1997 and has expanded rapidly, particularly since 2001, when the corresponding law came into force. Yet even today the system is very little used to purchase care services for aged 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 domestic help, in 2004 the corresponding figure was nearly 180 000 users that is 6.6 per cent of all households in Finland, and in 2009 360 000 users availed
themselves of the tax credit, which is almost ten per cent of all household.\(^2\) In 2009, roughly one-fourth of the total amount was used for domestic (17 per cent) and care (three per cent) services and the rest to repairs to the home (81 per cent).\(^3\) From these figures we see that the system of tax credit for domestic help has become very popular, but it is used mostly for repair work at home and not very much for the purposes of social care. A survey conducted in Tampere and Jyväskylä regions in 2010 supports these findings (Figure 3). Nearly 15 per cent of population of 75+ used the system of tax credit to purchase domestic services, mostly cleaning services. In addition, about 20 per cent of all respondents had purchased some private social- or health-care services with their own money. This means that every fifth person over 75 uses some private care-related services. We can expect that more aged persons will turn to private services in the future.

Figure 3: Use of private-care services among population 75+ in Tampere and Jyväskylä region, 2010

As already shown, marketization is a strong trend in the public political discourse. In this section we look at some outcomes of marketization at the level of policy practices. Within municipalities the market logic has become an important rationale. Municipalities have since the 1980s had the freedom to purchase services from non- and for-profit service providers. In some areas there is already a fairly long tradition of relying on non-profit service provision. This is most particularly the case in sheltered housing for aged and disabled persons. In some other service areas, such as home-help services, municipalities have dominated service provision up to the present time.

Generally speaking, we can discern a clear increase in both non- and for-profit service provision as measured by the share of personnel working in social services according to the status of the provider (see Table 4). The distinction between for- and non-profit providers is tricky, however, because most of the non-profit providers have been forced to transform themselves into business-

\(^2\) Source: Eurofound: [www.europfound.europa.eu/areas/labourmarket/tackling/cases/fi004.htm](http://www.europfound.europa.eu/areas/labourmarket/tackling/cases/fi004.htm).

like providers in order to be able to take part in competitive tendering arranged by the municipalities. In addition, there are no reliable figures from social-care services separately for all social services. In fact, this is not a big problem, because care of aged persons is one of the areas in which marketization process has been an exceptionally strong trend.

Table 4: The share of personnel working in public, non-profit and for-profit social services in Finland, 1990-2007

<table>
<thead>
<tr>
<th>Provider</th>
<th>% of total number of personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public providers</td>
<td>87.6</td>
</tr>
<tr>
<td>Non-profit providers</td>
<td>11.6</td>
</tr>
<tr>
<td>For-profit providers</td>
<td>0.5</td>
</tr>
<tr>
<td>Non- and for-profit (total)</td>
<td>12.1</td>
</tr>
</tbody>
</table>


The non-profit or third sector has historically been an important actor in social-service provision, particularly in old-age welfare, while the importance of private market-based social-service provision is a fairly recent phenomenon. This explains why in 1990 only one per cent of the total personnel working in social services were employed by private providers and 11 per cent by non-profit providers. In the ten years between 1990 and 2000 there was a clear increase in the share of private sector personnel. The early 2000s witnessed a rapid growth of both non- and for-profit sectors so that in 2007 the share of non- and for-profit of total personnel in social services had arisen to 30 per cent. To sum up, in the 17 years between 1990 and 2007 the role of public-sector service provision has clearly diminished. Private-service provision has been steadily increasing but has not exceeded the volume of the non-profit sector. Against this background we can speak of only a moderate marketization in the fields of social care and social services. Yet it is worth noting that the growth of private-sector enterprises in social services has been very rapid since 1990. In 2008, there were 4100 private enterprises in the field of social services in Finland, while the corresponding figure in 2000 was 2664 and in 1990 only 741 (Yksityinen palvelutuotanto, 2011).

As already mentioned, there is considerable variation between different services. Housing (sheltered and extra-care housing) is one of the social care-related services where the role of non-profit and for-profit service provision is most extensive. In 2008 (see Figure 2) more than one half of all sheltered housing for the elderly was provided by non- and for-profit providers and 65 per cent of this was provided by welfare organizations. The situation is slightly different regarding the care given in old-age homes. Of all old-age homes the share of non-public provision was only 12 per cent in 2008. Besides housing services, home-help service is of great importance for aged persons living at home. Home help also represents social-care service par excellence. It is estimated that one-third of home-help services was produced by non- and for-
profit providers in 2008. Roughly 56 per cent of non-public home-help service provision was for-profit and the rest non-profit provision (Yksityinen palvelutuotanto, 2011).

