Contesting 'quality' in Swedish eldercare under marketisation: whose interests do care quality measures represent?

Gabrielle Meagher
Department of Sociology,
Macquarie University, Australia;
Department of Social Work,
Stockholm University, Sweden
gabrielle.meagher@mq.edu.au

Marta Szebehely
Department of Social Work,
Stockholm University, Sweden
marta.szebehely@socarb.su.se

Paper presented at the 4th Transforming Care Conference
'Changing priorities: The making of care policy and practices'
Copenhagen, 24-26 June 2019

Introduction

In recent decades, the organisation and distribution of publicly financed care services for older people in Sweden have changed significantly. A major driver of change has been the introduction of market ideas and arrangements such as contracting, outsourcing, competition and consumer choice, as New Public Management (NPM) has swept through the Swedish public sector (Erlandsson et al. 2013; Montin 2017). For-profit providers now have a strong foothold, providing around a fifth of eldercare (both home-based and residential care) nationwide, and large corporations dominate (Meagher and Szebehely 2018). Meanwhile, across the same period, the share of the population of older people receiving eldercare services has fallen (Ulmanen and Szebehely 2015), and those who do receive care tend to be older and frailer. These changes pose new challenges for public authorities in maintaining and developing the quality of care services. On one hand, private providers operate externally to public institutions that fund and are expected to oversee their activities. On the other hand, tighter service targeting means that eldercare recipients, on average, need more complex care, which may be more difficult to monitor.

This paper examines the impact of the rise of the for-profit sector on service quality and its measurement in Swedish eldercare. Private provider interest organisations and large companies with a significant stake in the existence and flourishing of the market for private services have at least two, not entirely compatible, interests. As King argues, maintaining their reputation is 'a major survival or promotion variable for the sector overall' and '[n]o one wishes to have the whole industry jeopardized by the actions of a few rogues'. In this context, large companies may even act as 'ethical leaders' because of their superior resources (2007: 70).[1] Yet profitability is also a major driver, creating a strong incentive to resist regulation that materially increases costs of production. To

[1] King (2007) is writing specifically about the conditions under which self-regulation might be effective, not about Swedish care companies. However his characterisation of the interest of private providers in maintaining their reputation is particularly salient in delivery of social care services, and so helpful here.

manage these interests, the private sector cannot explicitly resist the concept, measurement or oversight of quality without facing criticism as profiteers, but instead needs to work both to influence the regulation of quality and to demonstrate commitment to its delivery.

Meanwhile, a large body of international research on residential care for older people has consistently found that the quality of care, on average, is poorer in for-profit facilities than in non-profit or public facilities (Bos et al. 2017, Comodore et al. 2009, Ronald et al. 2016).

Against this background, the paper seeks to answer the following questions: Which quality measures are used at the national level in Sweden? Why are these the measures used, and whose interests do they reflect? How have private interests sought to shape quality measurement? What quality differences, if any, between public and private providers are captured by the existing metrics?

Our analysis complements existing research on regulation of the quality of eldercare in Sweden. Several significant studies have examined the design, structure and efficacy of key institutions and practices of performance audit and supervision (Hagbjer 2014; Hanberger et al. 2017; Hanberger and Lindgren 2018; Hämberg 2013; Isaksson et al. 2018) and their impact on local governance of services (Andersson et al. 2018; Hanberger and Lindgren 2019). Other studies have examined whether audit processes enable or constrain social service workers' opportunities to improve their occupational status (Moberg et al. 2018). While Montin and colleagues (2018) include the activities of private providers and their organisations in the larger 'performance scrutiny regime', and note that 'different interests in relation to the definition of "quality" 'mean that 'objectivity is hard to find, the *politics* of quality measurement have yet to be fully explored.

Our analysis is primarily based on analysis of documents related to recent developments in policy and practice in public oversight of eldercare in Sweden (policies, reports, submissions and media) and publicly available quality data. To ground the analysis of quality measures used, advocated for, resisted and ignored, we draw on Donabedian's (1966) distinction between *structure*, *process* (both technical and relational) and *outcome* measures of care quality. Donabedian's framework provides a critical external reference point, based in care research, for capturing the complexity of care and the profile of quality measures used and debated. The paper will extend existing knowledge with a more systematic analysis of the political contestation over quality measurement in Sweden, and a critical exploration of whether existing quality measures provide good enough data for monitoring and comparing the performance of public and private providers in the eldercare market.

Regulating the quality of eldercare in Sweden

As noted above, eldercare in Sweden has been marketised over the last nearly three decades, and while the majority of services are still publicly provided, the system as a whole has been affected by the changing legislative and regulatory environment. As Montin (2017) puts it, the impact of NPM in Swedish eldercare has occurred via a 'marketisation stream' and a 'performance control stream' (our focus here). Accordingly, in line with developments around the world, marketisation has been has been accompanied by more, not less, regulatory activity, by both public and private actors (Vogel 2018). A recent overview of actors in the 'audit system' for Sweden's eldercare identified more than twenty main actors and processes, from the Health and Social Care Inspectorate (IVO) and other organs of national regulatory oversight, to the municipalities responsible for commissioning and/or delivering care, to the media, labour unions and older people's organisations, and older people

themselves (Hanberger and Lindgren 2018: 12-13). Most, if not all, of the activities in this audit system relate in some way to the quality of care services, and the institutions and quality requirements have been the subject of considerable policy attention and change in recent years.

To establish the foundation for our analysis of the politics of quality, in this section we seek to answer the question: How is quality regulated and which quality measures are used at the national level in Sweden? We consider briefly the roles of national legislation and authorities, municipalities, service providers' organisations and consumers.

In accordance with the constitutional principles of Swedish government, national legislation sets the broad framework for social policy, while municipalities have both autonomy to decide on implementation and responsibility for oversight. Within these arrangements, the quality of eldercare is governed by the Social Services Act, which specifies only that social services should be of good quality, that staff should have appropriate training and experience, and that service quality should be systematically and continuously developed and assured. No more specific quality measures are mandated by the legislation. The Local Government Act delegates the responsibility for monitoring the quality of social services to municipalities. These responsibilities remain in place when municipalities outsource services, such that municipalities are required to oversee the delivery and quality of any privately-delivered services. In this context, where services are outsourced the *procurement process* moves to the centre of quality specification and oversight.

