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Privatization in the Swedish elderly care

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Abstract

The Swedish welfare state alters radically the production of public services by introducing private operators. Consequently, this management scheme is expected to encourage competition in order to achieve greater effectiveness in the quality of services. This study analyzes from the user's perspective the effect of privatization on the perception of service quality in nursing homes. For this purpose defines eight qualitative variables that capture the quality perception of a user. In order to study whether the impact of privatization changes over time defines four models for comparison between year 2008 and 2011. The results show that the privatization level had a very weak negative effect on how users perceived the quality in the elderly care.

Keywords: Privatization, quasi-market, social welfare, state monopoly.
JEL classification: D6, H7.

Resumen

El estado de bienestar sueco modifica radicalmente la producción de servicios públicos al introducir la participación de operadores privados. Así, en este nuevo esquema de gestión se espera fomentar la competencia para lograr mayor efectividad en la calidad de los servicios. En este estudio se analiza desde la perspectiva

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del usuario, el efecto de la privatización sobre la percepción de la calidad del servicio en los hogares de ancianos. Para este propósito se definen ocho variables cualitativas que capturan la percepción de la calidad de un usuario. Con el fin de estudiar si el impacto de la privatización cambia a través del tiempo se definen cuatro modelos para comparar su desempeño entre los años 2008 y 2011. Los resultados muestran que el nivel de privatización tuvo un ligero efecto negativo sobre cómo los usuarios perciben la calidad del servicio en los hogares de ancianos.

Palabras clave: Privatización, cuasi mercado, bienestar social, monopolio estatal.
Clasificación JEL: D6, H7.

1 Introduction

The aging population is a challenge to Swedish welfare society. Official records show that in 1950 only 9.4 percent of the Swedish population were older than 65 years while in 2011 this proportion had increased to 18.8 percent. This represents two great challenges for the welfare state: Assuring enough funding for a growing number of pensioners, and offering adequate attention to the elderly. The pension system is amended by taking steps to ensure long-term financing. Moreover, the social welfare sector for the elderly is reformed by introducing a model which in economic theory is called "quasi-market". In this model, public as well as private operators are involved in the production of public services.

It should be noted that the adoption of this model implies the end of the former state monopoly in the production of welfare services. The new rules allow private operators to work in the field of social services funded by the state budget, creating a market that is governed by new laws. While the state monopoly is somehow abolished, the characteristics of this new market do not exactly correspond to those of a competitive market.

The purpose of this study is to analyze the effects of privatization on the perception of the quality in elderly care in Sweden of the users. The dependent variable captures how the user subjectively perceived the overall quality. Independent variables included the privatization and seven qualitative variables that capture different aspects of quality. The data comes

from two databases the "Öppna Jämförelser" (Oppen Comparations) developed by SALAR[2] and "Sveriges Oficiella Statistik" (Sweden´s Oficial Statistics) produced by the National Board of Health and Welfare[3].

The paper is organized as following. Section 2 presents the recent literature regarding the introduction of quasi-market in the welfare sector. Section 3 defines the theoretical foundations of the quasi-market and the reasons for the privatization of public services are discussed. Section 4 describes the Swedish elderly care. Section 5 describes the data. Section 6 presents the results. Finally, in Section 7 are presented the conclusions of this study.

2 Earlier literature

Stolt and Winblad (2009) extensively analyzed the characteristics of the process, which replaces homogeneous services production for another largely characterized by heterogeneous production of goods and services, and participation of diverse economic agents. The new service market involves several providers giving users the ability to leverage the freedom of choice. In Edelbalk and Svensson (2005) noted that freedom of choice reduces when it comes to small towns because they offer fewer options. The article from Meinow, Parker and Thorslund (2011) examines the ability of adults to both obtain the necessary information to make decisions about their own care, as for making such decisions itself. The authors found that among adults physical and cognitive barriers exist that disrupt both processes.