One of the most recent legal reforms, the law that allows the use of vouchers for buying both health- and social-care services, is of great importance from the marketization point of view. This reform certainly accelerates the process in which care becomes marketized. Before the 2009 law, service vouchers were used in home help. In 2006, the municipal authorities granted service vouchers to roughly 3000 service users and in 2009 the number had risen to nearly 7000 users. While the system of service vouchers is now extended to cover nearly all social- and health-care services, the real voucher boom is yet to come.

Conclusions

In this study we have established a framework for institutional policy analysis to evaluate if marketization has become a vocal element in Finnish elderly-care policies and practices. Drawing evidence from institutional legal changes framing mixed-care production, institutionalized responsibilities in care, elderly-care policy discourses, and policy outcomes in the field of social-care provision, we have arrived at the conclusion that market logic is intensively structuring Finnish social-care policies. All institutional aspects analysed in our study show a clear transition from universal social policies based on extensive public responsibility to market-friendly policies and the marketization of social care. However, the process of marketization is fairly strongly regulated by public authorities.

In Finland, public-sector service provision has now been redefined and reorganized so that the state and municipalities take less responsibility for producing care services-in-kind. This means that forerunners and late-comers in relation to market-related reforms are facing the same problem: how to produce care in a situation where neither family-based nor public-service provision can be the only or even major solution to meeting the increasing care needs of older people.

For historical reasons and the Finnish social-policy tradition, marketization represents a critical juncture in which to evaluate the overall pattern change. It really is time to ask if the pattern of social-care service provision is turning into something other than that of Nordic care regime. So far the Nordic social-care regime has rested firmly on the principle of universalism, meaning that services are designed for all citizens irrespective of their class, gender or ethnicity (Kröger et al., 2003). Universalism, however, is challenged by globalization, new liberalism, market-friendly social-policy doctrines, and demands to develop user-friendly service systems that make choice possible.

The transformation of public administration into public management and the influence of managerialism and New Public Management (NPM) on the recent public-sector reforms in many European countries have accelerated welfare state change.

The new market-friendly language of social-care policies is closely linked to an overall change in the welfare state. A very extensive and profound reform of social-care service provision is taking place in Finland. However, the change has been most dramatic since 2007. There are so far no reliable statistics on the recent developments. These changes mean that the mixed governance
mode will be strengthened and the earlier state-centred welfare production mode is at least partly withering away. In this respect Finland is approaching the liberal welfare states.

It is possible to argue that Finnish elderly-care policies are going through a change of a magnitude similar to the change of 30–40 years ago, when the politics of universalism was breaking through. The new direction points towards the market, although the role of welfare organization and similar associations remains important. As already stated non-profit third-sector providers have also been forced to transform their service ideology and practices into a market-rational form. The demarcation between non-profit and for-profit provision is becoming blurred because non-profit providers have to compete with for-profit providers under the same rules and same expectations of effectiveness and efficiency (Karsio, 2011). This way the market-like mechanisms are becoming extremely powerful in social-care policies for the elderly. In 2011, a governmental proposal for a new law on social care for the elderly was made. This law if passed would strengthen elderly persons’ rights to social care. It would also make it easier to control service providers and their possible failures (Luonnos laikisi..., 2011). This is important, because in Finland most political parties seem to celebrate the power of competition and markets. There is so far very little criticism of the new market-like mechanisms and operational practices adopted during the wave of liberalization and marketization. However, at the time of writing the True Finns political party achieved a landslide in the parliamentary election of April 2011, becoming the third biggest party in Finland after The National Coalition Party and the Social Democratic Party. The True Finns is a fairly new populist party that is very much opposed not only to migration but also to marketization, purchaser-provider models, and the decline of public-service provision.

References


The adoption of market-based practices within care for older people: is the work satisfaction of Nordic care workers at risk?

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Abstract
Market-based practices, including privatization and the increased emphasis on managerialism, have entered Nordic social- and health-care systems for older people. This article examines whether the adoption of these practices has affected the work satisfaction of care workers in Denmark, Finland, Norway, and Sweden. The data used comes from a postal survey conducted in spring 2005 among Nordic care workers, covering 2716 respondents who provided care for older people. The items analysed include background questions, Likert-scale questions on working conditions, and questions on the presence of different market-based practices in the workplace. The results indicate that there are many variations between the four Nordic countries concerning the adoption of market-inspired practices in the care for older people, with Denmark having been the most eager and Norway the least to introduce them. Employees of for-profit employers report a lower level of work satisfaction than public employees. On the other hand, the adoption of most market-based instruments correlates with higher and not lower levels of work satisfaction among care workers working with older people. The results do not show a simple connection between the adoption of market-based practices and lower levels of work satisfaction, which might have been expected on the basis of earlier research discussions. However, due to some weaknesses of the data and the many variations between individual market-based models as well as between different Nordic countries, there is cause for caution in the interpretation of the results. It is particularly necessary for policymakers to remain sensitive to the national context.

