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Marketization in Swedish Eldercare

Implications for Users, Professionals, and the State

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ACTA
UNIVERSITATIS
UPSALIENSIS
UPPSALA
2017

ISSN 1652-9030
ISBN 978-91-554-9886-3
urn:nbn:se:uu:diva-319504

Dissertation presented at Uppsala University to be publicly examined in Brusewitzsalen, Statsvetenskapliga institutionen, Gamla Torget 6, Uppsala, Friday, 2 June 2017 at 10:15 for the degree of Doctor of Philosophy. The examination will be conducted in Swedish. Faculty examiner: Professor Stig Montin (Förvaltningshögskolan, Göteborgs Universitet).

Abstract

Moberg, L. 2017. Marketization in Swedish Eldercare. Implications for Users, Professionals, and the State. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Social Sciences* 142. 48 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-554-9886-3.

During the last decades, Swedish policy makers have implemented various marketization reforms into the public welfare sector in order to make it more cost-efficient and to improve its quality. The aim of this dissertation is to investigate what implications this marketization trend has had for the organization of Swedish eldercare. In particular, the research question addressed is how marketization reforms such as privatized provision, increased competition, and user choice have transformed the relationship between the service users, the professionals, and the state. To answer the research question, four articles are presented in the dissertation, each corresponding to a separate empirical investigation. Together, the articles demonstrate that the increased reliance on marketization in Swedish eldercare has made it more difficult for the local authorities to directly control the quality of the services, since it reduces their ability to allocate public resources and expects them to govern the provision of eldercare through the entering of contracts. This development has also implied that service users themselves become increasingly responsible for ensuring that the quality of their care is high. Moreover, the articles show that the increased reliance on audit by the national government and its agencies has tended to undermine the professionalization of eldercare staff, thereby limiting their autonomy and ability to ensure service quality. As a whole, the dissertation contributes with a more comprehensive understanding of how marketization has altered the organization of Swedish eldercare and under what conditions it might undermine the goals of social equality and ensuring that all citizens have equal access to good quality care.

Keywords: Marketization, Eldercare, Universalism, Social care, Privatized provision, User choice, Competition, Swedish welfare state

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ISSN 1652-9030

ISBN 978-91-554-9886-3

urn:nbn:se:uu:diva-319504 (<http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-319504>)

*To my parents
In memory of Ingrid and Evald*

List of Articles

This dissertation is based on the following articles, which are referred to in the text by their Roman numerals.

- I Moberg, L., Blomqvist, P. and Winblad, U. (2016) User choice in Swedish eldercare – conditions for informed choice and enhanced service quality. *Journal of European Social Policy*, 26(3): 281–295.*
- II Moberg, L. (2016) Marketisation of Nordic eldercare – is the model still universal? *Journal of Social Policy*, published online December 21, 2016. Doi: 10.1017/S0047279416000830.*
- III Moberg, L., Blomqvist, P. and Winblad, U. (2017) Professionalized through audit? Care workers and the new audit regime in Sweden. *Social Policy & Administration*, submitted.
- IV Moberg, L. (2017) User choice and the changing notion of social citizenship in Swedish eldercare. Working Paper, Department of Government, Uppsala University.

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Acknowledgement

When I first began my doctoral studies nearly six years ago, I had no clear idea of what life as a PhD Candidate would entail. If anything, I envisioned conducting research to be a rather solitary undertaking. As I am now trying to summarize my experiences from this long but exciting journey, it is clear that I was mistaken. Not only have I had the privilege of working with a vast collection of skilled researchers, I have also been lucky enough to enjoy the support of colleagues and friends to whom I wish to extend my deepest gratitude.

To my dear supervisors, Paula Blomqvist and Ulrika Winblad, thank you for your continuous support and inspirational guidance over the years. Even when I have been faced with doubt and frustration, you have had the ability to make me feel enthusiastic about my work. Your encouragement and critical eyes have significantly improved both my abilities and the quality of this dissertation. Your enthusiasm for scientific work is truly contagious and you have served as a huge source of inspiration for me in my own academic development. Thank you both so much!

Many others have also taken the time to read and comment on my work over the years. I would especially like to thank David Feltenius, Joakim Palme, Urban Strandberg, Marta Szebehely and Helena Wockelberg for their thorough review of the manuscript in its final stages. Your comments provided me with valuable guidance in the process of finishing this dissertation. I would also like to thank Shirin Ahlbäck Öberg, David Isaksson, Linn Kullberg, Karl-Oskar Lindgren, Anna Mankell, Fredrik Olsson, Johanna Söderström, Sofie Wengberg, PerOla Öberg and Marcus Österman for their constructive feedback on individual articles within this dissertation.

During my time as a PhD Candidate, I have had the privilege of being part of two excellent and stimulating research environments: the Department of Government and the Health Services Research group at the Department of Public Health and Caring Science. Although I have occasionally been absent from the Department of Government, especially in times of intensive writing, its friendly and generous atmosphere has always instilled in me a sense of belonging. Indeed, it is difficult to imagine a work place that better stimulates individual development whilst maintaining the values of unity and collegiality. For this, I would like to extend my gratitude to all colleagues at the Department of Government.

A few people at the Department deserve special mentioning. First, my peers from the 2011 cohort. Together we embarked on this journey as 13 research novices and your company and moral support has been invaluable to me during these years. Now, as we are all beginning to glimpse the finish line of our doctoral studies, we sure have some great parties to look forward to. I would also like to extend a special thank you to Karin Leijon for always supporting me in times of doubt and for reminding me of the importance of celebrating when things go well. All of the co-teachers at ‘Metod C’ also deserve special mentioning. Thank you for showing me that teaching is a pleasant part of being in the business of academia, especially when it is done in good company. Lastly, I would also like to thank Jenny Jansson and Per-Ola Öberg for planting the idea of pursuing doctoral studies in my mind. You might not know it, but I would not have been here today if it was not for your early encouragement.

A vital condition for getting through the PhD program is to be surrounded by people who can ease the sometimes frustrating aspects of dissertation writing. In my case, many of these people can be found in the Health Services Research group. I am so grateful for all the extended coffee breaks and baffling lunch discussions through which you have enriched my workdays. More than just providing me with great company, the Health Services Research group also constitutes an inspiring work environment. I have greatly benefitted from all of the different perspectives being shared and discussed. Our lunch seminars and research groups meetings have, in particular, helped broaden my perspectives on what good research can be.

I have also had the pleasure of spending six months working on my dissertation at Stanford University and at the Scandinavian Consortium for Organizational Research. For this opportunity, I am grateful to Thun’s Scholarship Fund and to the Borbos Erik Hansson Foundation for making my trip to Stanford possible. Thanks also to Lotta, who shared these months in Palo Alto with me, and to Kären and Martin for making our stay more homelike.

My lovely friends outside of academia have all been crucial for me during these years. To Tove, thank you for always caring and for asking me how I felt, rather than how my writing was going. Christoffer and Lotta, our trinity has been invaluable during these years. In your company, I can always expect to learn new things and there is never a subject too narrow or too small to twist and turn in endless discussions. Agnes, Anders, Anna, Maria and Rebecka, thank you for your friendship and for putting up with me during periods of hard work. You have all been more important for my well-being than you will ever know.

While my time as a PhD Candidate in most aspects has been a rewarding and fun experience, I would not have been able to finish this book if it was not for the support of my family. Anna and Jonas, thank you for your companionship in moments of joy, as well as of hardship. To my brothers and their families, thank you for providing me with necessary breaks from writ-

ing this dissertation. Emilia, Lovisa, Felicia, Astrid and Einar, I hope you will continue to approach life and all of its questions and challenges with the same curiosity as the one you have demonstrated this far. I would also like to thank my parents, Ellinor and Lars, for being such caring people and for always making me feel appreciated and cherished just by being myself. Dad, thank you for being a constant reminder that learning undoubtedly is a lifetime pleasure. Mom, your commitment and concern for others is an inspiration. Thank you for teaching me the importance of fighting for what is right. And then there is Pär, my life companion and best friend. I had the fortune of meeting you on my very first day at the PhD program and since then you have continuously supported and encouraged me. I am so happy to have you in my life and I cannot wait to see what our future together holds. I love you!

Linda Moberg
Uppsala, 4 April 2017

Introduction

The Swedish welfare state has attracted considerable attention in the welfare state literature. By creating a public system based on comprehensive flat-rate and income related benefits, social assistance, and pension programs, the Swedish welfare state was, as it emerged in the post-war era, designed to protect its citizens from income loss. In addition, Sweden also developed an extensive system for tax-funded and publicly provided social services, which was designed to cover all citizens regardless of their income or position on the labor market. The unique organizational features of the Swedish welfare state, often referred to as *universal*, have created a broad scholarly interest in its development and sustainability. After 1970, the model came under increasing pressure. Reforms and retrenchment during the 1990s made researchers ask whether the Swedish welfare state has been able to retain its universal features (Clayton and Pontusson, 1998; Lindbom, 2001, 2011; Bergh, 2004; Bergqvist and Lindbom, 2003). The general conclusion from this literature appears to be that while cuts in spending led to somewhat tightened eligibility criteria and marginal reductions of benefit levels, the system largely retained its universal features.