In Szebehely and Trydegård, (2007), Hartman (2011) and Stolt, Blomkvist and Winblad (2011) it has been shown how the lack of freedom of choice or the inability to exercise it when possible, have hindered the expected development process of quasi-markets. Other authors, such as Hjalmarson (2003), point out, the lack of information users have about alternatives to choose a vendor of their convenience as a negative factor for achieving

[2] SALAR, Swedish Association of Local and Regional Authorities (in Swedish: Sveriges Kommuner och Landsting).

[3] The National Board of Health and Welfare (in Swedish: Socialstyrelsen).

the desired objectives. As quasi-markets are largely based on individual choices, the lack of information hinders its successful development. Ivarsson (2010) emphasized that the user may exercise the use of freedom of choice as long as there is good information on suppliers to choose from.

Recent literature emphasizes that the provision of social assistance services by private agents, financed by fiscal budget is not free from complexity. A report by Laura Hartman (2011) presents a set of papers analyzing the degree of coincidence between the results achieved and the expected results by the promoters of this market transformation process, so far serviced exclusively by the state. These studies show that empirically it is not possible to quantify the degree of coincidence between actual and expected performances as a result of the privatization. In Bergman et al (2012) study the effect of outside procurement on non-contractible quality dimensions. The authors analyzed non-contractible quality, as measured by survival rate, using a panel data with almost all Swedish municipalities over en period of up to 19 years. They conclude that the procurement on non-contractible has increased quality and reducing cost per user.

3 Theoretical Considerations

3.1 The quasi-market

The privatization of the social security sector called elderly care, in the framework of so-called quasi-market . Social services aimed at end users are neither bought nor sold in a traditional market where prices and quantities are determined by supply and demand. Unlike a traditional market, the quasi-market involves three operators. On the supply side, there is an agent (the supplier) who can be both a public enterprise as well as a private operator, while on the demand side, two agents are involved: people over 65 years (the users) and the municipal authority (the customer) who hires the welfare services by public tender.

In the quasi-market, the production of welfare services exclusively by state entities is replaced by independent companies competing with each other. The epithet"quasi" is mainly explained by characteristics of the

supply and demand sides (Le Grand, 1991). On the supply side, non-profit institutions, private and public companies, offer social welfare services competing on equal terms to attract users. Another important property is that economic agents do not necessarily maximize utility (Le Grand, 1991). This is basically true when it comes to non-profit institutions and local companies involved on the supply side. On the demand side, through public procurement, the municipal authority determines the available budget for the providers responsible for producing welfare services. Then, the user selects the fit operator among several providers available. Thus, user demand is not based on price, but on preferences, quality of service offered by the operator and the requirements of the goods.

Based on the above, in a quasi-market, the classic market elements are mainly expressed by the supply side. The demand is not subject to competition and it is determined by the budget. This means we need different evaluation criteria to those used in a market economy. Bartlett and Le Grand (1993) propose four criteria to evaluate the performance of this market:

1. Efficiency: the provider must offer welfare services of high quality and low cost,

2. Responsiveness: analyzes the capacity and speed of the quasi-market to adapt to the needs and preferences of the user,

3. Choice: freedom of choice is a prerequisite to foster competition and thus greater efficiency, and

4. Equity: freedom of choice will be satisfactory if the possibilities to choose are the same for all users. It is worth noting that freedom of choice and equality are important evaluative dimensions because they are part of the reasons for the existence of this market.

Successful operation of a quasi-market requires that certain conditions are met. In this regard, Bartlett and Le Grand (1993) define five conditions. *i)* a competitive market structure, *ii)* complete and accurate information

to reduce risk of asymmetric information, *iii)* low transaction costs and low uncertainty, *iv)* interaction in the motivational structure of suppliers and users, and *v)* absence of adverse selection as "cream-skimming". Naturally, there is always a risk that the economic and welfare policies do not match the five conditions listed. Thus, like in a traditional market, failures in the performance and enforcement of economic and social objectives are also identified in a quasi-market. Lowery (1998) presents a comprehensive analysis of quasi-market failures, where the institutional framework and consumer power are important explanatory components.