Keywords: Care work, older people, work satisfaction, Nordic countries, New Public Management, privatization, market-based practices
Introduction

Social- and health-care service systems of Nordic countries are well known as the most universal and publicly organized of their kind. While in many other countries, for-profit and non-profit organizations play a central role in the provision of social- and health-care services, in the Nordic region their role has been limited. It has instead been the public authorities at the central, regional, and particularly at the local levels that have assumed the overwhelming responsibility for providing the services and for employing care workers. The existence of publicly offered care services that are broad in coverage has led some researchers to call these services ‘the key to the Nordic welfare model’ or to conceptualize Nordic welfare states as ‘social-service states’, in contrast to, for example, Central European ‘social-insurance states’ that offer their citizens social-security cash benefits but not public-care services on a grand scale (Anttonen, 1990; Sipilä, 1997).

However, the Nordic region is not immune to international trends affecting the organization of public services everywhere. Models and doctrines that emphasize managerialism, cost-efficiency, and accountability have also spread to the social-democratic welfare regime, guiding the reforms of public administration since the late 1980s. Known as New Public Management (NPM), this trend has brought attributes of a new character, such as total-quality management, balanced scorecards, management by results, and cost-control mechanisms. These have appeared within Nordic public services and also in the care services for older people (Doyle & Timonen, 2007, 21–38; Hasselbladh et al., 2008; Højlund, 2001; Julkunen, 2004; Vabø, 2003). It has been said that Nordic care systems have seen ‘a cultural change where the rationality of efficiency has become a salient logic in formerly socially defined care’ (Wrede et al., 2008, 28).

In addition to the advancement of NPM, another influential international market-inspired tendency that has gained increasing strength since the 1980s has been the privatization of the provision of care services, following the example of Thatcher’s and Blair’s Britain (see e.g., Means et al., 2002; Wistow et al., 1994, 1996). The trend to outsource service provisions to for-profit providers reached the Nordic region in the 1990s (Behning, 2005; Lund Pedersen, 1998; Vabø, 2003). Since then, a growing number of Nordic municipalities have created quasi-markets of care and turned the primary role of local authorities from ‘in-house provision’ into purchasing services from a number of different providers. According to Means et al. (2002, 135), ‘quasi-markets are based on a belief in the cost effectiveness of getting a number of providers to compete for business from a single purchaser, namely the social services department’. Such a belief has become increasingly common within the Nordic countries.

Furthermore, new models that promote ‘consumer choice’ have been spreading in Nordic care service systems for older people (Edebalk & Svensson, 2005; Söderström, 2001). As another way to promote privatization, users of publicly organized and funded care services are more and more often given the option to choose between a public provider and one or more private providers. Also, the traditional in-house provision is still available if the user prefers it, but by offering for-profit and non-profit alternatives, authorities encourage privatization of at least some parts of public-care service provisions. In Finland, this consumer choice is primarily promoted through a new voucher system, formulated in a piece of special legislation in 2004, while in Denmark local authorities have in the case of home-based services been

All in all, market-based models are no longer foreign to the Nordic countries in the field of care services for older people. Here, both an increased focus on managerial control and efficiency as well as outright privatization of service provisions are counted as market-based practices. They arrived in the region more than a decade ago and their influence is becoming increasingly tangible. However, the five nations of the region are not identical in this regard, as the national governments in Denmark, Finland, Iceland, Norway, and Sweden have taken up market-inspired ideas and practices at different paces (Wrede et al., 2008, 26-27). Furthermore, as Nordic municipalities are largely autonomous in their making and implementation of care policies (see Kröger, 2011; Karlson et al., 2010; Lund Pedersen, 1998; Martimo, 1998), the advancement of market-based principles and practices has been asynchronous and patchy. Within-country variations are wide and complex, though often the trend has been fastest in major cities and considerably slower in the rural areas (e.g., Vabø, 2003).

Many Nordic care researchers have been very critical of the adoption of market-inspired models (e.g., Dahl, 2005; Koskiaho, 2008; Vabø, 2003). These have been said to challenge the Nordic welfare model that is based on universalism and public provision, and it has been argued that NPM represents an ideology that is opposite to the rationality of caring. Wrede et al. (2008) go so far as to state that the recent focus on efficiency and managerialism has caused a crisis in care work in the Nordic countries, bringing recruitment problems as well as medicalization and Taylorization of care work.

Does this mean that the work satisfaction of care workers who provide services to older people is also at risk? Does the adoption of market-based practices reduce the satisfaction of Nordic care workers with their work and working conditions? From earlier research it is known that work satisfaction is a critical factor for the recruitment and retention of staff, as well as for the quality of care for older people (see Trydegård, 2005), but has this satisfaction been affected by the emerging privatization and the advancement of managerialism in the Nordic countries?

