SURVIVING THE COMPETITION? ON MUNICIPAL HOME CARE SERVICES IN A MARKETIZED ELDERLY CARE (*)

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I. Introduction

Among recent developments in the Swedish welfare state, one of the most prominent could be referred to in terms of *marketization*, defined as "the penetration of essentially market-type relationships into the social welfare arena" (Salamon 1993: 17). A prime example of marketization is the Act on System of Choice in the Public Sector (*lagen om valfrihetssystem*, hereafter referred to as LOV) introduced in 2009 (Prop. 2008/09:29). The act gives the Swedish municipalities the option to introduce so-called choice systems in for example elderly care, especially within home care services. In April 2019, the system had been adopted by 159 of 290 Swedish municipalities (Swedish Association of Local Authorities and Regions, 2019).

Briefly, the system of choice in the case of LOV requires that the municipality sets up criteria that welfare service providers have to fulfill in order to be able to conduct a particular service. If the criteria are met, the service provider becomes an option in the system that the elderly can choose (Feltenius & Wide, 2015; Jordahl, 2013; Wide & Feltenius, 2016). However, first the elderly must have been granted home care service by the municipality. This is a decision formally taken by the responsible care manager of the municipality (Erlandsson et al., 2013).

Such marketization discussed has amounted to *privatization*. This refers to an increase in the "proportion of functions performed by the private or the third sector, for which the state has responsibility" (Ascoli & Ranci, 2002a: 4) However, at least in the Swedish welfare state, it is seldom the case that the public sector completely withdraw from the role of being a welfare provider. Therefore, the system of choice consists of a

so-called “welfare mix” with different types of providers: for-profit, non-profit and public (Ascoli & Ranci, 2002; Sivesind & Trætteberg, 2017).

“For-profit” providers, for example limited companies (Jordahl, 2013: 25), often conduct business in order to generate profit. To that end, it is important for them to develop services that attract a growing share of consumers (Trætteberg, 2015; Wollman, 2014). Thus, a common activity of for-profit actors is the creation of new niche markets within the field of care, such as services in different languages (Billis, 2010). “Non-profit” refers to actors whose activity is aimed at something else than generating a profit (Jordahl, 2013: 24). Instead, it is about the organization’s values having an impact on the concrete activities. It could be an ethic value or a specific idea of how the care should be offered or conducted (Smith & Lipsky, 1993).

Also, the mix of different providers includes the public provider, i.e. services provided by the municipality. The public provider are likely to develop its services with the “average-citizen” in mind (Trætteberg & Sivesind, 2015). Hence, the public provider tends to have services where “one-size fits all”, without taking notice to specific individuals and their needs. The reasons behind this is to be found in the hierarchical governing of the public provider in accordance to the logic of representative democracy. The public provider is being governed by written plans adopted by elected municipal politicians with the interest of the whole municipality, not particular groups (Trætteberg, 2015; Wollman, 2014).

The public provider is an interesting actor in the “welfare mix” of marketized welfare. When discussed in the literature, it is often viewed in critical terms, particularly in light

of their inflexibility in welfare provision and their hierarchical governance which shows little influence for the care provider. Against this background, the question addressed in this paper is whether the public welfare provider can survive amid competition with profit and non-profit providers of welfare and, by extension, how their dynamic in the market could be understood.

In broader terms, this paper aims to describe and discuss the position of the public provider in Swedish municipalities that have adopted LOV in offering home care services. We define the position of a provider as its share of care recipients in the municipality. Is there a variation between the municipalities regarding the position of the public provider? If there is any variation, how can it be explained or understood? Is it a question of the municipalities' socio-economic structure, or what else? This last question is only partly answered in this paper, leaving its full analysis and discussion to further research.