While municipalities have immediate responsibility for the oversight of service delivery and quality, since 2013, the national Health and Social Care Inspectorate, IVO, has been responsible for ensuring that service providers, public and private, fulfil the relevant legislated requirements (Hanberger et al. 2018). The creation of IVO from a more dispersed set of arrangements reflects international developments in regulatory infrastructure, which have seen a proliferation of independent public authorities charged specifically with overseeing the performance of publicly-financed services (REF). The Inspectorate has disciplinary functions, exercised following complaints or inspections informed by risk assessments. Private nursing homes have always been required to register with the predecessor of IVO and since 2019, also private homecare providers have been required to be registered with IVO, with registration criteria focusing mainly on financial sustainability and the appropriateness of the owner.[2]

Reflecting the long tradition of high-trust, collaborative governance in Sweden, IVO is also designed to support and guide quality improvement, and along with the National Board of Health and Welfare (NBHW; Socialstyrelsen) continues the more supportive, non-disciplinary role played by public authorities in relation to quality oversight (Hämberg 2013). Some data gathering has been routinised as part of this supporting and guiding role, and the measures change from year to year. When municipalities outsource eldercare, service quality is defined and managed through procurement processes. Within the national framing legislation on both social services and procurement, along with any other binding regulations such as those propagated by IVO, municipalities specify quality requirements in tender documents, which also specify the conditions of contracts with successful providers. A recent study of a sample of contracts by Isaksson and colleagues (2018) found that they were 'highly detailed, containing, on average, over 100 quality requirements, ranging from structural measures like the condition of the facilities or the composition of the staff to measures related to the

[2] https://www.ivo.se/tillstand/nya-tillstandsplikter-2019/

care process itself'. Performance is monitored through a range of practices, including self-reports by providers, performance data collected by municipal administrators, inspections and user surveys (Isaksson et al. 2018: 1648).

As noted above, outsourcing is governed by procurement as well as social services legislation, and state authorities that support procurement have issued guidance in recent years. In 2014, the Swedish Competition Authority (Konkurrensverket) issued guidance on procurement of home care services, while the new National Agency for Public Procurement (Upphandlingsmyndigheten; established in 2015) has issued guidance on administration and monitoring of health and social care contracts in 2016 and 2017 respectively. These documents are designed to make it easier for municipalities to specify, administer and monitor contracts for outsourced care services. The procurement agency's guidance updates and elaborates a 2014 document with the same purpose, put together by three employer organisations: the Swedish Association of Local Authorities and Regions (SALAR; Sveriges Kommuner och Landsting, SKL),[3] the Confederation of Swedish Industry (Svenskt Näringsliv), and the Association for Private Care Providers (Vårdföretagarna).

In line with corporatist traditions in Sweden, these organisations have been formally involved in different instruments of the national performance regime. One important national instrument is annual benchmarking in 'Open comparisons' (OC, Öppna jämförelser). OC have their origins in the 1990s in an inter-municipal benchmarking project supported by SALAR, which latter published the first, national OC for eldercare in 2007 (Montin et al. 2018: 102). Since 2008, following direction by the centre-right government, the NBHW and SALAR have jointly published OCs annually, and in 2009, Vårdföretagarna and Famna (the National Association of Mission-driven Welfare Services) joined the collaboration as part of a national strategy for quality development through open comparisons (Ministry of Health and Social Affairs et al. 2009). Vårdföretagarna's role is to ensure that the private health and care providers' perspective is taken into account in developing Open Comparisons. According to an updated version of the strategic plan (Ministry of Health and Social Affairs 2015), the various parties are to work together to identify how to use OCs to drive quality development, and select the areas of focus and measures is central to this work.

From the beginning, the information on eldercare collected in Open Comparisons was aimed for use in comparing municipalities as well as units (nursing homes or home care providers). The information was planned to be used on one hand by local politicians and civil servants in municipalities to compare their services to other municipalities and national average and improve accordingly, and on the other by older people or their families to compare and choose a nursing home or a home care provider (via the web-published Eldercare guide). Later, the information has also been used to compare public and private providers but that was not the initial focus.

The Ministry of Health and Social Affairs has expressed very high hopes about Open Comparisons, which it believed would 'contribute to world class quality and efficiency', and about the Eldercare guide: 'With Open Comparisons as a basis, citizens, patients and users will be so well-informed that they can freely choose the best care providers' (Ministry of Health and Social Affairs et al. 2009, p. 3; cited in Erlandsson et al 2013, p. 42).

[3] SALAR/SKL is formally a private, representative, employer organisation the members of which are the democratically elected municipalities and regions that deliver public services and commission privately delivered services. The organisation is steered by a board that represents the political majority of the 290 municipalities and 20 regions. Between 2006 and 2014, the board (like the national government) had a centre-right majority and from 2015 a red-green majority.

Participation in Open Comparisons is voluntary and its aim is supportive, not disciplinary; nevertheless 'its 40 or so performance indicators appear to have become a national standard for elderly care service quality' (Montin et al. 2018: 102). As noted, what is measured is determined by the participating organisations and the measures change over time, and in the following sections, we discuss this in more detail. Older people themselves also play a formal role in quality monitoring through an annual user survey, which collects data about their experiences and evaluations of eldercare services. Further, where consumer choice systems are in place, older people's choices, especially to exit a service with which they are unsatisfied and choose another, are expected to drive quality improvement.

Whether the information can be used in the way the Ministry hoped in 2009 depends both on the validity and reliability of the measures and on municipalities' and individuals' ability to use the information in the way expected. International evidence suggest that this is rarely the case (Glendinning 2008). Pollitt (2006, p. 48, quoted in Lindgren et al. 2012, p. 26) claims that: 'Grand statements about the importance of performance information ... sit alongside extensive if patchy evidence that ministers, legislators and citizens rarely make use of the volumes of performance information now thrust upon them'.

This section has outlined the regulatory arrangements established at the national level for performance control or audit of the quality of Swedish eldercare services. However, the regulation and/or audit of service quality is not simply technical. Rather, because regulation distributes, redistributes and constitutes social benefits and costs (Levi-Faur 2013: 610), social actors engage in conflict and strategic action to shape it. In other words, regulation and audit are political (Power 2003), and in the case of the regulation of eldercare, how quality itself should be defined and measured becomes a key object of conflict and strategic action. Unsurprisingly, then, there is no consensus in Sweden about how the quality of eldercare should be assessed. The debate has partisan inflections, with centre-right and green-left governments taking somewhat different approaches, within the broader shift towards audit and markets that has happened under NPM during governments of both colours.

In relation to the quality of eldercare specifically, several government commissions have argued that measurement is difficult if not impossible, while private providers' interest groups have argued that quality *can* be defined and measured, and an independent national system should be introduced forthwith. Nevertheless, over the last two decades, the policy, regulation, institutions and practice of quality measurement and oversight have been developed and contested. As this section has shown, much of this oversight infrastructure has been developed through corporatist-style collaboration between national public authorities and private organisations representing local and regional governments (SKL) and private providers. Further, in line with the findings of Braithwaite and colleagues (2007), care scandals have played an important role in prompting public debate and activity by governments and other actors. In the case of Sweden, two nursing home cases in 2010 and 2011, respectively, got intense media attention and led to extensive actions from both government and employers' interest organisations – in the first case, the activities mainly concerned whether or not to regulate staffing ratios, in the second, whether or not regulate profit-making. We report these cases and the activities they led to in the following section.

Why are these the measures that are used, and whose interests do they reflect?