The production of welfare services as a state monopoly activity began to be sharply questioned during the 1980s. The criticism emphasized the problems of efficiency caused by lack of competition and consumer power. Therefore, the quasi-market aroses as a response to operational and distributive inefficiencies. Le Grand (1991) points out that increased competition among several providers should improve allocation efficiency, since under monopoly conditions, game rules can cover inefficiencies. The operational inefficiency measures the difference between the actual cost and the lowest possible cost, which occurs due to lack of competition or internal conditions problems. The transformation of the state monopoly in a quasi-market is supposed to promote competition. It is therefore expected that the process of privatization will lead to a proper use of resources, reducing the inefficiency in the sector (Connolly and Munro, 1999).

Freedom of choice is another argument that justifies the introduction of quasi-market . Indeed, the supply of services in the quasi-market is provided by operators previously selected through a process of public procurement. Then, the user chooses the most convenient operator (Blomqvist and Rothstein, 2005). It is important to remember that the monopolization of the production and supply of social services by the state did not offer alternative options. Consequently, the state does not adequately respond to the needs and preferences of users.

3.2 Exit, voice and loyalty

Interacting forces in a quasi-market are not automatically regulated by the "invisible hand" of Adam Smith. Therefore, it requires the presence of effective regulatory institutions and active user participation. Hirschman (1970) places great emphasis on active participation of the individual in order to influence price and quality of the good or service in question. This means in other words that the user using the properties of the market can increase or maintain their individual welfare at the same time strengthens market efficiency.

As mentioned above, economic reality reveals that most markets do not function according to the laws of competition. There are numerous monopolistic and oligopolistic situations that totally contradict the assumptions of the perfectly competitive market. The quasi-market differs from the market economy in the fact that, despite promoting competition, the state appears as an intermediary between producer and consumer, which ultimately limits free competition. It also differs from monopolistic and oligopolistic markets, but have in common the lack of automatic mechanisms that lead to efficiency in production and consumption. In addition to requirements and conditions previously mentioned, successful operation of quasi-markets requires active user participation.

In this line, Hirschman (1970) develops a model which explains how user participation can influence market behavior. Hirschman's argument (1970) is summarized in the concepts of "Exit, voice and loyalty". "Exit" refers to the fact that users dissatisfied with their current suppliers can easily switch to another provider. "Voice" points to users dissatisfied with the services provided by the supplier. If users express their discontent and criticism in an open way, credibility of vendor in question can be reduced. Therefore, suppliers must improve their service delivery in order to avoid losing customers. The existence of adequate mechanisms that facilitate the possibility of voice is important to ensure competition. Thus, upon becoming discontent users can choose to switch suppliers (exit) or remains with the supplier in question, while expressing dissatisfaction (voice). "Loyalty" occurs when patients do not take any action despite their dissatisfaction.

Depending on the degree of loyalty, the user will use either “exit” or “voice”.

3.3 Privatization Theory

For many decades the state has played a leading role in Western Europe’s welfare economies. Thus, the welfare state assumed in different countries different degrees of liability in strategic sectors such as telecommunications, banking, and insurance. At the same time, the welfare state took over social sectors such as education, health and social security in order to ensure broad social coverage. Shleifer (1998) stresses that even in market economies, an important place is assigned to state. The degree of state involvement depends on the economies’ development—less so in Japan and the USA, while in Scandinavia, France and Austria, state participation is evident in the production of goods and services.

3.4 Privatization

Privatization of public enterprises in Europe is long-standing (Megginson & Netter, 2003; Robinsson, 2003). However, the beginning of privatization in the field of public services is commonly associated with the arrival of Margaret Thatcher’s Conservative government. Privatization activity is based on both political and economic reasons such as absence of incentive of the state to reduce costs and, in some cases, susceptibility to political pressure. This can cause operational inefficiency and deterioration in public finances. Among economic reasons that motivate privatization are the need to increase competition, improve public finances and change market structure (Megginson & Netter, 2003). Related to investment incentives, when the assets belong to the state, decision making is relatively weaker than when they are in private hands (Shleifer, 1998). On the other hand, it is argued that privatization per se is not the tool that leads to increased production and lower costs, but it is much more important than the institutional and regulatory framework in which it is developed (Megginson & Netter, 2001; Shirley & Walsh, 2001; Parker, D. & Kirkpatrick, C., 2003).