From an international perspective, one of the most characteristic features of the Swedish welfare state is its extensive coverage of social care services (Sipilä, 1997). In contrast to most other countries (outside of Scandinavia), this means that the public system for social services in Sweden not only includes health care and primary and secondary education, but also that all citizens have access to services such as eldercare and childcare (Anttonen et al., 2003; Sipilä, 1997; Daly and Lewis, 2000). Until the 1990s, the social service sector was organized virtually as a public monopoly, where the public sector not only funded but also provided the services through its own organization. This meant that the system offered very little choice to the citizens, who, regardless of income, social status, or cultural disposition were referred to public service providers in their area of residence (Blomqvist, 2004).

Despite the fact that most observers of the Swedish welfare state recognize the social service sector as one of its most characteristic elements, studies about its development and maintenance of universality have typically focused on retrenchment and reforms within the social insurance system (Bergh, 2004; Palme and Wennemo, 1997; Anderson, 2001). Moreover, when political scientists have paid attention to the development and potential

transformation of the social service sector, scholars have predominantly relied on quantitative measurements, like total spending, size of the public sector labor force, or degree of public funding (see, for instance, Clayton and Pontusson, 1998; Lindbom, 2001). During the last decades, however, the social service sector in Sweden has not been characterized by retrenchment as much as reform. In order to address criticism in the late 1980s and early 1990s that the virtually all-public system for social service provision created too little room for service diversity and user influence (Mellbourn, 1986; Gustafsson, 1994), the social policy agenda in Sweden became strongly influenced by the New Public Management movement, which resulted in an increased reliance on marketization in the form of privatization, increased competition and consumerism (Blomqvist, 2004; Green-Pedersen, 2002; Antman, 1994). Since marketization entails new institutional arrangements where economic incentives and the preferences of the service users should be more influential in the organization of public welfare, it represents a significant shift from how the Swedish system for social services developed after the second world war, where public provision and professional discretion were seen as the best means to ensure that all citizens had equal access to good quality services. This development has led to an increased scholarly interest in how marketization affects the organization and quality of the Swedish social service sector, and whether such reforms are compatible with universalism (Brennan et al., 2012; Blomqvist, 2016, Szebehely and Trydegård, 2012).

With this dissertation, I want to contribute to this discussion by studying what implications marketization has had for the organization of Swedish eldercare. Eldercare is one of the sectors in Sweden where the trend towards increased marketization has been particularly visible as several reforms aiming at privatization, enhanced competition and user choice of provider were implemented in the 1990s and the 2000s (Szebehely and Trydegård, 2012; Erlandsson et al., 2013; Stolt and Winblad 2009). Eldercare also constitutes an important sector to study because it actualizes the discussion about the potential benefits and drawbacks of increased privatization and user choice. Since the services often compromise most aspect of a person's living conditions, a free choice of provider could be seen as especially important for the preservation of personal autonomy (Moberg et al., 2016). On the other hand, studies have shown that choice entails an increased risk for inequalities in service outcome, where vulnerable users with little capacity to make an informed choice risk ending up with low quality providers (Eika, 2010; Fotaki, 2009; Meinow et al., 2011).

In order to study what implications marketization has had for the organization of Swedish eldercare, the dissertation asks how marketization in the form of privatized provision, increased competition, and user choice has transformed the relationship between eldercare users, professionals, and the state. The dissertation consists of four articles. In brief, they demonstrate that

the increased reliance on marketization in Swedish eldercare has circumscribed the regulatory power of local governments, the so-called municipalities, in several ways, such as supplementing direct steering with contractual governance and by transferring part of the responsibility for ensuring care quality to individual service users. Moreover, the articles also show that the increased reliance on audit by the national government and its agencies has tended to undermine the professionalization of eldercare staff, thereby limiting their autonomy and ability to ensure the quality of eldercare services. As a whole, the dissertation contributes to a more comprehensive understanding of how marketization has altered the organization of Swedish eldercare and under what conditions it might undermine the goals of social equality and ensuring that all citizens have equal access to good quality care.

This introduction proceeds as follows. In the forthcoming parts, the theoretical groundwork and contextual conditions of the dissertation are laid out. First, I introduce the relevance of studying social care within the field of political science and welfare state research. Thereafter, I describe how the Swedish system for social care was organized in the post-war era in order to uphold the value of universalism. In the following section, I turn to the theoretical assumptions underpinning the New Public Management movement and show how marketization has been introduced in Swedish eldercare. Having summarized the reforms for marketization, I discuss whether this development has the potential to alter the organizational logic of the Swedish eldercare sector and what implications it might have for the relationship between service users, professionals, and the state. In the results section, I present the most important findings from the four articles, as well as the design and method for each study. Then follows a section where I present my findings in relation to the overall research question. In the conclusions, I summarize the key results and discuss the potential empirical and theoretical contributions of this dissertation, followed by a short description of potential avenues for further research.

What is social care and why should we care?

The concept of social care was uncommon as an analytical category in the comparative welfare state literature until the 1990s. In their efforts to distinguish between different welfare regimes and explore their institutional logic, scholars tended to focus on the relationship between the state and the labor market or the social insurances, concentrating their analyses on the income security of wage earners in regular wage employment (Esping-Andersen, 1990; Korpi and Palme, 1998; Leibfried, 1993). It was mainly through the feminist turn in social policy research in the 1990s that social care became an analytical concept in welfare state research. An underlying trait of criticism in the feminist literature was that both the theoretical conceptualization

and the empirical analyses of welfare states focused on transfer systems and programs for cash-benefits, such as sickness and unemployment benefits and pensions, while neglecting to analyze the structure and function of social care services that are important to women (Anttonen, 2002; Abrahamson, 1997; Daly and Lewis, 2000; Sainsbury, 1996; Anttonen and Sipilä, 1996; Sipilä et al., 2003; Hernes, 1987).

Social care can be defined as the activities and the relations involved in meeting the physical and emotional needs of dependent adults and children (Daly and Lewis, 2000; Rostgaard, 2002; Esquivel, 2014; Gray and Heinsch, 2009). As such, the concept is often used to refer to services such as elder-care, childcare and care for the disabled (Anttonen and Sipilä, 1996). The feminist ambition to bring the concept of social care into the realm of welfare state research rested on the argument that the structures of care have important implications for women's life chances (Hernes, 1987; Sainsbury, 1996; Anttonen, 2002). In particular, it has been claimed that countries with comprehensive and public systems for child and eldercare, such as the Nordic ones, tend to be "women-friendly" (Hernes, 1987) since they strengthen women's labor market position and enable them to reconcile motherhood and wage labor (Borchorst and Siim, 2008; Sainsbury, 1996; Anttonen and Sipilä, 1996; Sipilä et al., 2003).

Although the feminist critique highlighted care as an analytic category in relation to welfare state research, it has been used rather selectively. As noted by Daly and Lewis (2000), there are two main strands that can be identified in the early care literature: a focus on interpersonal relations between receivers and recipients of care (e.g. Thomas, 1993; Graham, 1991; Lyonette and Yardley, 2003), and a comparison of the organization of social care work in different countries in order to identify distinctive care regimes (Alber, 1995; Sipilä, 1997; Anttonen and Sipilä, 1996). According to Daly and Lewis (2000), however, studies of the organization of social care have a wider analytic potential, not least when placed in the context of the restructuring and development of contemporary welfare states. By focusing on the macro-level of care, analyzing how the responsibility for providing and financing care is shared between the state, the market, the family, and the voluntary sector, the authors argue that we can deepen our understanding about variations in welfare states' commitment and to capture trajectories of change in contemporary welfare states (Daly and Lewis, 2000).

During the last decades, social care has gained an increased significance in contemporary welfare states' politics since nearly all post-industrial societies are confronted with new questions of how to structure the provision of care and support families with children and elderly that might need regular help (Anttonen et al., 2003; Ranci and Pavolini, 2013; Pavolini and Ranci, 2008). Because of demographic changes, foremost due to an ageing population, many countries face an increased need for social care. Moreover, changing norms about family and kin responsibilities, and the role of wom-

en, has transformed the conditions under which care traditionally has been carried out, increasing the demand for non-family provided care (Peng, 2002; Bettio and Plantenga, 2004; Anttonen et al., 2003; Hemerijck, 2013). At the same time, scholars have identified that financial factors and increased costs for social care have reduced many states' willingness or ability to meet these rising demands, implying that an enhanced responsibility for care has been placed on families, the voluntary sector, and the market (Daly and Lewis, 2000; Benería, 2008).