This section explores how organised private interests, primarily Vårdföretagarna (the Association for Private Care Providers), have been actively and reactively engaged in proposing a preferred vision of the nature and measurement of quality in Swedish eldercare.[4] A wide variety of platforms and strategies underpins the private care sector's 'quality work', and different approaches have been taken over time. Some of these have used formal channels of influence, such as participating in and responding to government commissions (reactive efforts), while others have used the considerable resources of employer organisations and large private companies to promote their ideas and interests through research, media, and direct lobbying of individual politicians (active efforts). Our aim here is to explore some of these efforts across different channels and over time, to understand the vision and practice of quality work that the private sector seeks to promote.

One of the most contested structural measures of quality in eldercare has been staffing levels. During the last decade, governments and public authorities have danced around the issue, as care scandals have prompted calls for action on staffing and have brought negative attention to the for-profit sector.

Regulating staffing in nursing homes: a highly contested attempt

In early September 2010, a whistle-blowing assistant nurse in a public nursing home in northern Sweden appeared on Swedish national television's main investigative documentary program, *Uppdrag granskning*, and reported that older people with dementia were being locked in in nursing home units at night without staff present. Shortly after the broadcast, the National Board of Health and Welfare (NBHW)[5] made an unannounced inspection, confirmed the whistle-blower's claim and demanded that the home increase night staffing.

Some weeks later NBHW followed up the issue by conducting unannounced inspections at night of 94 nursing homes around the country, which revealed that in 60% of homes, units were unstaffed for longer or shorter periods during the night. The report was published November 18, and the same day, the Left Party parliamentarian Eva Olofsson asked the centre-right government's Minister for Health and Social Affairs, Maria Larsson in parliament if the government was now prepared to have guidelines on staffing levels included in the new *National guidelines for dementia care*, which had been published by the NBHW in May 2010.[6] The minister responded that day with a key argument used to fend off such calls: the new guidelines had not ended up including staffing levels, because there was not sufficient evidence to support such recommendations.[7] She put the argument in stronger terms a week later, saying it would be 'inappropriate, impossible, incorrect to, based on current research and knowledge, specify a minimum staffing level', adding that staffing was the responsibility of municipalities.[8]

[4] It is important to note that also SALAR/SKL, the employer association representing public employers, has also been active in defending the interests of public employers, and its views on regulatory issues sometimes align with those of Vårdföretagarna. However, our focus here is on the activities of the for-profit private sector.
[5] At this time the NBHW was responsible for inspections, before IVO was created.
[6] https://www.riksdagen.se/sv/dokument-lagar/dokument/interpellation/bemanning-i-demensvarden_GY1034
[7] https://www.riksdagen.se/sv/dokument-lagar/dokument/protokoll/riksdagens-protokoll-20101117-torsdagen-den-18_GY0917/html
[8] https://www.riksdagen.se/sv/dokument-lagar/dokument/protokoll/riksdagens-protokoll-20101121-torsdagen-den-25_GY0921/html

Nevertheless, the issue did not die with the Minister's rejection. On 20 December 2010, two motions were discussed in the parliament's Social Affairs Committee: one by the Eva Olofsson and other members of the Left Party and a similar one by rightist Sweden Democrats. Both motions argued that guidelines on staffing levels should be added to the *national guidelines for dementia care*. The motions cited a recent report prepared by the Stockholm Gerontology Research Center (Äldrecentrum) at the request of Stockholm City Council. The report argued that it was possible and relatively simple to determine an appropriate level of staffing for dementia care units, concluded that three care workers per nine residents during the morning hours constituted 'adequate' staffing, and noted that this demand was clearly in line with the requirements in the Social Services Act and what guidelines said about 'person-centred care'.

The majority of the Social Affairs Committee agreed with the motions that the government should ask the NBHW to add guidelines on staffing to the national guidelines on dementia care. The centre-right minority government disagreed, but the motions were accepted by the parliament and the NBHW began this work after receiving the directive in February 2011.

On 11 October 2011, a new scandal broke, this time in a nursing home owned by the large corporation, Carema (Ambea). Low staffing levels were identified as part of the problem, but the media debate and subsequent political response focused more on for-profit ownership, particularly by private equity companies (Meagher and Szebehely 2019). At this time, both the two largest private eldercare companies, Carema and Attendo, were in private equity ownership. The public and political response to this scandal prompted a very strong response from Vårdföretagarna. This response is another thread in the story of the politics of quality to which we return below.

In this context, the government received a further push from the red-green parties in December 2011 to extend the NBHW's task to propose guidelines for staffing in *all* residential care, including consideration of quantitative, measurable indicators (Socialutkottet 2012). This change was made.

The NBHW published its proposed guidelines for consultation (remiss) in spring 2012. The Board argued that binding, rather than advisory, guidelines were necessary because its recent oversight activities had revealed staffing deficiencies (i.e. unattended wards) such that the standard of quality demanded by the Social Services Act was not always being met. Further, referring to the report by the Stockholm Gerontology Research Center, the Board argued that there was now sufficient evidence to support regulation of staffing levels. However, the guidelines were not specified as a fixed staffing ratio. Rather, they were framed as a requirement that *residents' individual needs* should determine staffing levels. To connect residents' needs to staffing levels, the Board proposed that each resident should have a detailed needs assessment, and aggregated assessments for all residents would form the foundation for unit staffing. Residents' needs were to be reviewed regularly by the municipality. In addition to this requirement, the Board also proposed that no units would be left unattended at night, with enough staff to be able to respond quickly to all residents 'in need of support or assistance to protect their life, personal security and health'. With the aim of ensuring that quality differences between municipalities were minimised, the Board proposed that the guidelines be established at the national, not local, level, essentially rejecting the Minister's argument that staffing questions should be left to municipalities. The Board calculated that to meet the requirements of the Social Services Act, staffing in residential care would need to increase by 10-20%. Given that municipalities are required to meet these requirements, the costs should be met

from existing municipal finances. Additional funding should only be provided to meet the costs of the new needs assessment process.

The NBHW's proposed guidelines were not welcomed by the employers' organisations. In particular, SALAR responded very critically in its response during the consultation. In SALAR's assessment, the Board had over-reached its authority. Implementing its proposal would lead to detailed steering by the state and increased administration and bureaucracy, with unclear benefit for older people themselves. Further, meeting the proposals's requirements would impose large cost increases that SALAR argued *should* be met by the state.[9]

Vårdföretagarna also responded negatively, rejecting the need for binding guidelines, and the Board's approach to defining how staffing needs should be assessed. Vårdföretagarna's arguments were framed in terms of provider autonomy to decide how resources should be used to meet needs specified by municipalities. Rather than reporting how much staff they have, providers should instead report that they have carried out the activities that municipal purchasers have ordered.

Despite these and other criticisms, the NBHW did not revise the guidelines, which it issued later in 2012 for proposed implementation in 2014. In early 2013, SALAR effectively declared war. Rejecting the Board's assessment of the state of quality in eldercare, they argued that the guidelines included recommendations that exceeded the demands of the Social Services Act, and only the government had the authority to introduce such a costly measure.[10] SALAR threatened to challenge the guidelines in court.