Despite the lively debate concerning the adoption of market-based models, empirical studies – in particular comparative Nordic ones – on the conditions of care work remain rare. The research question of this paper is to ask whether there are differences in the level of work satisfaction between those Nordic care workers caring for older people who have experienced the adoption of market-based models in their workplaces, and those care workers who have not yet had such a personal experience. The question of whether the adoption of market-based practices is connected with the level of work satisfaction will be analysed here through comparisons between four Nordic countries, and also through comparisons between different market-inspired models.

Data and methods

The data used comes from a postal survey that was conducted in spring 2005 among care workers in Denmark, Finland, Norway, and Sweden (Iceland being the only Nordic country that was not involved). The 12-page
questionnaire was designed jointly by a Nordic research team that included researchers from all the four countries, and was led by Marta Szebehely from the University of Stockholm (see Kröger et al., 2009). It was pilot tested and further developed in each of the four countries. The study (titled NORDCARE) was directed at basic-level care workers (nurses excluded) who during the previous 12 months had worked with older or disabled people within social- or health-care services, and who were employed by either public, for-profit or non-profit organizations. The questionnaire was posted to 1200 random sampled members of the main labour unions of care workers in each country (in Denmark: FOA; in Finland: JHL, Super and They; in Norway: Fagforbundet; in Sweden: Kommunal). The great majority of care workers in all Nordic countries are organized in labour unions – for example more than 80 per cent of home-care workers are unionized in Denmark (Doyle & Timonen, 2007, 33) – so the respondents represented the majority of Nordic care workers within social and health-care services. The number of responses was 3208 in total, with national response rates varying from 66.6 per cent in Sweden to 79.9 per cent in Denmark. For the analysis of this paper, only those respondents who were working with older people were included, which reduced the number of responses to 2716.

Although care work has been studied eagerly within the Nordic countries for decades, this questionnaire study was the first Nordic project that gathered original data from different countries, aiming through its design and sampling methods for the best possible comparability. The questionnaire covered a large number of issues because the aim of the project was to gain comparative knowledge on the general state of care work in the Nordic region. In addition to background variables such as age, gender, employer, training for care work, and work settings, two specific sets of questions provided the most essential data for this paper.

The first of these two sets was focused on work satisfaction. Work satisfaction has been the focus of intensive research for decades, which has also generated many theories on its causes and implications (see e.g., Locke, 1976; Rode, 2004; Weiss, 2002). In brief, work satisfaction describes how satisfied a person is with his or her work. There are many ways to measure it, among which Likert scales are the most commonly used. Research on work satisfaction has also been active concerning care work (see e.g., Hannan et al., 2001; Häggström et al., 2005; Redfern et al., 2002). On the basis of instruments used generally in work-satisfaction research, the Nordic research team of the NORDCARE project included ten items of work satisfaction in the questionnaire with which respondents were asked to evaluate different issues of their work and working conditions using a four-point Likert scale.

1 In Norway this sample was later supplemented with 150 additional people because in the original sample, care workers working in home-based care were found to be under-represented.

2 These questions were:
  a. Do you find your tasks interesting and meaningful?
  b. Have you got too much to do in your job?
  c. Does your work present the opportunity to learn new things and to develop professionally?
  d. Can you affect the daily planning of your work?
  e. Does your boss provide you with sufficient information regarding changes in your workplace?
  f. Have you got enough time to discuss difficulties in your work with your colleagues?
  g. Do you get support in your work from your line manager?
  h. Are you provided with the training necessary for your work?
  i. Do you ever feel inadequate because the care recipients are not receiving the help you think is necessary?
The other section of the questionnaire that is vital for this paper comprised questions concerning the care workers’ experience of the occurrence of different market-based practices. These questions covered the separation of needs-assessments from provision and asked about the existence of quality-control systems, local for-profit providers, customer choice, and competitive tendering. The development of quality-assurance systems offers managers a new instrument to document and monitor efficiency continuously and to standardize and formalize service provisions (Højlund, 2001; Szébeheley, 2001) while the existence of for-profit providers is clearly a condition for the privatization of public-care provisions. The separation of needs-assessments from provision makes outsourcing possible. Customer choice and competitive tendering, for their part, are instruments of the privatization of care services.

The article analyses variations between the four Nordic countries as well as between different market-based practices by using cross-tabulations, measuring statistical significance with $\chi^2$ and $p$-values. In addition, Pearson’s correlations are used in order to grasp the connections between the adoption of different market-based models and the work satisfaction of care workers.

The article describes first the basic characteristics of the respondents, presenting the similarities and dissimilarities between the four Nordic countries. After that, the occurrences of different market-based models and care workers’ evaluations on their work conditions are reported, with a focus on whether there are differences in self-reported work satisfaction between employees of public and non-public employers. Finally, there is an analysis and presentation of the associations between, on the one hand, privatization and the adoption of market-inspired mechanisms and, on the other hand, the work satisfaction of care workers in the four countries. The article concludes with a discussion on the findings and possible implications for policy.

j. Do you worry about possible changes in your work situation due to reorganization, completely new work methods or the like?'