According to Daly and Lewis (2000), this 'crisis of care' in many countries may lead reformers not only to restructure the conditions for care but also alter the nature of social rights, such as by tightening the eligibility criteria and reducing the state's commitment to funding and providing care to its citizens. This concern has given rise to questions about how different welfare states have chosen to form the conditions under which care is carried out, and what role the state has had in affecting such conditions (Daly and Lewis, 2000; Pfau-Effinger, 2005; Hemerijck, 2013; Peng, 2002). In addition, the worldwide spread and impact of New Public Management as a means to renew the provision of welfare services in many countries has led to an increased interest in how new market based models for public governance have affected the structure of care in mature welfare states (Greve, 2009; Rostgaard, 2011; Anttonen and Häikiö, 2011; Vabø and Szebehely, 2012). In this dissertation, I wish to contribute to this discussion by studying how the introduction of marketization reforms has reorganized the provision of eldercare in Sweden.

Social care in Sweden: the quest for universalism

One of the most characteristic aspects of the Swedish welfare state is found in how it has organized the provision of social care services, making them an integrated part of its public sector for social services. In contrast to many other welfare states (outside of Scandinavia), Sweden set out to develop a comprehensive care sector, including services like eldercare and childcare, which also were made available to the middle and upper middle classes (Anttonen and Sipilä, 2012; Sipilä, 1997). This public responsibility for social care has made scholars describe Sweden, and the other Nordic welfare states, in terms of a developed 'care regime', or a 'social service state' (Rostgaard and Szebehely, 2012; Trydegård and Thorslund, 2010; Anttonen, 1990; Trydegård, 2000a).

The organization of social service provision in Sweden is typically described as universalistic (Rothstien, 1994; Anttonen, 2002). Unlike the principle of selectivism, universalism implies that public services should be designed to include all citizens, regardless of income and insurance, and, in practice, that they should be used by a large majority of the population

(Sipilä, 1997). By making the provision of care services a public rather than a private responsibility, the Swedish welfare state also extended the content of social rights, or citizenship, making access to services such as eldercare and childcare a citizenship right (cf. Marshall, 1950; Anttonen, 2002; Antman, 1996). This extension of social citizenship has been particularly important for women, since it has helped to strengthen their labor market position and enabled them to reconcile their roles as mothers, daughters, and workers (Borchorst and Siim, 2008; Sainsbury, 1996; Hernes, 1987).

The political idea behind including *all* citizens, rather than just low-income groups, in the public system for social care was not only based on the expectation that the legitimacy and the public support for the sector would increase, but also that the willingness among citizens to fund the services through income taxation would remain high (Rothstein, 1994). This required the services provided through the public sector to be of such high quality that no demands for alternative, market-provided, services would ensue among the better off (Olsson, 1990; Rothstein, 1994). This political logic implied that social care services should be public, both with regard to their funding and their provision, which led to the state taking on the role as provider (directly or through local authorities) of carefully planned services (Heidenheimer and Elvander, 1980; Antman, 1994, 1996). The Swedish pursuit of universalism thus came to have major impacts on what role the family, the public sector, and the market have played in the provision and funding of social care services. Not least important, the political commitment to ensure that services were provided to all citizens on equal conditions led to private service providers largely vanishing from the system after 1960 (Antman, 1994, 1996; Blomqvist, 2004).

Another distinctive principle behind the Swedish social care regime was local responsibility for service provision. Although the national government and the parliament always have been able to set the framework for these services through their legislative power, it was the local authorities that were made responsible for organizing social care services, such as eldercare and childcare. In practice, this meant that the 290 municipalities, operated by elected party representatives, took on a responsibility to fund the services through local taxes and to ensure their citizens access to quality care (Hort, 2014; Szebehely and Trydegård, 2012). However, the municipal responsibility to fund and provide care services has not implied that the national level has been unimportant in the regulation of care. Rather, through the means of national legislation and regulations, national control and guidance, and financial incentives, the national government has had considerable opportunity to influence and standardize the social care sector in Sweden (Meagher and Szebehely, 2013; Erlandsson, 2013).

The virtually all-public system for social care provision that developed in Sweden in the post-war era entailed, however, that very little choice for service users was offered; instead, users were portrayed as largely passive re-

ceivers of municipal care and were typically directed to a provider in their own area of residence (Blomqvist, 2004). During the 1980s, criticism against the system increased, questioning not least the lack of user influence and the manner under which the services were carried out (Gustafsson, 1994; Antman, 1994; Mellbourn, 1986). The criticism followed two main streams. First, it was argued that the system had grown economically inefficient and that the state should reduce its direct involvement in the provision of services. Second, it was claimed that the Swedish welfare state had grown autocratic and that the monopolistic provision of services violated citizens' right to self-determination in matters that affect their own well-being (Rothstein, 1994; Blomqvist and Rothstein, 2000; Antman, 1994). In response to this critical debate, policy makers from both sides of the political spectrum started to question whether there was no better way to organize the provision of welfare services, such as social care, making them more cost efficient and user oriented without abandoning the idea that the services should be available to all citizens on equal conditions (Blomqvist and Rothstein, 2000).

NPM and marketization in Swedish social policy

When the global reform trend of New Public Management (NPM) reached Sweden during the late 1980s and the early 1990s, it was welcomed by many policy makers who saw it as offering a solution to the inefficiency and lack of user influence perceived in the provision of welfare services, without threatening the idea of an extensive and publicly funded welfare system (Blomqvist, 2016; Blomqvist and Rothstein, 2000; Gingrich, 2011). The NPM movement is a broad and complex phenomenon with many different policy expressions. Common elements of this reform trend, which has affected policy-making in many industrial countries during the 1990s and the 2000s, include decentralization, de-regulation, separation of purchaser and provider functions, privatization of provision, enhanced quality control, and consumer choice (Clarke and Newman, 1997; Kjær, 2004; Hood, 1991). The basic ideas underpinning NPM are drawn from neoclassical economic and neo-liberal theories, building on the assumption that markets are inherently more effective in producing goods and services than the state, since markets are exposed to competition and economic incentives. In that sense, an increased reliance on NPM has often come to imply a reorganization of the public sector by offering new steering tools like privatization or marketization (Clarke and Newman, 1997; Savas, 2000).

The term *marketization* means that market mechanisms, such as competition, private provision, economic incentives and user choice, are implemented into the public sector in order to make it more economically efficient and to improve its quality (cf. Pierre, 1995; Brennan et al., 2012). Some of these ideas were early formulated and presented by Milton and Rose Friedman

(1980), who argued in favor of a privatized public sector where citizens should have the possibility to purchase services from the providers that they considered best suited to ensure their personal needs. Later, these ideas became forcefully articulated by Osborne and Gaebler (1992), who argued that the state should leave the provision of public services to market actors while retaining the role of funding and regulating them; hence 'steering, not rowing'. The intention with this type of governance arrangement, which also is known as quasi-markets, is that the state should stop being both the funder and the provider of services and limit its role mainly to funding and regulation (Le Grand and Bartlett, 1993).

When the ideas of NPM became widely practiced as a market based model for public governance of social services during the 1990s, two main organizational devices for introducing marketization could be identified; contracting out services and user choice of provider (Gilbert, 2002; Savas, 2000). *Contracting out* can be defined as a practice whereby the state and public agencies delegate the task of providing public services to independent organizations in exchange for financial rewards by entering into contractual agreements with them (Walsh et al., 1997; Domberger and Jensen, 1997; Brown et al., 2006). Typically, contracting out implies that there is an open competition among private (and frequently also public) service providers for public contracts, and that the contracting public agency selects the one bidder who gets authorized to provide the services in questions. The selection is made either on the basis of price or quality, or through a combination of both (Savas, 2000; Van Slyke, 2002).

User choice of provider, sometimes also referred to as 'vouchers', generally refers to an arrangement where all willing providers (private or public) that meet some essential requirements, are authorized by public authorities to provide a certain service in a specific geographic area. The users are thereafter given a real or fictive voucher for the service in question, which they can use to freely choose among the available providers. The providers will thereafter be reimbursed on the basis of how many users they attract, according to a pre-decided formula (Le Grand, 2007; Greener, 2008). User choice thus works as a market mechanism which serves to allocate resources between competing service providers and to give them signals about how users view the quality of their services. In that way, user choice can be seen both as enhancing competition, as well as a means to improve the quality of the services since the providers need to take into account the preferences of the people who use the services in order to attract more customers (Le Grand, 2009). In addition, user choice is also expected to empower the users in relation to both the providers and the state by providing them with purchasing power and an exit option if dissatisfied with the received service (Le Grand, 2007; Friedman and Friedman 1980).