In the face of this resistance, the NBHW postponed implementation to 2015. SALAR's resistance continued. In 2015, the Board finally withdrew the guidelines[11] and referred the matter back to the government for further consideration. In 2016, the now red-green government decided that NBHW's proposal for tying staffing to detailed, individual needs assessment should not be implemented but that the requirement that all units are staffed around the clock, to meet needs without delay, be retained would be retained, this time in the form of a binding regulation.In this way, the only existing national quality measure tied to staffing was settled, and it has been used since by IVO in its inspections.

Reorienting the quality debate: Vårdföretagarna's interventions

While the contestation around the NBHW's guidelines played out, in the wake of the Carema scandal in 2011, Vårdföretagarna became extremely active on other, but related fronts. The 2010 scandal about unattended wards and the Carema scandal had brought significant public and political attention to the issue of staffing and nursing home quality (Lloyd et al., 2014, Jönson 2016). In the struggle over binding regulation of staffing in the NBHW's guidelines, SALAR's very strong resistance meant Vårdföretagarna did not have to work hard in that specific contest. However, the Carema scandal raised new threats specifically for for-profit private providers, and Vårdföretagarna's efforts were largely directed at addressing these. A detailed account of Vårdföretagarna's actions and reactions is provided in a book called *The Welfare Lobbyist* by the organisation's chief lobbyist Håkan

[9] https://skl.se/download/18.4aa1dc1e1653a5317a024823/1534429507594/13002.pdf
[10] https://skl.se/download/18.4aa1dc1e1653a5317a024823/1534429507594/13002.pdf
[11] https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/foreskrifter-och-allmanna-rad/2015-2-9.pdf

Tenelius (Tenelius and Selling, 2016), and we draw on this unusually candid insider source along with other organisational documents and reports here.

During 2011, one in five articles about eldercare in the Swedish media was about neglect and scandals. At first, Tenelius reports, Vårdföretagarna were not particularly concerned. However, they certainly became worried in mid-November, when the city of Stockholm (at that time, also under centre-right government) terminated Carema's contract and temporarily froze further out-sourcing. The same day, three ministers from the centre-right national government held a press conference to announce a commission to investigate how the capacity of private equity firms to export their profits to tax havens could be limited and to investigate whether there are any quality differences between public and private eldercare. This 'massive questioning of the whole sector' came as a shock, based, as Tenelius saw it, on 'a media report about an occasional experience in a handful of homes' (2016: 88). That '*everyone'* – including the centre-right politicians from whom they would normally expect support – 'now questioned competition and private providers' meant that the sector was 'in crisis' (2016: 94, emphasis in original).

In the context of the scandal, Vårdföretagarna had to reorient its lobbying goals, which had been to promote rapid growth of the private sector given the opportunity afforded by freedom of choice reforms in primary care and home care. Now seeking to redirect attention away from the connection in the public debate between neglect on one hand and large profits and tax evasion on the other, Vårdföretagarna went on the offensive, seeking to put itself on the right side by arguing for the need for 'national and independent quality measurement.[12]

Both Vårdföretagarna and Svenskt Näringsliv now put enormous resources into renewed lobbying work, with (overlapping) PR-oriented and research functions. They prepared and commissioned several research reports on quality and related issues, pursued self-regulation strategies with members and within the wider sector to pre-empt public regulation and developed a range of new, more obvious propaganda instruments.

An early effort was a report, called 'Private care facts' (Privat vårdfakta). Published first in 2012 and every year, the report presents 'Facts and statistics on the private health and social care sector'. The data are assembled from a variety of published, often official, sources with the aim of convincing privatisation-sceptical public opinion (including the right wing parties at the time of the first issue) of the benefits and merits of private provision. The report stresses the process quality measures on which private providers do better, rather than the structure quality measures on which they score worse, as we discuss in more detail below.

Svenskt Näringsliv set up a program for improving quality in welfare services to 'thereby strengthen the position of the private companies' (Tenelius, 2016: 156). One of the first activities undertaken was the establishment of an 'expert group for quality in welfare', most of whom were senior leaders in private care companies. The group's report, 'Quality recommendation for health, social care and schools', was published in 2013 (Svenskt Näringsliv 2013). The report follows a consumer logic, arguing for the need of accessible information to potential users so that they can make 'informed and active choices'. The report stresses the importance of process quality measures and user

[12] Vårdföretagarna's ethical board also signalled its seriousness by formally investigating its member organisation Carema, finding some problems but also serious attempts to improve, and the case was closed (Tenelius, 2016: 99).

satisfaction, while the handful of staff-related quality indicators it recommends do not include structure measures such as staffing ratios. Taking up other recurring themes in Vårdföretagarna's advocacy on these issues, the report claims that 'Quality issues are independent of ownership and the recommendations can be applied in both private and private organisations' (2013: 3), expresses great confidence in the measurability of quality and calls for its independent definition and measurement (2013: 6).

In 2012, Vårdföretagarna also commissioned an overview of nursing home procurement that showed that, despite the more than 200 contract specifications, very few specific terms were possible to monitor.[13] Published in 2013, this was the prompt for the collaboration they initiated with SALAR to create guidelines for procurement, and which were published later that year, as discussed above. Whether or not the guidelines were much used, the more important purpose for Vårdföretagarna was to show that they were taking responsibility, together with SALAR, for ensuring that quality was assured in procurement (Tenelius, 2016: 161).

In addition to these and several other reports on related topics, Vårdföretagarna engaged in other activities aimed at managing the potential threats of regulatory change. One was a major effort at pre-emptive self-regulation in the form of an 'Ethical platform for openness about quality, finances and employment conditions in publicly-financed providers of health and social care'. The main goals of the platform were transparency and comparability, regardless of ownership. Formally developed at the invitation of the centre-right government in 2012, an agreement on the platform was signed by four employer organisations (including Vårdföretagarna and SALAR) and thirteen unions in 2013.[14] Presumably because unions were involved, the platform included the requirement for providers to offer collective agreements, and to report their staffing levels and employees' education. In this way, the agreement was more demanding than other positions Vårdföretagarna had taken. On one hand, collective agreements were not particularly problematic for Vårdföretagarna's members; on the other, Svenskt Näringsliv protested strongly (Tenelius 2016: 167). Overall, given the broader political context, Vårdföretagarna saw it very much as a strategy to head off the Social Democrats' plans to regulate the private care sector.

The platform was launched in 2014, and its impact is opaque. It has no contemporary (June 2019) presence on the internet as an instrument in current use. At any rate, as a strategy, it was somewhat overtaken by events. By the time the platform was launched, the 2014 election campaign was underway, and the issue of regulating profit in the welfare sector was very much in focus (Meagher and Szebehely 2019). At this time, Vårdföretagarna decided to widen their strategy from making more technocratic interventions about quality to influence policy-makers. Changing public opinion moved to the centre of their work, as the public was sceptical, the media critical, and the Social Democrats now were (finally) moving against for-profit welfare provision with a proposal to limit profit-taking approved by their congress in April 2013 (Meagher and Szebehely, 2019).