For each question, the same four response alternatives were given: ‘most often’, ‘sometimes’, ‘only rarely’, and ‘never’.

These questions were preceded by an introduction:

‘Recently, quite a few municipalities have reorganized the care for older and disabled persons. Some have initiated a purchaser-provider model where a special needs-assessment officer decides the amount and form of help provided for a person and orders the assistance from a municipal or private provider unit. Some municipalities have initiated customer-choice models, where the care user chooses the provider she/he would like to be assisted by. Here are some questions regarding the organization at your workplace.’

The questions were:

‘a. Is there a certain needs-assessment officer (situated outside your workplace) who decides the assistance provided for the care recipients?

b. Are there any private for-profit providers of care and services for older and disabled persons in the municipality where you work?

c. Has your workplace been exposed to competitive tendering (meaning that different private and public providers have competed for a contract)?

d. If they want to, is it possible for care users to switch to another provider unit without extra cost (the so-called customer-choice or voucher system)?

e. Is your workplace regularly measured by quality standards and/or compared to other workplaces in the local care sector?’

For each question, the same three response alternatives were given: ‘yes’, ‘no’, and ‘I don’t know’.
Results

The profile of Nordic care workers working with older people

To put it briefly, in all four Nordic countries care workers who provide care for older people are, in general, middle-aged women who are born in their country of residence, who have training in and extensive experience of care work, who are employed by the public sector, and who work primarily in residential settings (table 1). A more detailed look shows the variations between Denmark, Finland, Norway, and Sweden to be statistically significant. For example, according to the data, Sweden has clearly the youngest staff (33.7 per cent being under 40) and Norway the oldest (44.5 per cent being 50 or over). Sweden is also the country that has the largest share of men (4.0 per cent) and migrants (12.9 per cent) working in care for older people.

Table 1. Background data on Nordic care workers working with older people by country (%; $\chi^2$)

<table>
<thead>
<tr>
<th>Variables</th>
<th>All participants (n=2716)</th>
<th>Denmark (n=790)</th>
<th>Finland (n=654)</th>
<th>Norway (n=716)</th>
<th>Sweden (n=556)</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 40 years</td>
<td>28.3</td>
<td>26.5</td>
<td>29.5</td>
<td>25.1</td>
<td>33.7</td>
<td>16.6*</td>
</tr>
<tr>
<td>40-49 years</td>
<td>30.4</td>
<td>33.2</td>
<td>28.6</td>
<td>30.5</td>
<td>28.6</td>
<td></td>
</tr>
<tr>
<td>50 years or over</td>
<td>41.3</td>
<td>40.4</td>
<td>41.9</td>
<td>44.5</td>
<td>37.7</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>97.7</td>
<td>98.3</td>
<td>98.8</td>
<td>97.3</td>
<td>96.0</td>
<td>12.2**</td>
</tr>
<tr>
<td>Man</td>
<td>2.3</td>
<td>1.7</td>
<td>1.2</td>
<td>2.7</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td><strong>Birth place</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90.0***</td>
</tr>
<tr>
<td>Country of residence</td>
<td>94.7</td>
<td>95.8</td>
<td>99.1</td>
<td>95.3</td>
<td>87.1</td>
<td></td>
</tr>
<tr>
<td>Abroad</td>
<td>5.3</td>
<td>4.2</td>
<td>0.9</td>
<td>4.7</td>
<td>12.9</td>
<td></td>
</tr>
<tr>
<td><strong>Care work training</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>117.2***</td>
</tr>
<tr>
<td>Under 1 year</td>
<td>20.1</td>
<td>16.4</td>
<td>12.8</td>
<td>25.2</td>
<td>27.6</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td>43.7</td>
<td>53.8</td>
<td>37.9</td>
<td>39.6</td>
<td>41.6</td>
<td></td>
</tr>
<tr>
<td>2 years or over</td>
<td>36.1</td>
<td>29.8</td>
<td>49.3</td>
<td>35.2</td>
<td>30.8</td>
<td></td>
</tr>
<tr>
<td><strong>Care work experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10 years</td>
<td>30.8</td>
<td>32.7</td>
<td>33.1</td>
<td>24.1</td>
<td>33.9</td>
<td>22.4**</td>
</tr>
<tr>
<td>10-19 years</td>
<td>33.0</td>
<td>30.7</td>
<td>32.2</td>
<td>36.4</td>
<td>33.0</td>
<td></td>
</tr>
<tr>
<td>20 years or over</td>
<td>36.2</td>
<td>36.5</td>
<td>34.8</td>
<td>39.6</td>
<td>33.0</td>
<td></td>
</tr>
<tr>
<td><strong>Work settings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home-based settings</td>
<td>22.6</td>
<td>28.0</td>
<td>19.0</td>
<td>16.3</td>
<td>27.3</td>
<td></td>
</tr>
<tr>
<td>Residential settings</td>
<td>60.9</td>
<td>52.7</td>
<td>69.4</td>
<td>63.6</td>
<td>59.3</td>
<td>83.1***</td>
</tr>
<tr>
<td>Both settings</td>
<td>12.4</td>
<td>14.2</td>
<td>7.1</td>
<td>16.8</td>
<td>10.6</td>
<td></td>
</tr>
<tr>
<td>Other settings</td>
<td>4.0</td>
<td>5.1</td>
<td>4.5</td>
<td>3.3</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td><strong>Employer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>94.4</td>
<td>97.0</td>
<td>86.1</td>
<td>98.6</td>
<td>95.2</td>
<td></td>
</tr>
<tr>
<td>Non-profit</td>
<td>2.3</td>
<td>1.6</td>
<td>7.0</td>
<td>0.7</td>
<td>0.0</td>
<td>149.9***</td>
</tr>
<tr>
<td>For-profit</td>
<td>2.5</td>
<td>0.5</td>
<td>5.2</td>
<td>0.6</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.8</td>
<td>0.9</td>
<td>1.7</td>
<td>0.1</td>
<td>0.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: NORDCARE data