One of the areas in which marketization through contracting out and user choice of provider has been most commonly practiced is the social service

sector (Gilbert, 2002). During the 1990s, Sweden became one of the countries where marketization became most influential in this sector (Taylor-Gooby, 2008; Blomqvist and Rothstein 2000). Especially after a non-Social Democratic government won the election in 1991, there was a strong political desire to widen the scope of user choice in the social service sector, and to open it up for private provision (Blomqvist, 2013; Millares, 2015). The first step in this direction was taken in 1992, when it became legal for local governments to contract out the provision of health care and social care services, such as eldercare and childcare to private actors, including for-profit firms (Government Bill, 1992). In the same year, the government also introduced a nationwide voucher system for the primary school sector, making it possible for parents and pupils to choose from a variety of public and private schools on the local school market (Government Bill, 1991). When the Social Democrats returned to office in 1994, the movement towards increased marketization continued (Green-Pedersen, 2002), and since then, Swedish policymakers have continued to gradually expand the opportunity for privatized provision and user choice in the welfare service sector (Blomqvist, 2013; Montin and Elander, 1995; Dahlberg et al., 2013; Winblad et al., 2015; Fredriksson, 2012; Hartman, 2011).

Marketization in Swedish eldercare

Marketization reforms have been especially salient in the Swedish eldercare sector (Szebehely and Trydegård, 2012; Erlandsson et al., 2013; Stolt et al., 2011; Stolt and Winblad, 2009; Gustafsson and Szebehely, 2009). Similar to all social care services in Sweden, the current system for eldercare is foremost a municipal responsibility where local authorities are legally responsible for financing the services through local income tax and for giving all residents over 65 years of age, regardless of income or prior employment, access to highly subsidized care services to meet their needs.¹ The care services come in two major forms: residential care and home-based services.

In the eldercare sector, the opportunities for user choice have traditionally been few and private alternatives to public provision highly marginalized. As late as 1993, only 2.5 per cent of all eldercare was provided by private (non-profit) organizations (Trydegård, 2001). In the same year, however, this situation began to change due to the enactment of the national reform for *increased competition in municipal services* (Government Bill, 1992). By allowing a separation of the purchaser and provider functions in Swedish eldercare, this legislative change enabled local governments to contract out the provision of social care services to private actors, including for-profit firms, through competitive tendering. The rules that apply for contracting out

¹ Aggregated, the user fees in Sweden cover approximately four to five per cent of the eldercare costs (Szebehely and Trydegård, 2012).

are stipulated in the Law on public procurement (*Lagen om offentlig upphandling*) and emphasize that when a municipality decides to contract out the provision of, for example, a residential home for the elderly, it cannot freely choose who the provider should be. Instead, it must allow for free competition by publishing a call for tender in which it specifies the type of service to be procured, quality requirements, and the selection criteria used in order to determine the winning bid (SFS 2016:1145). By allowing for contracting out the provision of care, the municipalities could thus decide to leave the previous system of direct administrative control, but retained the responsibility to fund and regulate the sector through contractual agreements, and to assess needs to determine eligibility for care (Government Bill, 1992). During the 1990s, interest in contracting out the provision of eldercare grew among Swedish municipalities. In 2001, 12 per cent of all residential eldercare was provided by private contractors, and eight per cent of the home-care services (Swedish Association for Local Authorities, 2004).

To contract out specific service tasks to independent providers constituted the most common form of marketization in Swedish eldercare up until 2006, when the Social Democratic government was replaced by a coalition government consisting of the Moderate party, the Liberal party, the Center party, and the Christian Democrats. During their time in office, which lasted from 2006 to 2014, the center-right government further deepened the marketization of Swedish eldercare by introducing user choice of provider (Government Bill, 2008). Following a decision in the Swedish parliament, the so-called Act on Free Choice Systems (*Lagen om valfrihetssystem*) became effective in January 2009, creating a legal framework through which local governments could implement user choice in their provision of eldercare. The prime objectives behind this reform were to make it easier for private providers to establish on the publicly funded care market, to enhance user choice and control, and to improve service quality (Government Bill, 2008).

The leading idea behind the Free Choice Act was that all private providers that meet the essential requirements, set out by the municipalities, should be authorized to provide eldercare within the municipality in exchange for public funding. The providers will thereafter be reimbursed based on the number of customers they attract, according to a locally decided and pre-set formula which also considers the extent of the users' need for care (Government Bill, 2008). In this way, the choice reform created a competition between public and private providers based not on price, but on quality and the preferences of the users. According to the Free Choice Act, public and private providers would thus be integrated into the same publicly regulated system, where they would be treated equally in terms of regulation, opportunities for users to choose between them, and the conditions for financial reimbursement from the local government. This also means that there is no difference in the fees paid by the users, regardless of whether they choose a private or a public provider (Government Bill, 2008).

It was not made mandatory for local governments to implement the Free Choice Act; rather, it was understood as an alternative to contracting out for those municipalities that wanted to purchase services from private providers (Government Bill, 2008). The interest in introducing user choice models, however, turned out to be large among the municipalities and in 2016, 158 of 290 municipalities had implemented the Free Choice Act in home-based eldercare, and 15 municipalities offered choice in their residential care for the elderly (SALAR, 2017). The reliance on user choice of provider has also further increased the share of private provision and in 2015, 21 per cent of all residential eldercare was privately provided, and 23 per cent of the home-care services (National Board of Health and Welfare, 2016). The number of private providers differs quite substantially between local authorities, ranging from just one or two in smaller municipalities up to 100 in larger cities like Stockholm (Szebehely, 2011; Moberg et al., 2016). In addition, the increase in privately provided eldercare in Sweden has foremost consisted of for-profit companies, whereas the share of non-profit providers has remained stable over time (Erlandsson et al., 2013).² Although the number of private companies that provide publicly funded eldercare has increased over time, the eldercare sector is still dominated by a few companies. In home-based eldercare, the four largest providers carry out approximately 40 per cent of all privately provided services. In residential care, the corresponding numbers amounts to 52 per cent (Bergman and Jordahl, 2014).

In the wake of NPM reforms such as contracting and user choice, many governments have also increased their reliance on means such as contractual monitoring and audit in order to ensure that providers comply with public regulations and that the quality of their services is high (Gendron et al., 2007; Lapsley, 2008; Hood et al., 1998; Romzek and Johnston, 2005). This tendency has also been seen with regard to Swedish eldercare. When local authorities increase their reliance on private provision, their ability to directly control and regulate the content and quality of eldercare services through in-house provision decreases. Instead, the municipalities' ability to control and regulate quality becomes more dependent on the contractual agreement entered between them and the private providers (Winblad et al., 2015). Moreover, in order to control that providers of publicly funded eldercare fulfill requirements stipulated in national and local regulations, there has also been an enhanced audit system through which public authorities have increased their control over providers in this area, for instance by asking pro-

² Official statistics do not specify whether private providers are for-profit or non-profit. To assess the extent of non-profit providers, one needs to rely on statistics that account for the number of employees in each type of organization. According to these statistics, the share of employees working in non-profit organizations has remained relatively stable since the early 1990s, only fluctuating between 2 and 4 per cent. In for-profit organizations, however, the share of employees increased from 0.5 per cent in 1993, to 16 per cent in 2010 (Szebehely, 2011; Trydegård, 2001).

viders to report their results on various quality and performance measures (Montin, 2015; Winblad et al., 2015; Johansson and Lindgren, 2013; Lindgren, 2014; Ek, 2012; Montin, 2016). As a result, new audit measures have been introduced both at the local and national levels of governance. At the national level, public agencies such as the National Board of Health and Welfare (*Socialstyrelsen*) and the Health and Social Care Inspectorate (*Inspektionen för vård och omsorg*), which was established in 2013, use national regulation, quality measurements and inspections on site as means to control the quality of Swedish elderly care services. Audit is also conducted on the local level. Although the municipalities have increased their reliance on audit during the last decades, studies have showed that there is often a lack of systematicity and continuity in how the local quality control is conducted (Winblad et al., forthcoming; Montin, 2016; Commission of Inquiry, 2013).