Initially, privatization theory focused mainly on public asset privati-

zation. During recent decades, the privatization of welfare services such as education, health, and care for the elderly is gaining strength in some developed economies. In Nordic countries in general, and Sweden in particular, the State is almost entirely responsible for the production of welfare services.

In general, it is argued that privatization of welfare services is due to budget deficit and public administration failures. Ideological reasons also play an important role in making decisions related to privatization. The privatization approach emphasizes that the welfare state, financed via taxes, inhibits the incentive structure. This reason, according to the theory of privatization, explains the inefficient performance of the service delivery units of welfare and at the same time provides grounds to justify privatization.

Privatization theory assumes that the market, by definition, assigns and distributes resources efficiently, which means revisiting the central assumptions of classical economics. Therefore, economic equilibrium is obtained thanks to the free play of market forces. However, empirical evidence shows that the market mechanism does not always generate a socially optimal economic equilibrium. Connolly and Munro (1999) emphasize that privatization can also generate a production volume beneath the socially optimal level, particularly when individual and social interests do not match.

In many cases, decision makers can perceive externalities that individual traders do not perceive. An interesting example is the higher education market. Normally in this market, due to asymmetric information and financial resources problems, not every applicant will be included. Consequently, society as a whole will waste human resources, and this adversely affects human capital formation. While this point may seem out of the interest of individual providers of this service, the decision makers must be able to perceive the social need.

4 The Swedish elderly care

Elderly care in Sweden is an important component of Swedish social welfare policy. According to Esping-Andersen, welfare state typology, the respon-

sibility of society for older people care, in Swedish rests almost exclusively on the state pillar[4]. Thus, Swedish society assigns virtually zero participation to the family and market pillars. Since the 1980s from ideological, economic and political angles, it begins to question whether this sector is the sole responsibility of the welfare state.

The organizational change in the service sector of care for the elderly goes back two decades. In effect, the Community Care Reform (in Swedish: ÄDEL-reform) that came into force in January 1992 assigned financial and organizational responsibility of social welfare services to municipalities, including nursing home. Then operational and financial responsibilities for such services were transferred from the county councils to the municipalities. Moreover, the Local Government Act (1991:900) and its subsequent amendments allowed municipalities to hire private companies, cooperatives or non-profit foundations to take charge of the nursing home.

As previously mentioned, a quasi-market differs from a traditional competitive market in many ways; however, the presence of market failures is a common denominator. Therefore, the proper functioning of a quasi-market demands a legal regulatory framework to fully control the three economic agents involved: users, suppliers and customer. The Swedish Public Procurement Act (2007:1091) (in Swedish: Lagen om Offentlig Upphandling, LOU), which came into force on January 1, 2008 specifies the rules to be submitted for the private operator. The Swedish Public Procurement Act aims to enable, on equal terms, the participation of a large number of companies in the bidding process. With this law, municipalities hoped to minimize the costs by choosing the right provider.

Since the 1990's, the nursing home social welfare sector in some municipalities of Sweden has been submitted to competition. Despite the steady increase in private providers in the early years, it has not stood high in the official statistics yet. In 1999, the participation of private providers in the sector reached 10 percent (Szebehely, 2000). Official statistics reveals that in 2011, the percentage share of the private sector that provides this

[4] Esping-Andersen (2003) defined three pillars on which the welfare state rests: market, family and state.

service did not increase significantly. Indeed, private providers have recently recorded a share of 20 percent (Eek, 2012), which has remained relatively stable since the Swedish Public Procurement Act approval in 2007. However, although after two decades of privatization, the private providers percentage has not increased as expected, though the recent trend is upward. Interestingly, the distribution of private operators in the sector is not homogeneous across the country, with a high concentration of private operators observed in the Stockholm region while privatization in municipalities located in the northern region is quite marginal. An extreme example is Nacka municipality situated in the Stockholm region, which has the highest number of privatizations and nowadays has 55 percent of nursing home operated under private regime (Socialstyrelsen, 2012a).