In our empirical investigation, we analyzed the Swedish municipalities that had the Act on System of Choice (LOV) in operation in home care services in 2018 (152 of 290 municipalities). Data about those municipalities have been available from the Swedish Association of Local Authorities and Regions (2019). Data on the share of individuals assessing care from different type of providers, i.e. public and private, have been available from the National Board of Health and Welfare (*Socialstyrelsen*). In addition, we have also analyzed data from Statistics Sweden (*SCB*) regarding the socio-economic structure of the municipalities.

This paper is structured as follows. To begin, in the next section, the theoretical assumptions about different kind of welfare providers (for-profit, non-profit and public) is elaborated. In the third section, the results of the empirical investigation are presented and discussed. We will show the increase of the number of municipalities with LOV and the position of the public provider as well as an investigation of the patterns between the position of the public provider and type of municipality. Thereafter, in the fourth section, we will discuss plausible explanations to these patterns. The fifth and final part provides the reader with a short summary of the paper.

II. Different providers of home care services

Marketization and the 'Welfare mix'

In recent decades, the Swedish welfare state has undergone major changes towards marketization (Petersen & Hjelmar, 2013; Pierre, 1995; Salamon, 1993), defined as "the penetration of essentially market-type relationships into the social welfare arena" (Salamon 1993: 17). In provision of elderly care, one of the most evident examples of marketization has been the adoption of different types of models for procurements. The most established of these models derives from the Public Procurement Act (*lagen om offentliga upphandlingar,* LOU) and can be summarized in terms of "the-winner-takes-it-all". In this model, the contract is awarded to the actor with the most attractive bid in terms of the quality descriptions or cost of services, if not both (Segaard & Saglie, 2017). In Sweden, that way of contracting welfare services has for instance been applied in nursing homes for elderly (Feltenius, 2017).

By contrast, a system of choice such as LOV accomodates more than one winner. In fact, all welfare providers who meet the criteria stipulated by each municipality are permitted to offer services. After being granted by the municipality, the providers success or failure is depends entirely on if the citizens prefer them. In the provision of elderly care, LOV has been most evident in home care services (Feltenius & Wide, 2015) in which there is a "welfare mix" of different providers: profit, non-profit and public (Ascoli & Ranci, 2002b).

Both in the case of LOV and LOU, it is important to point out that municipalities are not required to implement these acts in elderly care. Thus, a municipality can choose whether a nursing home for the elderly should be run by the municipality or if it should be procured. The same applies to LOV, where the municipalities can choose between implementing the law or not.

For-profit providers

In research on elderly care, considerable attention has been paid to for-profit and non-profit welfare providers (Feltenius, 2017; Meagher & Szebehely, 2013; Sivesind, 2017; Trætteberg, 2017). In the case of for-profit providers, it has been noticed that the rationale of their operations is seeking profits (Trætteberg, 2015). The outcomes of this depend on the structure of the system in which they operate. In this particular case, a system of choice, it is vital to them to develop services that can attract an increasing greater share of customers (Trætteberg, 2015; Wollman, 2014). One example of this is establishing services in different languages (Billis, 2010).

Gavanas has a Swedish home care provider's success in creating an ethnic niche in its home care service for Iranian individuals. The inspiration for this strategy came after witnessing how a home care provider with a Finnish profile had succeeded in attracting consumers (Gavanas, 2011). Accordingly, in a study of home care providers in the city of Stockholm, older people with another mother tongue than Swedish have been identified as winners in the system with LOV (Hjalmarsson & Wånell, 2013).

Another reported strategy of private providers has been to have older staff, aged 55 years and older, in order to guarantee that the care was delivered by experienced staff. It was in contrast to younger staff, that were thus considered to lack the life experience that many customers in home care services demand (Thörnquist, 2013).

Overall, however, research has shown that the profile of private providers is somewhat unclear, possibly due to legislation in the area that does not allow for any major deviations in provision. Another explanation could be that a company that over-invests in a single niche becomes vulnerable to fluctuating demand over time (Svensson & Edebalk, 2010).