In sum, marketization reforms in Swedish eldercare have led to an increased reliance on private provision and the introduction of competition through contracting out and user choice. Politicians, however, has remained reluctant to fully privatize these services, i.e. to privatize not only the provision, but also the regulation and financing of services, as it would create an uneven access to services that are important for citizens' well-being and older individuals' ability to live a dignified life (cf. Blomqvist and Rothstein, 2000; Lundqvist, 2010). Instead, the aim behind marketization reforms has been to restructure the publicly funded eldercare sector. Repeatedly, reformers, such as the 2006 center-right coalition government, have argued that current marketization reforms do not challenge the objective of universalism in the system since services are still publicly funded and formally open to all citizens (Government Bill, 2008). Even so, it is apparent that the marketization reforms involve a significant reorientation of the Swedish system for providing eldercare services.

Towards a new organizational logic in eldercare: new roles of users, professionals and the state?

When Social Democratic reformers in Sweden started to expand and modernize the public system for eldercare provision in the post-war era, the sector gradually became a near public monopoly of tax-funded and publicly provided services. As noted above, the strong reliance on public provision was based on the idea that only by providing the services itself could the state guarantee access to high quality services for all citizens (Antman, 1996; Szebehely, 2011; Trydegård, 2000a). In eldercare, like other social services, this meant that the municipalities were given the role as providers of eldercare services. Moreover, they enjoyed considerable freedom to, within na-

tional legislative limits, organize their provision of care and decide how resources should be distributed between different eldercare services (such as home-based and residential care) and in different areas of the municipality.

This way of organizing eldercare prevailed up until the late 1980s and the early 1990s, when the municipalities still provided virtually all formal eldercare directly through their own organizations. Since the local authorities governed the content and quality of eldercare directly through in-house provision, systematic quality control through measurement of performance was not common during the 1980s (cf. Montin, 2015). This also applied to national agencies such as the National Board for Health and Welfare, which rarely measured the service systematically through performance indicators (cf. Montin, 2015; Government Bill, 1988). Rather, the National Board for Health and Welfare regulated the eldercare sector by issuing national regulations, supervising its structural components, and controlling that citizens had access to care regardless of where in the country they lived (Government Bill, 1979a). Moreover, it was not until the late 1980s that the agency was proposed to adapt national quality and efficiency measurements as a means to improve its supervision of eldercare (Governmental Bill, 1988).

For eldercare professionals, this implied that their work performance was rarely audited or controlled in a more detailed way. Rather, research has shown that the relatively low degree of detailed regulation regarding *how* the services should be carried out gave care workers considerable discretion to adapt and personalize eldercare services based on the individual needs of the service users (Szebehely and Meagher, forthcoming; Vabø and Szebehely, 2012; Dahl, 2004). Furthermore, the development of modern Swedish eldercare has also been guided by the policy goal that services should be professionalized and preferably provided by workers who had formal training in the field. These demands, however, were seldom realized in practice (Antman, 1996). Although the aspiration for education became apparent at a rather early stage in the institution or residential care of elderly, the workforce in the home-care sector, as it started to expand after the 1950s, often consisted of untrained and part-time staff (Trydegård, 2000a, 2000b; Korpi 1995).

Taken together, it can be argued that the organizational logic behind the Swedish eldercare sector was, up until 1990, based on the assumption that public regulation and provision, in combination with trust in the discretion of eldercare workers, were the best means to ensure that eldercare services of high quality were available to all citizens in need of them. In this light, the introduction of marketization reforms marks a turning point in the organization and governance structures of Swedish eldercare. Although the system is still based on tax-funding and offers all eligible citizens access to care services, the provision of care has been partially privatized and the organizational logic of the system has become increasingly based on the ideas of competition and consumerism. As such, the increased reliance on marketiza-

tion in this sector implies that the users should have a more active role in the governance of the eldercare sector and that their choices to a greater extent should steer the quality of the services. Given the way in which the Swedish eldercare sector was organized up until the early 1990s, this development gives rise to questions regarding what new organizational structures the increased reliance on marketization actually has created and what it has implied for the ability to ensure that all citizens have equal access to quality care.

Analyzing organizational changes due to marketization

One way to study what implications marketization has had for the organization of Swedish eldercare is to use Eliot Freidson's (2001) typology over three different organizational logics through which the governance of social services can be structured: the bureaucratic logic, the market logic, and professional logic. First, the bureaucratic logic refers to a system in which the production and distribution of services are planned and regulated through the administration of large organizations, typically the state and its public agencies (Freidson, 2001: 1). According to Freidson, the bureaucratic logic is based on the idea that standardized planning and political regulation can invoke service quality and efficiency through an elaborate set of rules and objectives (Freidson, 2001: 8, 115). Second, the market logic implies that it should be up to market mechanisms, such as consumer preferences and the forces of demand and supply, to decide which services should be produced and how. According to Freidson, this logic is based on the assumption that free and unregulated competition in the market sphere will encourage innovation and increase the quality of services (Freidson, 2001: 1). Moreover, the market logic is organized around the principle of consumption, implying that the preferences of the consumers should determine what services will withstand the competition and remain available in the market (Freidson, 2001: 3). Last, the professional logic advocates occupational rather than consumer or bureaucratic control. According to Freidson, this implies that it is the professional workers in an area who have the knowledge required to provide a certain service; and it is thus this group who should have the main power, or autonomy, to organize and control the system by deciding which services are provided (Freidson, 2001: 1). The professional logic also suggests that only those who are members of an occupation, or profession, are capable of evaluating the quality of the services they provide, meaning that they also should have the autonomy to decide *how* these services should be carried out (Freidson, 2001: 2).

Freidson notes that none of the three logics can be claimed to perfectly mirror the empirical world. Rather they should be understood as distinct ideal types, implying that they, albeit to different degrees, can co-exist in the same system, and perhaps even amplify one another (Freidson, 2001: 2f).

However, he also stresses that since the organizational logics are built on quite different theoretical assumptions and mechanisms for steering and quality assurance, they might also *conflict* with one another, implying, for example, that an excessive reliance on the bureaucratic logic might undermine the scope for professional and consumer control or vice versa (see Figure 1 for a schematic summary of Freidson’s model). By adopting Freidson’s model, it thus becomes possible to study how an increased reliance on marketization affects the organization of social services by analyzing how it alters the relationship between the bureaucratic logic, the market logic, and the professional logic. Since the three logics are built on different mechanisms for how to regulate and improve the quality of social services, the model also enables an analysis about how it is expected that quality should be upheld.

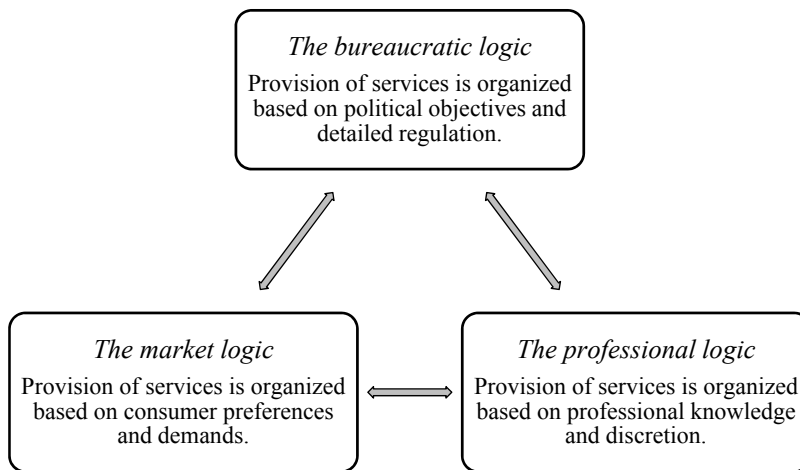


Figure 1: The three organizational logics.

Following Freidson’s typology, it can be argued that the previous system for Swedish eldercare, prior to 1990, was organized mainly according to the bureaucratic and the professional logic, relying on a combination of public regulation and professional discretion. By introducing marketization, however, the sector has come to rely more on the market logic in the sense that the wishes and demands of the service users should have more impact when steering the supply and quality of publicly funded eldercare. In contrast to Freidson’s ideal type model, however, this development in Sweden has not entailed a full-scale adaptation to the market logic since providers do not compete for customers in an unregulated market. Rather, it has been characterized by a market orientation, where the values of competition and consumerism have become more prominent in a system which is still publicly regulated and funded and where the main bulk of services are still provided

by the public sector. The question that emerges, thus, is what this new “market logic” in Swedish eldercare actually entails and what it has come to mean for the relationships between service users, the state (locally and nationally) and the professionals when it comes to organizing the provision of care and ensuring the quality of the services provided.

Aim and research questions

The general aim of this dissertation is to investigate what implications marketization has had for the organization of Swedish eldercare. The overarching research question in this dissertation is, thus, *how marketization reforms such as privatized provision, increased competition, and user choice have transformed the relationship between service users, professionals, and the state in Swedish eldercare?* To answer this research question, three more specific questions are posed:

1. What new role have users been given in the reformed Swedish eldercare system?
2. What is the new role of the state? How is it expected to act in order to regulate the sector and ensure that citizens have equal access to good quality care?
3. What is the new role of professionals within the sector? Do they retain their ability to ensure service quality?