Accordingly, in the autumn 2013 (a year before the election), Vårdföretagarna organised a meeting of the communications teams of the larger care companies to discuss what they could do change the public opinion. As Tenelius saw it, 'To win this struggle, we must talk directly to the public. We must

[13] They published another report on a related theme, called 'One wants to know what's required! A report on quality in eldercare' (Vårdföretagarna 2013), reflecting the typical demand of private providers in social service markets for measures to be tightly specified and clearly demonstrable (Braithwaite et al. 2007).

[14] https://web.archive.org/web/20161111215505/http://etiskplattform.se/Oeverenskommelsen/

use our opponents' best weapons and start talking feelings. And we must start now' (Tenelius, 2016: 181). They consulted public relations and advertising companies and one outcome was a campaign, still running, which draws heavily on social movement tactics and tropes – the first of these being the campaign's name, 'We make a difference' (WMD; in Swedish 'Vi gör skillnad'; www.vigorskillnad.se). Initially a single page site, with a petition for supporters to sign in defence of freedom of choice and diversity of providers, the WMD website has develop into a sophisticated, multi-dimensional communication platform with associated social media (FaceBook, Twitter, Instagram). The website uses a variety of discursive strategies to reframe and legitimise private provision and profit-making, and to delegitimise the public sector. Some appeal to readers' reason, in the style of *Private care facts* – presenting selected data to present the private sector in a positive light. Others appeal to people's emotions. Early additions to the site were short 'Films from reality' showing individuals telling personal stories about how private providers have made their lives better. The implicit or explicit comparison with public providers in these films speaks to the claims of higher quality in the private sector that is a touchstone of Vårdföretagarna's work.

When the centre-right parties lost the election and a red-green minority government came to power in 2014, the government needed support from the Left Party, which had argued more strongly than the other red and green parties against profit making in welfare services. Pushed from the left but also by the grassroots within the party, in October 2014, the government together with the left party announced that a commission would be charged to propose a regulation to limit profit-taking by private welfare companies, and to investigate whether staffing levels can be regulated 'so that it would not be possible to reduce staff density or staffing costs to make a profit'.

The commission's task, as framed in the initial directives quoted above, posed a significant threat to private care companies. Vårdföretagarna worked hard to try to change the commission's directives with limited success (Meagher and Szebehely 2019) and continued their efforts to change public opinion. In December 2014, they launched Systemmannen (the System Man). As Tenelius writes, they 'had to create a new enemy' and using feelings (this time humour), to show the public that 'free choice could not be taken for granted (Tenelius, 2016: 219). The 'System man' was the right enemy: a fat, middle-aged man in an ugly suit arguing that freedom of choice has gone too far. By focusing on the 'right to choose' (rather than on the right to make a profit), the organisation hoped to show politicians that 'there is a strong opinion guarding freedom of choice and which values the availability of alternatives' (Tenelius, 2016: 240).[15]

Vårdföretagarna and Svenskt Näringsliv also made submissions to consultations on the commission's reports (remissvar) in which they argued that quality, regardless of ownership, should be the focus of policy in welfare services, thereby seeking to deflect the entire question of profit-taking. [this point to be developed in a later draft].

The red-green government's minority status meant that it lost the parliamentary vote on a proposal to limit profit. In this context, Vårdföretagarna could reorient its work towards de-politicising the issues of ownership and profits. With the issue of profits no longer high on the agenda, those who can provide politicians and bureaucrats with technical information that seems to provide solutions to agreed problems become increasingly important. Vårdföretagarna and the private companies have

[15] https://www.youtube.com/channel/UCnQ6ISSCJJsWrasUn5OTj4w/videos

become successful in this respect: 'The sector overall has significant resources to plough into investigations and to draw on external experts (Selling 2016: 253).

Working with private providers in the sector, rather than with or against policy makers and the public, Vårdföretagarna also provides strategies for its members to help them to demonstrate their seriousness and commitment to quality services. In the association's words, membership itself 'is a quality seal and guarantee that a member follows our code of conduct'.[16]

In 2017, Vårdföretagarna began to offer residential eldercare providers a 'members benefit' in the form of a 'Quality declaration'. The organisation claims itself to be a 'forerunner' in the area of quality measurement, because 'There are no national principles for how quality should be measured and reported'.[17] Members can choose to apply for this certification, and complete a form in which they provide information on their quality systems among other things. With this instrument Vårdföretagarna offers members a way to 'perform' quality for a wider audience. Further, both Vårdföretagarna and private companies also make prominent use of public quality information to underpin claims about the quality of their services, announcing on their websites selected positive results from the annual user survey and other official materials, in addition to Vårdföretagarna's use of this data in more formal publications.[18]

It is not surprising that Vårdföretagarna developed the 'Quality declaration' and the membership logo to connote 'serious actors'. As noted above, King (2007) points to the potential for large private companies to play a leading role in self-regulation. This is confirmed in the case of Swedish care companies. Large private providers have been very active in the public performance of their stated commitment to high quality services. In the two largest companies, Attendo and Ambea, some of this work has been routinized. Ambea has published its own quality 'balance sheets' since 2011,[19] and gives its internal quality system 'Qualitymax' prominence in these reports and on its website.[20] Attendo styles its quality work through a system it calls 'Qualitywheel', and also publishes annual quality balance sheets.[21]

In summary, private providers and their interest organisations have, in different ways depending on the wider context, worked hard to manage and deflect quality oversight in Swedish eldercare. The question of if and how much these efforts have succeeded is put in a different light in the following section, which takes a more forensic look at the measurement of quality differences between public and private providers.

Quality differences between public and private providers

In the previous sections, we have shown that during recent years, high hopes and a lot of effort have gone into developing measures for comparing municipalities and providers. We have also pointed out the role of Vårdföretagarna in the development of existing measures and is increasingly using information gathered at the national level in their publication *Private Care Facts* and elsewhere to

[16] See https://www.vardforetagarna.se/om-oss/vardforetagarnas_etikrad/
[17] See https://www.vardforetagarna.se/medlemskap/vardforetagarnas-kvalitetsdeklaration-en-medlemsforman/
[18] See, for example, https://www.humana.se/humana/press/nyheter/2015/11/humana-har-nojdare-kunder-an-rikssnittet-enligt-socialstyrelsen/; https://www.vardforetagarna.se/2015/12/stockholms-aldre-mer-nojda-i-privat-regi/; https://www.attendo.se/nyheter/attendo-%C3%A5bov%C3%A4gen-i-topp-enligt-socialstyrelsens-unders%C3%B6kning.
[19] See for example https://www.ambea.se/kvalitet-hallbarhet/bokslut-och-redovisningar/ (in Swedish)
[20] See https://www.ambea.com/quality-sustainability/quality-policy/qualimax-for-management-and-follow-up/
[21] See https://www.attendo.se/om-attendo/kvalitet-i-attendo

point to the high(er) quality in private eldercare. In this section we will look into the present measures in Open Comparisons based in the survey to public and private units. These measures are reported by the National Board of Health and Welfare in an excel file showing the results for all municipalities and for each unit, and the file also reports an aggregated comparison of public and private providers. Table 1 below shows the measures collected and reported for residential care units and the national averages for public and private providers in 2018, as reported by NBHW 2018.[22]