$p<0.05; \quad p<0.01; \quad p<0.001$
On the other hand, Finnish care workers have backgrounds of longer professional training (49.3 per cent having had training of at least two years) than their Nordic colleagues, and working in residential settings (including different forms of sheltered housing, in addition to traditional institutional care) is also most common in Finland (69.4 per cent). The largest variations between the four countries concern employers of care workers. Whereas, according to the data, non-public employers in care for older people are still very rare in Norway and Denmark, they are more common in other countries, particularly in Finland, which has the highest proportions of both non-profit (7.0 per cent) and for-profit (5.2 per cent) employers.

The adoption of market-based practices

Market-inspired instruments have been applied differently within care for older people in the Nordic region. The variation between the four countries is statistically significant for every single instrument (table 2). According to the data, customer choice and competitive tendering are still experienced by the minority of care workers, while quality-control mechanisms, the separation of needs-assessments, and the presence of for-profit providers affect the majority, that is, over 60 per cent of respondents.

Table 2. The adoption of market-based practices according to Nordic care workers by country (%; $\chi^2$)

<table>
<thead>
<tr>
<th>Variables</th>
<th>All participants (n=2716)</th>
<th>Denmark (n=790)</th>
<th>Finland (n=654)</th>
<th>Norway (n=716)</th>
<th>Sweden (n=556)</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality control (n=1499) Yes (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For-profit providers in municipality (n=2257)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (%)</td>
<td>68.3</td>
<td>82.5</td>
<td>65.7</td>
<td>61.2</td>
<td>59.9</td>
<td>58.3***</td>
</tr>
<tr>
<td>Separate needs assessments (n=2279) Yes (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60.7</td>
<td></td>
<td>83.5</td>
<td>29.2</td>
<td>42.1</td>
<td>77.7</td>
<td>501.7***</td>
</tr>
<tr>
<td>Customer choice (n=1619) Yes (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.9</td>
<td></td>
<td>69.8</td>
<td>30.6</td>
<td>12.7</td>
<td>13.3</td>
<td>418.9***</td>
</tr>
<tr>
<td>Competitive tendering (n=1990) Yes (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.5</td>
<td></td>
<td>44.4</td>
<td>22.2</td>
<td>4.9</td>
<td>16.6</td>
<td>271.4***</td>
</tr>
</tbody>
</table>

Source: NORDCARE data

*p<0.05; **p<0.01; ***p<0.001

Overall, market-based practices seem to be most widespread in Denmark, as it displays in the data the highest proportions of care workers who have experienced quality control (82.5 per cent), separation of needs-assessments (83.5 per cent), customer choice (69.8 per cent) as well as competitive...
tendering (44.4 per cent) in their workplaces. Finland has the highest prevalence of for-profit providers (86.2 per cent), while in Sweden the separation of needs-assessments from provision (77.7 per cent) is the most widely applied market-based practice. In Norway the frequency of each of these models remains below the all-Nordic level within the data. However, the number of missing values is exceptionally high for all of these five items. Concerning the existence of quality-control mechanisms and customer choice in the workplace, more than a third of respondents did not answer the question. It seems that for a large proportion of care workers, market-based models and their names were so unfamiliar that many had to leave these questions unanswered.