Non-profit providers

Researchers have also paid attention to non-profit actors in the care of the elderly. It has been argued that this type of providers often applies other strategies in their business than public and for-profit alternatives do (Mariani & Cavenago, 2013; Osborne, 1998, 2010; Salamon, 1987; Salamon & Abramson, 1982).

According to Salamon (1993), non-profit providers are more flexible in their business activities, often due to their decentralized decision-making that facilitates a higher degree of adaptation from situation to situation. Non-profit providers can also offer a greater diversity in terms of the content of the services. Among other things, services can be adapted to the individual's specific needs. This is made possible by non-profit organizations that often work more small-scale compared to private and public actors (Salamon, 1987; Weisbrod, 1977).

The share of non-profit providers in welfare service delivery differs between the Scandinavian countries. Denmark, for instance, has a long tradition of non-profit providers which thus form the largest share in the Danish system of welfare service provision. There, within the entire field of welfare services, including ones related to education, healthcare and social services, non-profit actors' share of paid employment in 2013 was 14%. In Sweden, by contrast, that figure for the same year was only 3%, whereas between them Norway's was 8% (Sivesind, 2017).

Public providers

Compared to non-profit and pro-profit providers of welfare services, however, the public provider has received little attention in the literature, possibly because it has in been taken for granted in one way or another. Unlike for-profit and non-profit providers, the public provider does not constitute any breakthrough in welfare provision because it has always existed, both before and during the marketization of the welfare state.

An important point of departure is that the public provider belongs to the political steering chain of the representative democracy. The public provider is the "agent" in

this chain, while the elected politicians operate as the "principal" that issue the instructions. In this system, accountability is vital. The principal is accountable towards the citizens and has to be able to hold the agent accountable for its actions (Warrren, 2014). One way of ensuring this is the practice of the Weberian system for organizing the bureaucracy, with hierarchies of command and control (Pollitt & Bouckaert, 2011).

In this particular context, the public provider of welfare services represents the agent and is to be held accountable in relation to elected politicians. Accordingly, the public provider and its services is governed by written plans adopted by municipal politicians. Considering this top-down steering, it is assumed that elected politicians take their decisions with the "best interest of the municipality". Accordingly, elected politicians are assumed to have "the average citizen" in mind, rather than particular groups (Trætteberg, 2015). As a result, the content of care offered by the public provider ultimately tends to be designed according the "one size fits all"-principle, which leaves little room for "tailor made" solutions that meet specific individual needs of care (Salamon, 1987; Trætteberg & Sivesind, 2015).

The inability of the public provider to offer such tailor-made solutions has prompted the conclusion that such solutions are important within the "welfare mix", in which the shortcomings of one type of provider might be met by the strengths of another. What is assumed here is the greater possibilities of non-profit actors to provide tailor-made services (Salamon, 1987).

Why study the public provider?

In the "welfare mix" of marketized welfare states, the public provider occupies an interesting position. Although the public provider of welfare has attracted less attention than for-profit and non-profit providers, the attention that it has received has often been critical. For one, the public provider is organized hierarchically with little input for the care-giving organizations. Instead, it is steered by elected politicians who rather has the "average citizen" in mind than specific groups. This creates little, if any, room for differentiation of public welfare services. Conversely, for-profit and non-profit providers tend to develop broader portfolios of welfare services, which raises the question of whether the public provider can survive amid such competition and, if so, how.

III. The position of public providers in Swedish home care services

Number of municipalities with LOV

Since 2009, when the Swedish parliament decided on the Act on System of Choice in the Public Sector, elderly care in Sweden has undergone major changes with the market as a model. Most municipalities that have decided to introduce LOV have done so within home care services. There are a few municipalities (less than five) that have only implemented LOV within other public services, such as disability care. In figure 1 the number of municipalities with LOV is shown (home care services and other services).