Table 1: Quality in residential eldercare, Sweden, 2018

		Public	Private
Personalised care and user influence			
Residents committee	Percentage of units that offer each person the opportunity to participate in residents' committee meetings.	55	91
Care plans	Percentage of residents with a current care plan.	90	96
	Percentage of residents with a plan that includes documentation about how the person participated in the development/change of their care plan.	77	90
Protective measures	Percentage of residents who have documentation about why they have a protective/restrictive measure in place.	86	93
Meals	Percentage of units which have procedures for arranging all the meals of the day	33	81
	Percentage of residents with care plans about the older people's preferences and needs in relation to meals.	80	90
Safe health and social care			
Cooperation and collaboration	Percentage of units with a procedure in relation to concern / identification that a person being subject to violence or abuse by a relative or other close person	44	67
	Percentage of units that have a procedure in relation to concern / identification that a person is dependent on / abuses medicines	27	66
	Percentage of units that have a procedure in relation to concern / identification that a person is dependent on / abuses alcohol or other addictive substances (not medicines)	28	66
	Percentage of units that have a procedure for how staff collaborates with a resident's family.	39	72
Activities and exercise	Percentage of units with access to an exercise facility	43	62
	Percentage of units with an internal environment arranged to support individual residents	19	34
	Percentage of units where residents have access to the outdoors when they so wish.	80	95
Procedures for health care planning	Percentage of units with procedures for planning how individual residents' health care (health care planning) will be carried out in collaboration with other care providers. How individual residents participated in the plan should be documented in their file.	57	76
	Percentage of units that have procedures for planning how individual residents' health care (health care planning) will be carried out in collaboration with the responsible medical and other health and care personnel	51	82
Medication reviews	Percentage of units that have procedures for how detailed medication reviews shall be carried out, with the resident's participation documented in their file. The	41	76

[22] NBHW (2018) Enhetsundersökningen om äldreomsorg och kommunal hälso- och sjukvård 2018

	procedure should cover all residents in a unit.		
	Percentage of units with procedures for how detailed medication reviews will be carried out in collaboration with the responsible medical and other health and care personnel	35	64
Bladder dysfunction	Percentage of persons 65 years and older in residential care with a current, basic assessment of bladder dysfunction	45	71
	Percentage of persons 65 years and older in residential care who are receiving at least one preventative measure or treatment in addition to individually prescribed continence aids or catheterisation	74	74
Knowledge-based care			
National quality registers	Percentage of units that have entered unit-level activities in the register Senior Alert, and used the compilation of the results to improve unit-level operations	77	77
	Percentage of units that have entered unit-level activities in the Swedish Dementia Registry and used the compilation of the results to improve unit-level operations	3	2
	Percentage of units that have entered unit-level activities in the Behavioural and Psychological symptoms in Dementia Register (BPSD) and used the compilation of the results to improve unit-level operations	67	55
	Percentage of units that have entered unit-level activities in the Swedish Palliative Care Register and used the compilation of the results to improve unit-level operations	69	72
Care staff's training	Percentage of care staff with adequate training, weekdays	81	80
	Percentage of care staff with adequate training, weekends	78	79
Available care			
Registered nurses	Number of registered nurses per number of residents, weekdays	0.038	0.043
	Number of registered nurses per resident, weekends	0.006	0.007
Care staff	Number of care staff per resident in the unit, weekdays	0.31	0.28
	Number of care staff per resident in the unit, weekends	0.26	0.25

The first time similar comparative data were reported by the NBHW was 2012 (based on data collected in 2011). This first report was initiated by Minister of Health and Social Affairs Maria Larsson in November 2011 as part of the governmental reaction to the Carema scandal (NBHW 2012), and in this section we compare both the indicators and the results in these two reports.

As the table shows, the 2018 unit survey collected a large number of indicators, and the number of questions has increased from 16 in 2011 to 29 in 2018 (reported in the table). The length of the instructions for completing the survey has also increased: the current instructions document is 78 pages long. The indicators have changed more or less every year, and virtually none of the measures reported in 2011 are identical to those in the most recent set.

What is also clear from the table is that, today, data on very few structure quality measures are collected. Instead, the vast majority of the measures refer to procedures about processes. Compared to the 2012 report, the number of technical process measures has increased while the number of structure measures has declined. Further, the table also shows that a much higher proportion of the private providers report that they meet these process quality criteria measured by the presence of

documents. The public providers instead score higher in structure measures such as staffing ratio although not in the reported number of registered nurses or training levels.

In the earlier comparison, the Board also found that the public sector showed better results on structure measures while the private sector scored much higher on process quality measures such as risk assessment for pressure sores, falls and malnutrition (measures not collected in the 2018 version of the survey, and measures that do not capture the incidence of actual pressure sores, falls or malnutrition). Further, its 2012 report drew on data from the user survey and found no significant differences in user satisfaction between older people receiving private versus public care. However, it also found a small (yet significant) difference in user satisfaction between municipalities with a high versus a low proportion of private services. Comparing only municipalities with at least some private provision, average satisfaction was higher in municipalities with a low proportion of private providers.

In the 2012 report, the following differences between public and private providers on structure measures were reported: in residential care staffing ratio in the for-profit sector was 0.8 per resident, 17% were employed by the hour and 22% were lacking adequate training, compared to 0.9,[23] 13% and 19%, respectively in the public. In home care the differences were bigger: 34% of the home care workers in the for-profit sector lacked formal training and 33% were employed by the hour compared to 25% and 15% respectively in the public sector (NBHW 2012, diagrams 2,4,5,6; see also Erlandsson et al. 2013: 62).

The same data (from different years) has been used in comparative studies by other researchers (Stolt et al. 2011, Arfwidsson and Westerberg 2012; Winblad et al. 2017). These studies have used more sophisticated analyses (controlling for relevant background variables) and have found a similar pattern (and more specifically that private equity owned companies score worse in structure measures and better in the process measures than other private companies).

From our perspective, the shift from structure measures to technical process quality measures in the main national quality data collection and reporting system is important. Already when NBHW published the comparison between public and private providers in 2012 the Board reported that several of the employment measures would disappear, such as turnover rate, employment by the hour and staffing ratios in residential care (NBHW 2012). According to the Board, providers found it difficult to submit the information, but there was also a push from the centre-right Government of the time: in 2012, it had asked the Board to develop new quality indicators focusing on processes rather than structural aspects of quality of care (Government Bill 2012/13:1, p. 199; cited in Erlandsson et al 2013: 63-64). (As we discussed above, the Minister was strongly opposed to the inclusion of mandated staffing levels in the contest over the NBHW's guidelines on residential care.)