In order to answer the research questions formulated above, four research articles are presented, each corresponding to a separate empirical investigation. Together, the articles shed light on how marketization policies alter the role and responsibilities of the service users, care professionals, and the state. As such they help us understand the intricate processes through which marketization policies during the 1990s and the 2000s have transformed the relationship between different actors in the eldercare system and re-allocated power between them. In the following section I present the articles and their findings in more detail.

Presenting the articles: aims, methods and key findings

Article I: User choice in Swedish eldercare – conditions for informed choice and enhanced service quality³

An often highlighted condition for user choice to have quality enhancing effects is that the users make informed choices (Baxter et al., 2008; Hibbard and Peters, 2003). By informed choice, it is implied that users both have access to relevant information about quality differences between the providers, and that they actually make their choices based on this information (Dixon et al., 2010). The aim of this article, entitled *User choice in Swedish eldercare – conditions for informed choice and enhanced service quality*, was to investigate the preconditions for user choice to enhance service quality by studying whether users of home-based eldercare in Sweden are able to make an informed choice of care provider.

Through the method of content analysis (Hsieh and Shannon, 2005; Krippendorff, 2004) the article analyzed information regarding 223 home care providers in ten Swedish municipalities, assessing its content and design. The included municipalities can be seen as most likely cases in that they all had a relatively long experience of user choice in the area of home-based eldercare, indicating a political commitment to the idea of user choice. Following the logic of a most likely case selection, this implies that if the information in these municipalities did not enable users to make informed choices, it is likely that these findings also hold for other local authorities in Sweden (Flyvbjerg, 2006). In order to examine whether the content of the information provided necessary conditions for making informed choices, an analytical framework was constructed based on four central dimensions for eldercare quality: staff competence, staff continuity, user influence, and user satisfaction. The design of the information was assessed through three criteria: its accessibility, its reliability, and whether the information was tailored to the specific needs of the users. Taken together, the analytical framework consisted of 22 indicators, 14 relating to the content of the information, and eight relating to its design.

The findings in the article demonstrated that the information about providers made available to the elderly home-care users was poor and that it could not be said to enable them to make informed choices. Out of the 14 quality indicators examined, there were only two on which any substantive information was offered: the language spoken by the staff and whether users would be given a contact person. The design of the information was considered accessible and reliable in most cases, but not crafted in such a way that

³ This article was co-authored by Linda Moberg, Paula Blomqvist, and Ulrika Winblad. The three authors framed the research question and planned the article together. The empirical research and the drafting of the article were done by main author Linda Moberg. All three authors critically revised the paper before it was published.

it was possible for the elderly users to make systematic comparisons between the providers. Taken together, these results indicated that users of home-based eldercare did not have access to information about qualitative differences between the providers. The poor quality of the information provided to the elderly indicated, moreover, that their choices were not likely to contribute to a general improvement in the quality of home-based eldercare in Sweden.

Article II: Marketisation of Nordic eldercare – is the model still universal?

The objective of the second article, *Marketisation of Nordic eldercare – is the model still universal*, was to analyze whether, and if so how, the marketization reforms that have been undertaken in recent decades have challenged the universality of eldercare in Sweden, Denmark, Finland, and Norway. The study focused on national reforms for contracting out and user choice of provider, analyzing their implications for four universalistic dimensions: (i) equal inclusion based on needs; (ii) public funding, potentially combined with subsidized user fees; (iii) public provision; and (iv) comprehensive usage, meaning that a majority of the citizens use the public system rather than turning to the private market.

To answer whether contracting out and user choice of provider has challenged the universality of eldercare, marketization reforms enacted between 1990 and 2015 in Sweden, Denmark, Finland, and Norway was analyzed through a comparative case analysis (Brady and Collier, 2010). The empirical materials consisted of political steering documents such as government bills and legislative acts, complemented by policy evaluations and previous research to gain a more thorough understanding of the reform effects in each country. After presenting a detailed description of the enacted marketization reforms and their policy outcomes in each country, their development was compared based on the four dimensions of universalism. The findings in the article suggest that marketization has challenged the universality of eldercare in at least three of the four countries: Sweden, Denmark, and Finland. Through marketization, these countries have extended their reliance on private provision. Furthermore, the introduction of user choice has enabled users of home-based care in all three countries to top-up their publicly funded care by purchasing so-called additional services. This means that users with economic resources can turn to the private market to top-up the comprehensiveness and quality of their publicly granted care. By introducing marketization, Sweden, Denmark, and Finland have undermined the universalistic character of their eldercare systems, especially the home-care sector, in two dimensions of the concept: public provision and comprehensive usage. On the other hand, the analysis showed that the dimensions of equal

inclusion and public funding have remained relatively unaffected by the introduction of marketization, indicating that the most fundamental principles of universalism remain intact in the three countries. In Norway, the marketization trend has been less salient than in the other Nordic countries, and their eldercare system has generally remained more in line with the definition of universalism. Compared to Sweden, Denmark, and Finland, there are still very few private providers in Norway, and private markets for eldercare services are less developed.

Article III: Professionalized through audit? Care workers and the new audit regime in Sweden⁴

The aim of the third article, *Professionalized through audit? Care workers and the new audit regime in Sweden*, was to investigate whether the national audit processes adopted in Swedish eldercare and childcare support or undermine the professionalization of the occupations working in these sectors, that is, nurses, nursing assistants, pre-school teachers, and child minders. In previous research, it has been shown that increased audit tends to de-professionalize welfare professions such as doctors and teachers (Jespersen and Wrede, 2009; Taylor, 2007; Evetts, 2009). In particular the study asked whether the three main forms of audit, standard-setting, inspections, and quality measurements, tended to support or undermine the occupations' ability to achieve professional closure and enhance their external and internal autonomy.

To answer this question the method of deductive content analysis was used (Potter and Levine-Donnerstein, 1999). Documents containing the national regulations, inspection protocols, and statistical reports of the quality measurements utilized by the national audit agencies were analyzed. The findings showed that the national audit processes appeared non-supportive of professionalization in the eldercare sector but supportive of it in the childcare sector, particularly for pre-school teachers. In eldercare, audit practices tended to obscure the specific competence of trained nurses and nursing assistants, as stipulated routines to secure quality tended to be generic and not mention staff skills. Moreover, the responsibility to develop quality was typically held by someone in addition to the onsite staff, such as the municipality or the firms that run the private providers. In the childcare sector, in contrast, the responsibilities of pre-school teachers and child minders were clearly specified and the meaning of 'quality' was defined in a way that served to highlight the professional knowledge of these groups. These find-

⁴ This article was co-authored by Linda Moberg, Paula Blomqvist, and Ulrika Winblad. The three authors framed the research question and planned the article together. The empirical research and the drafting of the article were carried out by main author Linda Moberg. All authors critically revised the paper before it was submitted for peer-review.

ings suggested that audit processes do not have to be detrimental to professionalization. Instead, it appears that the state can design them in such a way that they make visible the competence of care workers, and close the work tasks of specific staff groups, and thereby support, rather than undermine, their professional development.

Article IV: User choice and the changing notion of social citizenship in Swedish eldercare

In the fourth article, *User choice and the changing notion of social citizenship in Swedish eldercare*, the aim was to analyze how the center-right coalition government that introduced the choice reform reasoned with regard to the alleged tension between increased user choice and citizens' equal right to high quality care. In order to clarify the content of the arguments put forward by the policy makers, and to illuminate the principles on which these arguments rested, the analysis was conducted through the method of qualitative text analysis (Kuckartz, 2014), and structured around three main dimensions: (i) what role did the Swedish choice reform assign to the users and how did the policy makers view their ability to make an informed choice; (ii) how did the policymakers view the role and responsibility of the local authorities and which tools were they given to ensure equivalent and quality eldercare for all citizens; and last (iii) did the new policies entail a new form of social citizenship for older people?

The main empirical materials used to answer these questions consisted of the government bill that presented the 2009 choice reform, i.e. the Act on Free Choice Systems (Government Bill, 2008) and the Act itself (SFS 2008:962). The content of the social citizenship that existed prior to the Free Choice Act was in large measure constructed by the Social Service Act (SFS 2001:453), the main framework legislation that underpins all social care services in Sweden. To address the question of what implications user choice has had for the social citizenship of the elderly in Sweden, the Free Choice Act was contrasted with the Swedish Social Service Act (SFS 2001:453). To analyze the underlying values of the Social Service Act, which was first introduced in 1982 and amended in 2001, the study also drew on the government bill introducing it (Government Bill, 1979b).