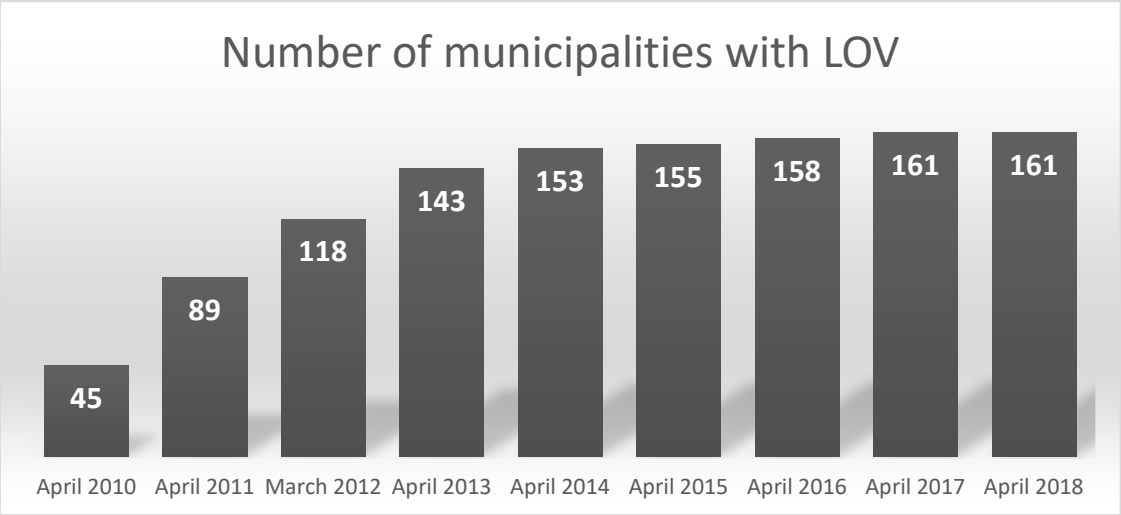

Figure 1: Number of municipalities with LOV 2010-2018.

Note: The data includes home-care services as well as other services, but few municipalities with LOV has not implemented it in home-care services.
Source: Data from the Swedish Association of Local Authorities and Regions (2019).

Figure 1 shows that the number of municipalities with LOV seems to have plateaued in the past few years. However, it should be recognized that every year some municipalities have decided to abolish there use of LOV whereas others have chosen to adopt it. More than other reasons, municipalities have abandoned LOV because few care recipients have chosen private providers or that no private providers have established themselves in the municipality (Swedish Association of Local Authorities and Regions 2019).

Different groups of municipalities

Municipalities that have decided on LOV differ significantly in the types of home care providers that they host, from exclusively public ones to exclusively private ones. By deciding on LOV the municipality seeks to create a market of different providers of home-care services. Thereafter, in the next stage, elderly entitled to home-care services may choose from a variety of providers. However, the result of LOV considering the

type and number of providers vary considerably from municipality to municipality. Thus the appearance of the market of home-care services in the municipalities is heterogeneous.