Today, as we see in Table 1, measures on staffing ratios in residential care are again presented (in a different way), but there is no longer any information on staff turnover or employment by the hour in either residential care or in home care. Further, information on staff training levels is no longer collected for home care. [We plan to interview representatives of the organisations involved in

[23] Note that the indicator is not measured in the same way in 2011 and 2018, but the difference is of a similar size (11-12% higher staffing in the public than in the private sector)

setting up/changing the Open Comparison measures and hope that we will learn more about the actors behind and arguments used for these changes.]

A crucial aspect of all surveys is whether the information is valid and reliable. Are there any reasons to be sceptical about the surveys underlying Open Comparisons?

As Table 1 shows, the majority of the indicators are about procedures, for instance, procedures for how staff collaborates with a resident's family. According to the table, 72% of the private and 39% of the public nursing homes reported having such procedures. The measure is based on two questions asking whether there is any procedure, in writing and decided by the management, about how staff can collaborate with residents' families, and whether this procedure has been followed up during the last year (yes to both questions needed for yes overall). Whether or not staff actually have better relations with family members of residents in private nursing homes is not measured and so cannot be discerned from this indicator, making its validity uncertain.

Another example is the indicator of whether a resident has participated in developing or changing the care plan (private nursing homes report on average that 90% of the residents have done so compared to 77% of the residents in public nursing homes). However, an analysis by the NBHW of a variant of this measure used in a previous survey found no correlation between being involved in the drawing up of the care plan and a resident's perception of being able to have a say in how the service is provided (NBHW 2011, reported in Erlandsson et al 2013: 64). Again, the validity of the indicator as a measure of 'personalised care and user influence' is not obvious.

The Swedish Agency for Health and Care Services Analysis (Vårdanalys), which was charged with evaluating an early version of Open Comparisons, has also questioned the validity of the measures at the unit level. Its report referred specifically to nursing homes caught up in scandals, where inspections had found serious deficits in homes where the OC measures were good or average (Vårdanalys 2013: 45). Respondents to the survey have reported similar doubts about the validity of the measures, and concern about having understood the questions correctly (Lindgren et al. 2012).

There are reasons to be sceptical about the validity of the process measures, but structure measures such as staffing ratios and training level are less problematic in this respect, since research shows that staffing levels and skills correlate with care quality (Harrington, REFS). However, structure measures also need to be based on valid indicators and underlying data needs to be reliable.

The indicator for staffing levels in the 2018 survey is measured by number of employees on the roster at 9am divided by the number of residents in the unit. We do not know from this measure the actual number of care workers who are at work. Table 1 shows that public nursing homes report 11% higher staffing than private homes. Whether there is a difference in actual staffing depends on whether there is a difference between public and private providers in the extent to which a person who is sick or on leave is replaced – data on which is not collected.

Adequate training in residential care in 2018 is measured by the providers reporting the number of care workers with and without adequate training according to the roster (adequate training corresponds to at least one year of training or persons validated to having the same level of skills). In contrast to the situation in 2011, when private providers performed worse, according to this

measure there is no longer any difference between public and private providers: 81 and 80 per cent, respectively, are reported having adequate training.

There are some reasons why the quality of self-reported data from private providers may not be reliable. As we have argued, private providers and their interest organisations are acutely aware of published quality data, and use positive results widely in their advocacy and marketing activities. In an increasingly competitive environment, there may well be a temptation for providers to seek to ensure they are seen in a positive light (Lindgren et al. 2012). Indeed, the political and media climate, and the increasingly competitive environment in which consumer choice models have become more common also in residential care, mean that poor results for the private sector relative to the public could pose a significant reputational, and perhaps existential threat. Given this, is there any reason to believe that the information on training levels have become less reliable over time?

There is other evidence that suggests quite a large difference in employment conditions and skill levels between public and private providers. One source is from the city of Stockholm, where more than 60% of eldercare services are privately provided. The city requires in their contract specifications that at least half of the home care workers should have 'adequate training', defined as at least 600 hours or 30 weeks of other vocational training in care. The city formerly ask the providers to report only the proportion of workers with training (as the NBHW does in the unit survey), without further monitoring. In 2015, only 10% of providers (public and private combined) reported not fulfilling this requirement. In 2016, the city asked for confirming documentation, and the proportion of providers fulfilling the requirement decreased significantly – with a very big difference between public and private providers. Among public home care units, 80% fulfilled the requirement, compared to 51% of private units (Kommunalarbetaren 2017-03-17 [this information has to be confirmed by information from the city itself].

Another reliable source of data on workforce issues is the Swedish Occupational Register (Yrkesregistret), collected and maintained by the national agency, Statistics Sweden.[24] This register includes information on the more skilled assistant nurses and the less skilled care aides in eldercare (SSYK code 5321 and 5330, respectively) employed by municipalities, for-profit companies and other organisations. In 2017, in total 214,000 assistant nurses and care aides were working the eldercare sector: 78% were employed by municipalities, 18% by for-profit providers and slightly more than 3% were employed by other organisations (mainly non-profits). According to this source 64 per cent of the care workers were assistant nurses (with more formal training) and 36 per cent were care aides with no or shorter training. These numbers are close to those reported by other sources (e.g. SOU 2017:21: 259).

According to this data source, the workforce in for-profit eldercare sector has a much lower training level: in 2017, of the care workers in the for-profit sector 52% were care aides and 48% were assistant nurses compared to 33% and 67% respectively in the public sector.[25]

[24] Statistics Sweden has been collecting information about the Swedish population and workforce for a very long period, and the quality of the data is generally considered to be very high.
[25] Authors' own calculations from Statistics Sweden: Employees 16-64 years at national level by occupation (4-digit SSYK 2012), sector and sex. Year 2014 – 2017 (visited June 12, 2019)
http://www.statistikdatabasen.scb.se/pxweb/sv/ssd/START__AM__AM0208__AM0208E/YREG50/table/tableViewLayout1/

In a recent report, the Municipal Workers Union (Kommunal) used other sources from Statistics Sweden to compare employment conditions in the public and private sector. They conclude that the employment conditions are generally problematic in care services, but clearly worse in the private sector than in the public. In 2017, 27% of the eldercare workforce had temporary employment compared to 37% in the private sector overall (and 16% in the entire labour market) (Kommunal 2018: 14). Part-time employment is also very common in both sectors but more common in private eldercare: 72% compared to 61% (Kommunal 2018: 15). Unions also have interests in selecting and presenting data for advocacy purposes. However, the reasoning behind the comparisons is well-argued and data is presented in a transparent way.