The findings showed that the Free Choice Act aimed to provide eldercare users with a new and more active role, especially with regard to ensuring service quality through their choices. By creating a system where service users in effect would allocate resources between competing providers through their choices, the policy makers provided care users with the responsibility to not only choose a provider that could meet their individual preferences, but also to improve the service quality within the system at large. It was also demonstrated in the article that the choice reform would limit the

regulatory capacity of local authorities who decided to introduce the Free Choice Act, as it confined their control over resource allocation. Although the municipalities remained formally responsible to ensure citizens' access to good quality eldercare, the Free Choice Act also stipulated that their ability to do so would be restricted to formulating establishment requirements, entering into contractual agreements, and retrospectively monitoring that these agreements have been met. With regard to the citizenship of older people, the paper argued that the Swedish choice reform entails a more libertarian notion of social citizenship than the Social Service Act, suggesting that users are to take on greater responsibility for their own well-being and protection against social risks.

The implications of marketization for users, professionals and the state

In this introduction, I have argued that we can understand what implications marketization has had for the organization of Swedish eldercare by analyzing how privatized provision, increased competition, and user choice have transformed the relationship between service users, professionals, and the state. In the following section, the most important overall findings of this dissertation with regard to this question are presented.

The new role of eldercare users: an increased responsibility for service quality

Prior to the introduction of marketization, the service users had a rather passive role in the organization of Swedish eldercare, generally acting as receivers of public care without any right to leave a provider if dissatisfied with the service. In order to assess whether this role of the users has altered due to marketization, and, if so, what the new role entails, it is important to distinguish between marketization through contracting out and marketization through user choice of provider.

When the first marketization reform was introduced in the eldercare sector in the early 1990s it enabled municipalities to create competition between providers by contracting out the provision of both home-based and residential care. As shown in Article II, however, this reform did not change the fact that users typically were directed to a provider appointed by the municipality, implying that the choices of the elderly themselves in practice were still limited (cf. Jordahl and Öhrvall, 2013; Stolt and Winblad, 2009). This situation changed in 2009 due to the enactment of the Act on Free Choice Systems. As shown in Articles I, II, and IV, this reform changed the role of the eldercare users, as it gave them the opportunity to choose their provider

freely. In addition, it is the choices of the users which thereafter are used to reimburse the providers. As demonstrated in Article II and Article IV, this implies that the Free Choice Act, which has been implemented in home-based eldercare in about half of all Swedish municipalities, transferred distributive power from the local authorities to the users, who are expected to use their right to choose as a means to reward the providers they perceive as the best.

When Swedish eldercare users were given this role to allocate resources among competing providers, it was, as demonstrated in Article IV, expected that their choices would help improve the quality of the services. Since providers must attract customers to increase their revenues, increased consumer power on behalf of the users was expected to make the providers improve their quality in order to withstand the competition. Moreover, Article IV showed that providers are expected to respond to the risk of losing customers by tailoring their services to the needs and preferences of the eldercare users. For the system to have this kind of quality enhancing effects, however, users must make rational and informed choices, requiring that they collect and weigh quality information about the different alternatives before they make their choice of provider. As demonstrated in Articles I and IV, it is in practice not always possible for them to do so.

Taken together, findings in the articles have shown that marketization in the form of user choice has altered the role of eldercare users in two ways. First, it transferred the right to allocate public resources among the providers from the municipalities to the individual users (Articles II and IV). Second, by using their right to make choices between competing providers, the users were expected to reward the best performing providers and thereby increase the overall quality within the system (Articles I and IV). In this sense, the Free Choice Act did not only alter the role of eldercare users by inducing them to make active choices, but it also made them, at least indirectly, responsible for ensuring and developing service quality (Article IV).

The new role of the state: weakened municipalities but increased reliance on national audit

In order to address what implications marketization has had for the role and responsibility of the state, it is important to focus both on how it has affected local authorities as well as the nation level of government. With regard to local authorities, the articles in this dissertation have shown that marketization, especially through an increased reliance on user choice, has altered their role in two ways. First, Article II and Article IV demonstrated that the most prominent way in which marketization altered the role of local authorities was that it enabled them to act as contractors of privately provided care. For the municipalities that choose to privatize their provision of care, this

implies that their main tool to govern the private eldercare sector and secure service quality is through the process of public procurement and the entering of contracts with authorized providers (Articles II and IV). However, whereas the 1992 contracting out reform enabled the municipalities to enter into contract only with the provider that won a specific procurement, the Free Choice Act has had a more profound impact on the regulatory role of the municipalities that decided to implement it. As demonstrated in Articles I, II, and IV, the Free Choice Act made the local authorities obliged to authorize *all* willing providers that meet the pre-identified establishment requirements. Taken together, the marketization reforms have thus altered the regulatory powers of local governments in that they are more often dependent on formulating contracts in order to control the provision and quality of eldercare services. According to Article IV, this increased focus on contractual regulation has also affected the role of the municipalities in that it makes them responsible for evaluating and monitoring whether providers comply with the contractual agreements.

Second, the studies in this dissertation also showed that marketization in the form of user choice alters the role of municipalities by making them responsible for providing accurate information about the available service alternatives (Article I and Article IV). As noted by Baxter et al. (2008) and Hibbard and Peters (2003) access to such information is regarded as a prerequisite for user choice to have quality enhancing effects (for an overview of this literature see Winblad et al., 2011). However, when it was investigated in Article I whether the municipalities had adhered to their new responsibility, the results showed that the municipalities did not in fact provide relevant information about the available providers. In particular, it proved impossible to get information about the qualitative differences. This implies that while the 2009 choice reform created a system where users are encouraged to use their choice as a means to increase the quality within the system, they most likely lack access to information that could enable such choices.

With regard to the national level, Article III demonstrated that the government and its agencies have increased their reliance on systematic audit as a means to ensure that eldercare providers meet the basic quality demands that are stipulated in national regulations and legislation. An increased reliance on audit can be seen as connected to marketization reforms as these imply a deregulation of care-provision and thus require that the state finds new means to coordinate and steer the services (cf. Lapsley, 2008; Montin, 2015). Moreover, the development towards increased national audit in Swedish eldercare should be seen in relation to an overall trend of intensified performance scrutiny by which the national government has increased its control over municipal responsibilities through supervision, inspections, quality standards, and quality measurements (Montin, 2016; The Swedish Agency for Public Management, 2016).

Taken together, this dissertation has shown that marketization has not affected the formal responsibility of the municipalities to organize eldercare and ensure that all citizens have access to high quality care. However, for municipalities that choose to increase their reliance on private provision and user choice, they have to rely on partly new steering tools. Rather than to directly steer the sector through resource allocation and in-house provision, municipalities now increasingly regulate the content of care and monitor the outcome of eldercare services through contracts. While the regulatory role of the local government has been altered through increased marketization, Article III also indicates that a more active role has been adopted by the national state in the eldercare sector.

A changing role for eldercare professionals?

It is not only the roles of the service users and the state that have been altered by the introduction of marketization in Swedish eldercare; it has also had implications for the professionals and their ability to ensure the quality of services. As noted by scholars such as Sehested (2006) and Evetts (2009), the trend of New Public Management and marketization have served to weaken the status of various welfare professionals since it tends to result in an increased focus on audit, meaning that public agencies control that providers (both public and private) of publicly funded services fulfill binding requirements and stipulated objectives. Arguments presented in favor of this de-professionalization thesis claim that auditing challenges the autonomy and discretion of welfare professions due to an increased reliance on external regulation and enhanced performance control which makes it difficult for the professionals to organize their own work and define the meaning of a job well done (Evetts, 2009, 2011; Ahlbäck Öberg et al., 2016).

As noted above, the reliance on audit has also increased in Swedish eldercare. Especially at the national level, public agencies such as the National Board for Health and Welfare and the Health and Social Care Inspectorate have come to increase their reliance on national standard setting, onsite inspection and various quality measurements in order to ensure that service providers comply with national regulations and quality demands (Article III). As argued in Article III, there are three ways in which the national audit process has the potential to weaken the ability of eldercare professionals to use their own professional knowledge to promote quality in eldercare. First, the quality goals in this sector are described by national regulators in such a way that the skills and competence of the staff is given very little role; instead, reliance is placed with routines that should be developed by the municipalities. Second, the responsibility for quality development is foremost placed with the local authorities and the firms that run the private providers, rather than with the on-site staff itself. Last, user satisfaction is generally given heavy weight when the state assesses the quality of services.

In sum, these findings indicate that the autonomy of the staff in the eldercare sector has been limited by the national audit process since this undermines their ability to decide independently how their work should be carried out and how good service quality should be defined. Moreover, the findings in the dissertation suggest that the audit process tends to place the responsibility for ensuring and developing eldercare quality with someone other than the on-site staff, such as the municipality or private providers. Taken together, this means that the audit process not only makes invisible the role of the eldercare professionals, but also that it limits the staff's own ability to ensure and promote service quality.