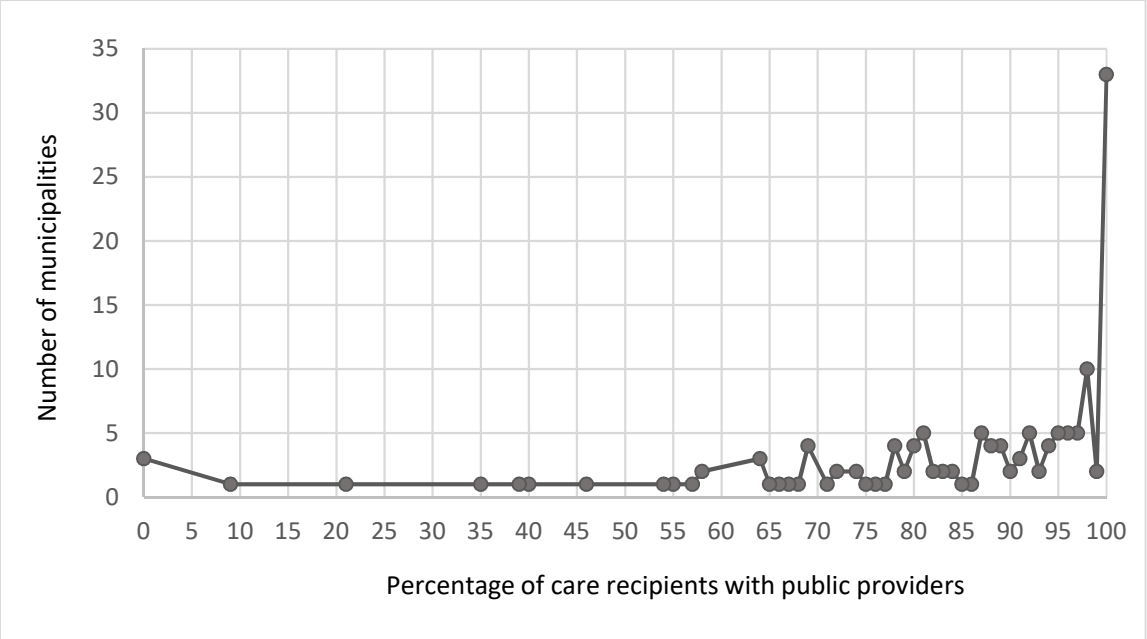

Figure 2. Share of care recipients with public providers in home-care services. Number of municipalities for each percentage, 2018. Total: 145 municipalities.

Source: Data from the National Board of Health and Welfare (2019).

Figure 2 and Table 1 show this heterogeneous landscape of marketized home-care services. In average 84 % of the care recipients in the municipalities with LOV still have public home-care services. This means that, seen to the country as a whole, the public home-care is dominant. However, as shown the picture is more diverse. In some municipalities there are only private providers, while in others the municipality has yet not succeed in attracting any private providers. The data in Table 1 highlight that, in a group of 11 municipalities, 0-55% of the care recipients have the public provider. In a group of 32 other municipalities, the percentage is 55-80%. In a large group of 47 municipalities, 81-100% of the care recipients have public providers.

Table 1. Share of care recipients with public providers in home-care services. Number of municipalities, 2018. Total: 145 municipalities.

Percentage of care recipients with public provider														
	0-20%	21-40%	41-50%	51-55%	56-60%	61-65%	66-70%	71-75%	76-80%	81-85%	86-90%	91-95%	96-100%	Total
Number of municipalities	5	3	1	2	3	4	7	6	12	12	16	19	55	145

Source: Data from the National Board of Health and Welfare (2019).

Municipal structure and private providers of home care services

Why is there a variation between the municipalities as seen in Table 1? This might of course depend on several factors, but one reason is probably that some municipalities are simply more lucrative than others to private providers. Densely populated urban municipalities with large potential customer bases are generally more enticing to private providers than sparsely populated areas with limited opportunities to efficiency. One example in the first category is the capital Stockholm with 562,154 inhabitants and an area of 187 km^2 (population density: 5,140 inhabitants per km^2). One example in the second category is Storuman, a small municipality in northern Sweden with 5,912 inhabitants and an area of 8,234 km^2 (population density: <1 inhabitant per km^2).

We will investigate the relationship between the percentage of care recipients with public home-care providers and the population as well as the population density of the municipalities. As Figure 2 and 3 show, a correlation seem to exist between the population structure and the share of care recipients with public providers.