Work satisfaction of care workers

Has the privatization of care services affected work satisfaction of Nordic social- and health-care staff working with older people? This can be analysed most directly by comparing the responses of publicly employed care workers with those of other care workers. Is there a variation between care staff employed by public, non-profit, for-profit and other employers?

Table 3. Work satisfaction of Nordic care workers working with older people by employer (%; mean; \(\chi^2\))

<table>
<thead>
<tr>
<th>Variables</th>
<th>All participants (n=2642)</th>
<th>Public employer (n=2495)</th>
<th>Non-profit employer (n=61)</th>
<th>For-profit employer (n=65)</th>
<th>Other employer (n=21)</th>
<th>(\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work tasks interesting and meaningful (n=2669)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>77.5</td>
<td>77.8</td>
<td>83.3</td>
<td>63.1</td>
<td>76.2</td>
<td>10.6</td>
</tr>
<tr>
<td>Opportunity to develop professionally (n=2675)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>30.4</td>
<td>29.9</td>
<td>40.7</td>
<td>35.4</td>
<td>52.4</td>
<td>16.6</td>
</tr>
<tr>
<td>Opportunity to affect the daily planning of work (n=2673)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>43.8</td>
<td>43.7</td>
<td>45.9</td>
<td>46.2</td>
<td>47.6</td>
<td>15.3</td>
</tr>
<tr>
<td>Sufficient information on changes at workplace (n=2678)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>44.2</td>
<td>43.8</td>
<td>53.3</td>
<td>53.8</td>
<td>38.1</td>
<td>19.2*</td>
</tr>
<tr>
<td>Enough time to discuss with colleagues (n=2688)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>51.7</td>
<td>51.8</td>
<td>55.7</td>
<td>45.3</td>
<td>38.1</td>
<td>26.9**</td>
</tr>
<tr>
<td>Support from closest manager (n=2670)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>44.4</td>
<td>44.4</td>
<td>45.9</td>
<td>46.9</td>
<td>28.6</td>
<td>9.2</td>
</tr>
<tr>
<td>Access to in-service training (n=2616)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most often (%)</td>
<td>24.1</td>
<td>24.4</td>
<td>23.0</td>
<td>18.3</td>
<td>15.0</td>
<td>7.1</td>
</tr>
<tr>
<td>Work-satisfaction summary index(^a) (n=2507) (mean)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.7</td>
<td>22.7</td>
<td>23.1</td>
<td>21.8</td>
<td>21.6</td>
<td>88.4**</td>
<td></td>
</tr>
</tbody>
</table>

Source: NORDCARE data
\(^a\) Summary index was calculated by summing up the values of the seven above-mentioned items of work satisfaction where each item received a value from 1 to 4 (1='never'; 2='only rarely'; 3='sometimes'; 4='most often'); ranging from 7 = fully unsatisfied to 28 = fully satisfied
* \(p<0.05\); ** \(p<0.01\); *** \(p<0.001\)
The short answer to these questions is both yes and no. Concerning two items of work satisfaction, whether care workers receive sufficient information on changes in the workplace and whether there is enough time to discuss work problems with colleagues, there is statistically significant variation (table 3). However, the results are contradictory because care workers employed by for-profit organizations are less satisfied with their opportunities for collegial discussion compared with publicly employed staff, whereas they are the most satisfied employee group when it is the availability of information on workplace changes that is in question. Concerning the other five items of work satisfaction included in the analysis, there are no statistically significant variations between different kinds of employers. The number of cases in all non-publicly employed care-worker groups remained rather low, which weakens the analysis and its statistical significance.

Nevertheless, when a summary index of work satisfaction is constructed, statistically significant variation reappears. The highest average summary score of work satisfaction (23.1) is found among care workers employed by non-profit organizations, followed by public employees (22.7). Correspondingly, care workers employed by for-profit and other employers have on average the lowest total values of the work satisfaction summary index (21.8 and 21.6).

Connections between the adoption of market-based models and work satisfaction

Pearson’s correlations are used here to analyse the connections between work satisfaction and the adoption of different market-based practices within care services for older people. If these practices are detrimental to work satisfaction, those care workers who have experienced the adoption of these models in their workplace would be expected to have lower values for the summary index.

Correlation values are counted for the whole sample but also country by country so that it is possible to compare the results both between the four Nordic countries and between different market-based instruments. Three of the five instruments studied receive statistically significant correlations with work satisfaction within the whole sample. These are the introduction of quality control mechanisms (.214**), customer choice (.095**), and the presence of for-profit providers (.060**). What is remarkable is that each of these three correlations are positive, which means that the adoption of these market-based practices is connected with higher and not lower levels of work satisfaction. The only market-inspired model that receives a negative correlation with the work-satisfaction summary index within the all-Nordic sample is the separation of needs-assessments from service provision, but this correlation is not statistically significant.