This assessment of the quality of the quality data that Vårdföretagarna relies on to support claims of higher quality in private services has revealed some problems and discrepancies that deserve closer attention. Yet despite these concerns, it is noteworthy that even the source on which Vårdföretagarna relies finds daytime care worker staffing is 11% lower in private facilities. Along with the much higher proportion of lower skilled staff in private facilities shown by Statistic Sweden's Occupational Register, an account of the source of the handsome profits of private care companies begins to emerge, along with demonstration of the clear interest private providers' interest organisations have in deflecting and preventing regulation of staffing levels. At any rate, this is how the Social Democrats reasoned in explaining the governent's directives to the commission to investigate restricting profit-taking that we noted above:

> Today we see that large profits are generated through the consistently lower staff density in, for example, independent schools and in private nursing homes. In light of this, staffing density, staffing costs or other quality-related costs should be regulated so that they cannot be significantly lower in private operations than in the respective municipal or county council operations. The purpose is to increase the quality and ensure a more efficient use of tax funds. This should be regulated by laws and regulations.[26]

[26] https://news.cision.com/se/socialdemokraterna/r/nationella-kvalitetslagar-for-ordning-och-reda-i-valfarden,c9325949

References (incomplete)

Andersson, K., Hanberger, A., & Nygren, L. (2018). Governance, accountability, and organizational development: Eldercare unit managers' and local politicians' experiences of and responses to state supervision of Swedish eldercare. *Journal of Aging & Social Policy*, *30*(5), 419-439.

Bos, A., Boselie, P., & Trappenburg, M. (2017). Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review. *Health Care Management Review*, 42(4), 352-368.

Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*, *44*(3), 166-206.

Erlandsson, S., Storm, P., Stranz, A., Szebehely, M., & Trydegård, G. B. (2013). Marketising trends in Swedish eldercare: competition, choice and calls for stricter regulation. In Meagher, G. and Szebehely, M. (eds) *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences*, Stockholm University.

Hagbjer, E. (2014). *Välfärdstjänster: tillstånd, tillsyn och uppföljning*. SNS Förlag, Stockholm.

Hämberg, E. (2013). Supervision as control system: the design of supervision as a regulatory instrument in the social services sector in Sweden. *Scandinavian Journal of Public Administration*, 17(3), 45-64.

Hanberger, A., & Lindgren, L. (2018a). *Perspektiv på granskning inom offentlig sektor*. Gleerups Utbildning AB.

Hanberger, A., & Lindgren, L. (2019) Evaluation systems in local eldercare governance. *Journal of Social Work*, 19(2), 233–252.

Hanberger, A., Nygren, L., & Andersson, K. (2017). Can state supervision improve eldercare? An analysis of the soundness of the Swedish supervision model. *British Journal of Social Work*, 48(2), 371-389.

Isaksson, D., Blomqvist, P., & Winblad, U. (2018). Privatization of social care delivery–how can contracts be specified? *Public Management Review*, 20(11), 1643-1662.

Jönson H (2016) Framing scandalous nursing home care: what is the problem? *Ageing and Society* 36(2):400-419.

King, R. (2007). *The regulatory state in an age of governance: soft words and big sticks*. Palgrave Macmillan, Cham.

Konkurrensverket (2014) *Kravspecifikation för upphandling av hemtjänst*, Vägledning från Konkurrensverket 2.

Levi-Faur, D. (2014). The welfare state: A regulatory perspective. *Public Administration*, 92(3), 599-614.

Lindgren et al. (2012)

Meagher, G., Szebehely, M. (2019) 'The politics of profit in Swedish welfare services: Four decades of Social Democratic ambivalence', *Critical Social Policy*, 39(3): 455–476.

Moberg, L., Blomqvist, P., & Winblad, U. (2018). Professionalized through audit? Care workers and the new audit regime in Sweden. *Social Policy & Administration*, 52(3), 631-645.

Montin, S. (2017). The politics and management of eldercare in flux – the case of Sweden, paper for conference COST Action on 'Local Public Sector Reforms: An International Comparison (LocRef)', 9-10 March.

Montin, S., Johansson, V., & Lindgren, L. (2018). The Institutionalisation of Performance Scrutiny Regimes and Beyond: The Case of Education and Elderly Care in Sweden. In I Koprić, H Wollmann and G Marcou (eds) *Evaluating Reforms of Local Public and Social Services in Europe*. Palgrave Macmillan, Cham. (pp. 97-114)

Power, M. (2003). Evaluating the audit explosion. *Law & Policy*, 25(3), 185-202.

Regeringskansliet (2015) Öppna jämförelser inom socialtjänsten och hemsjukvården - Handlingsplan 2015–2018. https://www.regeringen.se/rapporter/2015/12/oppna-jamforelser-inom-socialtjansten-och-hemsjukvarden/

Ronald, L. A., McGregor, M. J., Harrington, C., Pollock, A., & Lexchin, J. (2016). 'Observational evidence of for-profit delivery and inferior nursing home care: when is there enough evidence for policy change?' *PLoS Medicine*, 13(4), e1001995.

SKL, Svenskt näringsliv and Vårdföretagarna (2014) *Upphandla bättre: guide för styrning mot kvalitet i upphandling av särskilt boende inom äldreomsorgen*, https://webbutik.skl.se/bilder/artiklar/pdf/5338.pdf

Socialutskottet (2012) Socialutskottets betänkande 2011/12:SoU11 (23 Feb)

SOU 2017:38 Kvalitet i välfärden – bättre upphandling och uppföljning https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2017/05/sou-201738/

Stolt, R., Blomqvist, P., & Winblad, U. (2011). Privatization of social services: Quality differences in Swedish elderly care. *Social Science & Medicine*, *72*(4), 560-567.

Svenskt Näringsliv (2013) *Kvalitetsrekommendation för vård, skola och omsorg*. Stockholm.

Tenelius H & Selling N (2016) *Välfärdslobbyisten.* Stockholm: Ekerlids förlag.

Ulmanen, P., & Szebehely, M. (2015). From the state to the family or to the market? Consequences of reduced residential eldercare in Sweden. *International Journal of Social Welfare*, 24(1), 81-92.

Upphandlingsmyndigheten (2016) *Avtalsförvaltning*,Vägledning no. 2. https://www.upphandlingsmyndigheten.se/globalassets/publikationer/vagledningar/2016_2_avtalsforvaltning.pdf.

Upphandlingsmyndigheten (2017) *Avtalsuppföljning av vård och omsorg*,Vägledning no. 3. https://www.upphandlingsmyndigheten.se/globalassets/publikationer/vagledningar/upphandlingsmyndigheten_vagledning_avtalsuppfoljningvardomsorga4_low_170214.pdf.

Vogel, S. K. (2018). *Marketcraft: How Governments Make Markets Work*. Oxford University Press.

Vårdanalys (2013)

Vårdföretagarna (2013) *Man vill veta vad som gäller! - en rapport om kvalitet i äldreomsorgen*. https://www.vardforetagarna.se/app/uploads/sites/3/imported/VF-Man-vill-veta-vad-som-galle-A.pdf

Vårdföretagarna (2014) Remissvar; SIS standard 'Kvalitet i omsorg, service, omvårdnad och rehabilitering för äldre med omfattande behov i ordinärt och särskilt boende' (SIS-remiss 12412), https://www.vardforetagarna.se/app/uploads/sites/3/imported/VF-SIS-12412-Kvalitet-i-aldreb-A.pdf

Winblad, U., Blomqvist, P., & Karlsson, A. (2017). Do public nursing home care providers deliver higher quality than private providers? Evidence from Sweden. *BMC health services research*, *17*(1), 487.