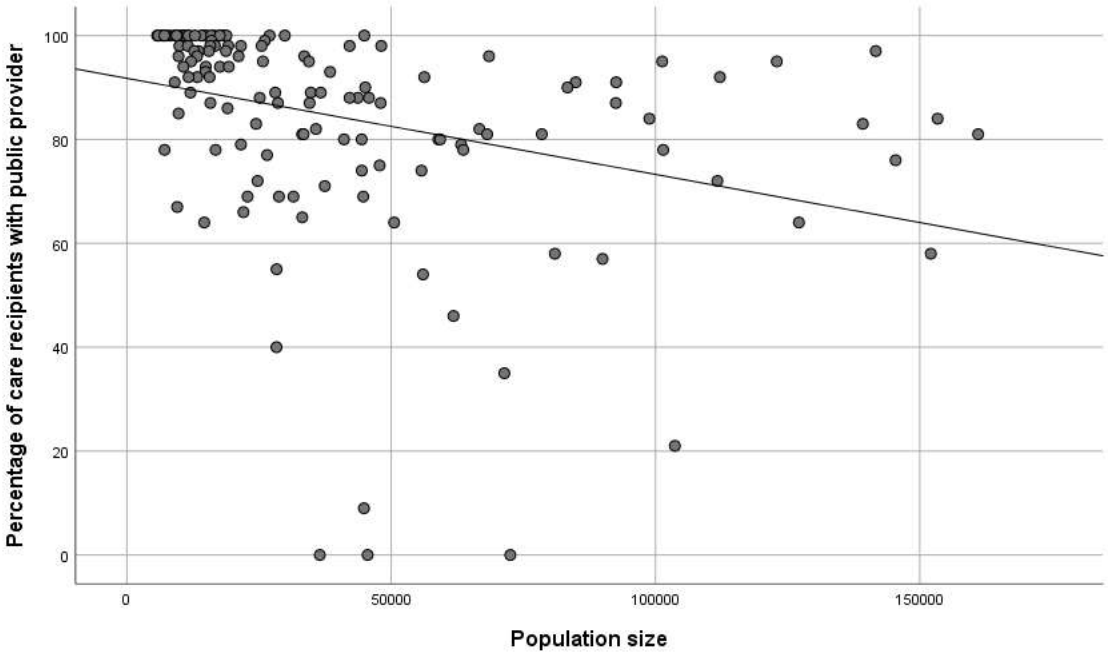

Figure 2. Correlation between population size and care recipients with public providers.

Note: To facilitate interpretation, we excluded municipalities with the largest populations (extreme values).
Sources: Data from Statistics Sweden and the National Board of Health and Welfare (2019).