4 The summary index displays a very satisfactory level of reliability (Cronbach α = 0.763). Out of the original ten work-satisfaction items of the questionnaire, three items (b, i, and j) were left out of the summary index – and out of table 2, as well – as they would have slightly weakened the reliability of the summary index.
Table 4. Correlations between the adoption of market-based practices and work satisfaction of Nordic care workers working with older people by country

<table>
<thead>
<tr>
<th>Variables</th>
<th>Denmark (n=741)</th>
<th>Finland (n=618)</th>
<th>Norway (n=626)</th>
<th>Sweden (n=522)</th>
<th>All participants (n=2507)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality control (n=1499)</td>
<td>r .092</td>
<td>.158&quot;</td>
<td>.343&quot;</td>
<td>.167'</td>
<td>.214&quot;</td>
</tr>
<tr>
<td>For-profit providers in municipality (n=2257)</td>
<td>r .003</td>
<td>.073</td>
<td>-.038</td>
<td>-.001</td>
<td>.060&quot;</td>
</tr>
<tr>
<td>Separate needs assessments (n=2279)</td>
<td>r -.066</td>
<td>.012</td>
<td>-.030</td>
<td>-.023</td>
<td>-.037</td>
</tr>
<tr>
<td>Customer choice (n=1619)</td>
<td>r .064</td>
<td>.116'</td>
<td>.062</td>
<td>-.092</td>
<td>.095&quot;</td>
</tr>
<tr>
<td>Competitive tendering (n=1990)</td>
<td>r -.063</td>
<td>.071</td>
<td>-.021</td>
<td>.033</td>
<td>.028</td>
</tr>
</tbody>
</table>

Source: NORDCARE data
a Pearson correlation value
b 0 = no; 1 = yes; ‘does not know’ marked as missing value
c Summary index ranging from 7 = fully unsatisfied to 28 = fully satisfied
‘p<0.05 ‘p<0.01 (2-tailed significance test)

Within national samples, there are four statistically significant correlations between work satisfaction of care workers and the presence of market-based practices. Each of the four correlations is positive, and three of them concern the adoption of quality-assurance mechanisms: in Norway (.343"), Finland (.158"), and Sweden (.167") the quality control of care services is correlated with higher levels of work satisfaction. Also the presence of customer choice has a positive correlation of statistical significance with the work-satisfaction summary index in the sample from Finland (.116*). There are also negative correlations between work satisfaction and the adoption of market-based practices in national samples (for example, concerning customer choice in Sweden: -.092), but none of these have statistical significance.

Discussion

The aim of this article has been to address the question of whether the recent adoption of market-based practices within Nordic care services for older people constitutes a risk for the work satisfaction of care workers. Earlier research discussion on the changing character of Nordic care service systems, juxtaposing the rationality of caring with the rationality of efficiency inherent in the NPM approach, suggests the existence of such a risk. As a way to find answers to this research question, the article has analysed comparative Nordic questionnaire data looking at whether there are
the data, individual market-inspired models could be connected with a higher level of work satisfaction in one country and with a lower level in another country. It is thus not only the model in itself but also the national context that is decisive. The four Nordic countries are clearly at different stages in adopting the new models, the extremes being Denmark, where all the studied market-based practices are already widely applied, and Norway, where most of these models are still experienced only by a minority of care workers working with older people. The national context structures the interaction between market-based models and work satisfaction, and results from the all-Nordic level cannot be used as a simple guideline for policy-making at the national level.

Finally, caution in making firm conclusions and policy recommendations is also needed because of some weaknesses of the data. The Nordic team that gathered the data aimed for the best possible comparability between countries, but having the questionnaire translated into four different languages in itself weakens the comparability. The terms used have different meanings in different languages, which cannot be avoided. The four Nordic countries are not identical: their cultures, occupational structures, and care service systems have their national characteristics and all these make full comparability of responses difficult to achieve. Furthermore, within the data there were only a few care workers who were employed by non-public employers, and the number of missing values in questions on the workplace presence of the market-based models was high. These weaknesses of the data call for extra caution in the interpretation of the findings.

All in all, it is not possible to make general policy recommendations for or against the adoption of market-based instruments on the basis of the results of this study. It is necessary for policymakers to remain sensitive to the national context, as this seems to have vital importance. It also seems that market-based instruments should not be perceived as one single package since the connections between individual instruments and work satisfaction of care workers are non-identical. Finally, it is necessary to remember that the work satisfaction of care workers is only one among numerous different indicators that could be used to evaluate the adoption of market-based models in Nordic care policies. Work strain, work-family balance, remuneration levels, and many other criteria could be used to analyse whether the adoption of market-based models represents a change for good or for bad for care workers. Moreover, care workers are certainly not the only group that is affected by changing care systems. In order to obtain a full picture, researchers should not forget to examine the implications of policy switches for care users and their family members.

References