Conclusions

The overall aim of this dissertation has been to investigate what implications marketization has had for the organization of Swedish eldercare. In particular, it has asked how marketization, in the form of privatized provision, increased competition, and user choice, has transformed the relationship between service users, professionals, and the state. Taken together, the findings from the four articles in this dissertation showed that marketization, especially in the form of user choice of provider, has altered the relationship between eldercare users, professionals, and the state quite substantially. With regard to the service users, the Free Choice Act provided them with a new and more active role, according to which they have become responsible not only to choose a provider that can meet their own individual preferences, but also to choose so wisely that the overall quality within the sector increases. At the same time, the findings in the dissertation indicate that users most likely lack access to information that can enable them to make active and informed choices of provider. In addition, previous research has shown that the same frailty and dependency that creates the need for care may limit consumer sovereignty, implying that eldercare users often lack the ability to find and evaluate information on their own (Meinow et al., 2011; Eika, 2009, 2010). Taken together, these findings indicate that not even the most basic premises for the expected positive effects of user choice are fulfilled in the Swedish case. First, in the moment of making a choice, it is uncertain whether the preferences of the users themselves will be met. Second, if the users do not have access to information regarding the quality of available providers when choosing, the allocation of resources will not necessarily favor high-quality providers, which means that user choice is unlikely to promote the goal of quality enhancement in the system at large.

Secondly, the overall findings in the dissertation suggest that the regulatory power of the local authorities has altered due to privatization and user choice since these changes have reduced their ability to allocate public resources and to steer the sector through direct provision of care, especially

with regard to home-care services. Instead, municipalities are increasingly expected to govern the provision of eldercare through the entering of contracts and to retrospectively monitor that the providers comply with the contractual agreements. Previous research has indicated, however, that municipalities' ability to write monitorable contracts often is inadequate and that the requirements often are formulated in such a way that it cannot be retrospectively assessed whether the providers have adhered to them (Winblad et al., 2014). In addition, scholars have also found that few municipalities audit and evaluate their eldercare on a regular basis (Winblad et al., forthcoming). Taken together, this indicates that it is not unproblematic for the municipalities to take on the altered regulatory role that the marketization reforms have assigned to them. Furthermore, the lack of direct public control over the quality in the system may result in, if quality differences between different providers become too wide, an undermining of the long standing goal of social equality in the Swedish eldercare system. An apparent risk, given the difficulty in obtaining information about quality differences between providers documented in the dissertation, is that better-educated or more resourceful users gain an advantage in making informed choices and thereby get access to the best services (cf. Baxter et al., 2008; Higgs, 1998).

The dissertation has also shown that the state has increased its control over the eldercare sector through enhanced national audit. Through national standard setting, onsite inspection, and quality measurements, the national government and its agencies has taken on a more active role in order to ensure that all providers comply with national legislation and quality demands. As demonstrated, however, this enhanced audit risks reducing the autonomy and visibility of the eldercare workers. In this sense, the increased reliance on marketization has not only altered the regulatory relationship between the users and the municipalities, it has also contributed to a system where the ability of the staff to control and enforce service quality within eldercare risks being reduced.

An overriding conclusion in the dissertation is thus that the introduction of marketization has altered the organizational logic of Swedish eldercare, principally by transferring power from the local authorities to the users, but also by generating a perceived need for audit and performance measurement which has undermined the autonomy of the staff. These transformations have made it more difficult for the municipalities to directly control the quality of services while at the same time making the service users themselves increasingly responsible for ensuring that the quality of their care is high. For eldercare workers, the transformed steering logic means that their work routines are increasingly influenced by the national audit process. Referring back to Freidson's model over the three organizational logics, these findings indicate that the users and the national level of government have become more significant in the organization of Swedish eldercare. In addition, the professionals and the municipalities have become more restricted in their ability to organ-

ize the provision of care and to promote service quality. In the remaining sections of this introduction, I outline the main scientific contributions of this dissertation and its four articles and thereafter I give a few suggestions for further research.

Empirical and theoretical contributions

Through this dissertation, I make three principle contributions to the previous literature. First, and most important, the articles in this dissertation contribute to our empirical knowledge about how marketization has altered the organizational logic of Swedish eldercare. The analyses in Articles I, II, and IV have all showed, in different ways, that the implementation of user choice in Swedish eldercare has made older citizens more individually responsible for the outcome of their care. Moreover, an increased reliance on consumer power on behalf of the users has altered the regulatory role of municipalities, making it more difficult for them to ensure that all citizens have equal access to quality care. Although the system still is based on public financing and equal inclusion based on need, previous studies has also shown that not all elderly users can be relied upon to make informed choices and that the ability to make an informed choice can be dependent on social resources such as education and/or income (Meinow et al., 2011; Baxter et al., 2008; Higgs, 1998; Winblad and Blomqvist, 2013). In that sense, the results from Articles I, II, and IV together indicate that user choice risks undermining the goals of social equality and ensuring that all users have equal access to good quality care.

Second, this dissertation also contributes to existing research regarding professionalization and what consequences an increased reliance on public audit might have for welfare professionals. Although the de-professionalization hypothesis is well documented (Evetts, 2009, 2011; Jespersen and Wrede, 2009; Taylor, 2007) and supported by Article III with regard to the case of eldercare, the comparison with how the audit process is carried out in Swedish childcare indicates that audit does not have to be detrimental to professionalization. Instead it appears that the state can design their audit processes in such a way that they make visible and close the work tasks of specific staff groups and thereby support, rather than undermine, their professional development. These findings support the arguments presented by Roach-Anleu (1992) and Tilbury (2004), who claimed that explicit guidelines and performance measures, if rightly designed, can help care workers to uphold their professional jurisdiction and make their work more visible.

Third, the dissertation puts forward an important addition to the welfare state literature and the analysis of the Swedish welfare state by highlighting the concept of social care. More specifically, the second article in this dissertation contributes to the contemporary welfare state literature by defining the

concept of universality in relation to social services. In recent years, the question of how universality should be understood in relation to social services has become more salient (Béland et al., 2014; Goul-Andersen, 2012; Blomqvist and Palme, 2015). The analysis in Article II provides an argument of how the concept of universalism should be understood and applied in relation to social services, which I argue needs to be different from how it has been understood with regard to the social insurance sector. Additionally, the analysis in Article II also contributes to the study of the Swedish welfare state by providing a fuller understanding of how universalism can be undermined by the introduction of new organizational logics such as marketization. The conclusion that marketization can undermine universalism has also been drawn by Szebehely and Meagher (forthcoming), who show that marketization has weakened the universality of Swedish eldercare although no restrictions of formal rights have occurred. In Article IV, I further extend the discussion regarding how social rights in Swedish eldercare have been affected by marketization by studying how such reforms can change the content of social citizenship rights.

Avenues for further research

This dissertation has identified three important areas for further research. First, it is clear that more studies that tackle the organizational consequences of marketization in Swedish eldercare are needed. Although we have seen that marketization, foremost through user choice, has altered the regulatory role of local authorities by transferring power to the individual users, we have limited understanding about how the local authorities actually work to combine their new regulatory role with their legislative responsibility to ensure that all citizens have equal access to quality care. If the municipalities, as seen in Article I, do not provide quality information about the available providers, are there other ways in which they can facilitate the choices of eldercare users and thereby increase their autonomy in relation to the service providers?

Second, an important avenue for further research is to study the interplay between public audit and professionalization of social care workers. In Article III, we could see that the state has developed different audit processes in Swedish eldercare and childcare, but the study did not provide any clues as to why this has happened. This question has not been possible to address within the scope of this dissertation but calls for more scrutiny, not least in order to understand how different audit processes can affect occupational groups that generally lack a strong sense of professionalism, but who strive for further professionalization.

Finally, more studies should focus on the state of universalism in Swedish eldercare (as well as the social service sector in general) and how it is affected by increased marketization. With regard to this issue, I would particularly

advise future researchers to pay attention to the introduction of additional services, which has allowed users of privately provided home-care to top-up their publicly granted eldercare, such as by purchasing more domestic services or increasing their service frequency. Particular questions to ask with regard to this tendency are how the uptake of additional services is distributed among the eldercare users, following lines of social privilege, and how it interferes with the public commitment to publicly finance eldercare, both with regard to citizens' willingness to pay taxes and to public policy preferences. In addition, the findings in this dissertation suggest that subsequent research should pay more attention to the limits of universality. Although the concept of universalism foremost should be understood as an ideal type, it is important to establish how far from this ideal type a system can wander before it loses its universal traits.

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