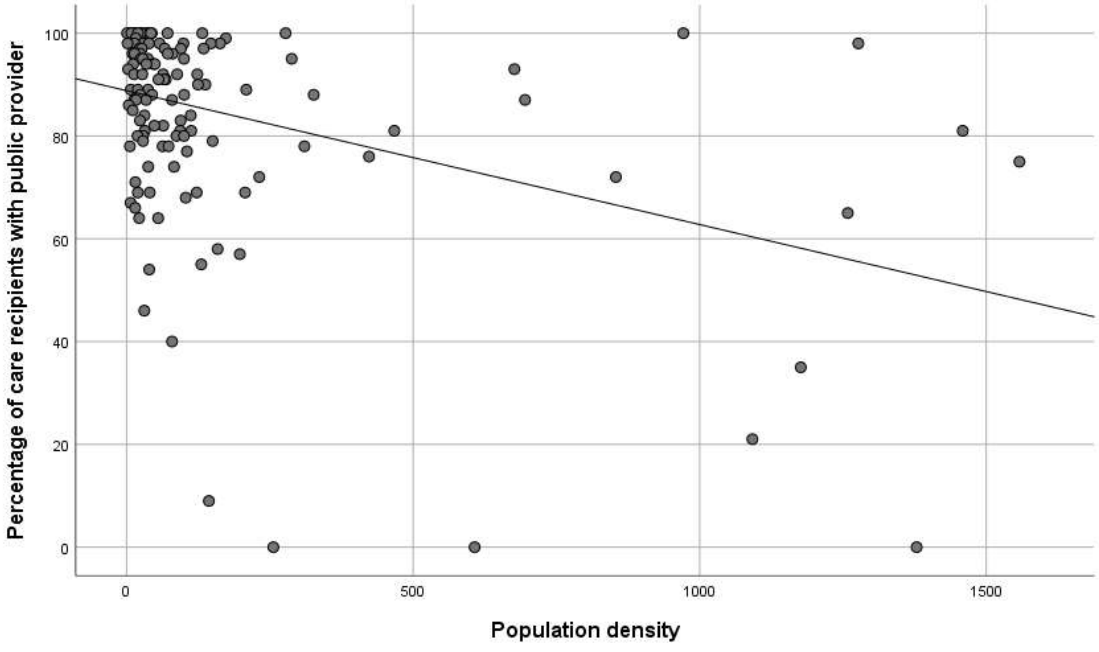

Figure 3. Correlation between population density and care recipients with public providers.

Note: To facilitate interpretation, we excluded municipalities with the highest population density (extreme values).
Sources: Data from Statistics Sweden and the National Board of Health and Welfare (2019).

We further analyzed our findings with bivariate correlation analysis, in which we log-transformed population size and population density to prevent extreme values from potentially distorting the results. There is a significant negative correlation between care recipients with public providers and population size (Pearson's r=-.432***; *p*=.000; N=145) as well as between care recipients with public providers and population density (Pearson's r=-.465***; *p*=.000; N=145). As Figure 2 and 3 illustrate, there are deviant municipalities. Some of them might be explained by other structural characteristics. For example, there are several suburbs of Stockholm with a small population size. In these cases, the closeness to other suburbs and good opportunities to coordinate the work is probably more crucial than the mere size of the population.

IV. What explains the position of the public provider and its variation: towards a research agenda

Structural explanations

Our findings indicate that the public home care provider continue to be a strong player in most municipalities that have introduced LOV. However, the findings also reveal a variation among those municipalities. In some, the public provider occupies a weak position whereas in others they outnumber the private providers. To elucidate those trends, we considered several tentative factors and indicate directions for future research.

In the previous section, we also tested whether there is a correlation between the municipality's population structure and the position of the public providers. The analysis showed that there is a significant correlation, but that there are plenty of

deviant municipalities. Thus we need to go further and investigate also other types of characteristics of the municipalities, such as political governing (left or right) and the demographics of residents. Possibly the public provider enjoy more favorable conditions in municipalities that are governed by left-wing parties. At the same time a high proportion of elderly residents in the municipality could mean a larger market that might incentivize the establishment of private providers.

Strategies as an explanatory factor

Likely the explanations concerns structural factors to some extent. However, we argue that also actors and municipal strategies for public home-care services are important. Purposeful strategies for the public provider in a competitive elderly care might explain the variation in their position from municipality to municipality.

We want to explain the potential influence of the use of strategies, or lack thereof, to position municipal home care service providers in relation to other providers. We start from a classical rationalist definition of the concept of strategy as a rational process involving long-term planning to maximize future benefits (Whittington, 2002: 8-12). According to the definition, strategies can consist of (a) goals for the services provided, (b) ideas of how the provision of those services should be organized. Both goals and organization, according to the theory, affect the content of the services provided by influencing the practical activities, working methods and use of resources of the municipal home-care service.

By *goals*, we mean operational goals that the organization wishes to achieve or realize in the future as defined in organizational theory. Goals affect an organization's structure, staff, priorities and evaluations (Christensen et al. 2007, 80-82).

By *organization,* we mean the formal organizational structure. It consists of routines, rules and procedures regarding who among the organization's personnel should and may perform various tasks as well as how the organization is controlled. This also includes the relationship to the municipal administration, as well as the relationship with other entities, e.g. other parts of the municipality's activities (Christensen et al. 2007, 23-27).

Convergence or divergence?

We believe that the design of *strategies* the municipal home care provider can be characterized by either convergence or divergence. *Convergence* means that the municipal home care provider models itself after private providers as role models and tries to imitate private providers by copy their solutions.

It might seek to maximize the number of users for which intensive marketing of the public services is a natural consequence. In particular such marketing can stress the provision of home care services in different languages or an ethical philosophy of delivering such care. In terms of organization, it may be about introducing reward systems for skilled personnel as well as performance-based pay systems.

By *divergence* we mean that the municipal provider seeks to differentiate itself from private providers. Thus the municipal home care provider models itself more according

to public organizations in general and focus less on goals common to private companies, such as efficiency. Consequently, strategies developed distance the municipal home care services from the private providers. Instead, democracy issues, such as ethics, equal treatment, transparency, co-determination, predictability and influence, are emphasized in balance with cost efficiency and service quality (Christensen et al., 2007: 6-8).

The chief goal of the public welfare provider in Swedish municipalities is to uphold the decisions made by the democratically elected political leadership in the municipality. The organization of the public provider is also characterized by equal treatment, i.e. individual achievements are not rewarded. Instead, all the staff are treated equally. In conclusion, this strategy emphasizes democratic values, which are usually associated with the public administration's primary source of legitimacy (Christensen et al., 2007; Lundquist, 1994; Lundquist, 2014; Rothstein, 2014).

Both convergence and divergence can be seen as an issue of lesson-learning. Theories on lesson-learning, as formulated in the policy analysis, contribute to our understanding of the formulation of a policy in an area (Heclo, 1974). The explanation is, according to the theory, that actors draw lessons from how other actors have solved similar problems (Bennet & Howlett, 1992). Applied to this particular case, the municipality has "learned" from other municipalities acting in an environment of a marketized elderly care or from the private home care providers. It could be the case of strategic lesson-learning to achieve goals (Rose, 1991; Christensen et al. 2007; Marsh & Sharman 2009), such as more customers, higher quality, more satisfied employees or higher efficiency. In the case of convergence it could also be a fumbling effort just to change

something, without any clear goals. In the literature this is described as imitation, i.e. in a highly uncertain environment an organization tries to emulate other organizations that are perceived to be successful (DiMaggio & Powell, 1983; Marsh & Sharman, 2009; Christensen et al. 2007 70-72).

Further research

In a forthcoming research project (2019-2020), we intend to examine the strategies of public welfare providers in a number of Swedish municipalities with LOV. The sample of municipalities will represent the variation in factors that we could identify in the third section of this paper. Thus, a few of municipalities are chosen with a robust environment for the public provider, a few with a balance between private and public providers and finally a few where the public provider has a weak position. We intend to conduct interviews with politicians, civil servants, personnel in home care and care recipients.

According to our understanding, it is important to also interview personnel and care recipients. We are not only interested in whether the municipalities have developed strategies and, if so, what these consist of. It is also important to analyse the reception and implementation of strategies among personnel and care recipients in home care. Otherwise we cannot know for sure if the strategies actually have had an impact. If the strategies have no effect, the explanations for the variation must be sought elsewhere.

V. Conclusions

This paper aimed to describe and discuss the position of the public provider of home care in Swedish municipalities with LOV. The empirical study of the public provider departed from the literature on the "welfare mix", i.e. the co-existence of different types of providers: public, profit and non-profit. According to the literature, the public provider is organized hierarchically with little influence of the actual organizations performing care. Therefor the position of the public provider in the competition with profit and non-profit providers is investigated.

The result of the empirical investigation shows that the public provider still is the dominant provider in municipalities with LOV. However, there is a variation between the municipalities. In a group of 11 municipalities, 0-55% of the care recipients have the public provider. In a group of 32 other municipalities, the percentage is 55-80%. In a large group of 47 municipalities, 81-100% of the care recipients have public providers.

In the paper, the reason for the variation is discussed in terms of a future research agenda. Structural factors that may explain the position of the public provider are for example population size and density. The position of the public provider is weaker in municipalities with a high population rate and a high population density. However, we believe that it is also important to consider more actor-oriented explanations. One such explanation targets the municipalities' strategies for the public provider. It is argued in the paper that purposeful strategies can explain the identified variation between the municipalities.

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