5 The Data

Every variable, except the degree of privatization, comes from the "Öppna Jämförelser" database (Oppen Comparations) developed by the Swedish Association of Local and Regional Authorities (Sveriges och Kommuner Landsting)[5] and the National Board of Health and Welfare (Socialstyrelsen). This database includes 256 of the 289 municipalities in Sweden. The degree of privatization variable comes from the database "Sveriges Oficiella Statistik" produced by the National Board of Health and Welfare[6].

Table 1 shows the dependent variable Total perception. This measure subjectively collects how patients perceive the quality of the whole service. The independent variables $(2-8)$ capture from different angles how users perceive the quality of service. Therefore, these variables measure the subjective perception of a user about the quality of service and to what extent the service received by the user corresponds to predetermined expectations. A description of the content of the independent variables can be summarized as follows:

[5] Socialstyrelsen & Sveriges Kommuner och Landsting (2012), Öppna Jämförelser-2012, SKL och Socialstyrelsen.

[6] Socialstyrelsen (2012b), Sveriges officiella statistik, Socialstyrelsen.

- Treatment: measures the degree of patient satisfaction with the treatment received from the staff.
- Influence: measures the degree of user satisfaction with the way the staff takes their views into account.
- Security: indicates the proportion of users who are confident about living in nursing home units.
- Food: indicates the proportion of users who are very satisfied with the taste of the food.
- Activities: measures how satisfied users feel with social activities offered.
- Outdoors: measures the proportion of patients who are very pleased with the opportunity to get outdoors.
- Privatization: measures the percentage of hours of service provided by private providers in each municipality.

Dependent and independent variables $(2-8)$ are at the municipality level. Independent variables collected information from people over 65 living in a nursing home. The values of the variables indicate the proportion of people who answered between 8 and 10 on a survey with a 10-point scale. The range $8-10$ indicates that the respondent (the user) assigned a high degree of satisfaction and approval. These variables were indexed and converted into percentages. For example, if a variable in a certain municipality has the number 85, it means that at least 85 percent of respondents assigned a value between 8 and 10 on the 10-point scale. Variables are taken from a database composed of people over 65 years old living in a nursing home.

Table 1 shows descriptive statistics for selected variables. The dispersion of the dependent variable Total perception is the lowest among the analyzed variables. As we can see, this variable also decreases during the period. On the other hand, the dispersion of the variables Treatment, Security, and Influence decrease significantly between 2008 and 2011. At the same

time we observe a high dispersion in the variables Food, Activities, and Outdoors. It is worth adding that the range of variation of the variable Activities was between zero and 64 percent in 2008 and between zero and 72 percent in 2011. This result can be interpreted as a lack or absence of social activity in some nursing homes. One possible explanation may be that some municipalities do not invest enough in staffing and procedures to schedule social activities. The high degree of dispersion of the privatization variable indicates a wide range of variation (between zero and 100 percent). At the same time, the low average value reveals that the degree of privatization to date is considerably low.

Table 1. Descriptive statistics

	2008		2011	
	Mean	Std. deviation	Mean	Std. deviation
1 Total perception	70,86	5,26	70,01	4,92
2 Treatment	70,18	10,66	66,64	7,19
3 Influence	52,42	10,37	50,58	8,85
4 Security	78,64	10,91	75,76	6,96
5 Food	51,24	10,94	50,21	9,93
6 Activities	33,58	11,54	37,77	11,65
7 Outdoors	25,63	9,00	31,43	9,04
8 Privatization	8,64	17,24	13,14	22,61

Source: Variables 1 – 7, Swedish Association of Local and Regional Authorities and National Board of Health and Welfare. Variabel 8, National Board of Health and Welfare.

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The average value of Total perception, Treatment, and Security variables is high compared with the other variables (taking into account that the variables can take values between zero and 100). The high valuation of

these three variables, to some extent, shows user satisfaction and approval of the nursing home staff. This positive response probably results from a low staff turnover, as well as secondary but significant variables like staff education and working conditions. On the contrary, the low average value of the variables Influence, Food, Activities, and Outdoors indicates that users are not fully satisfied with these services. The lowest average value observed is for the Privatization variable. One explanation is the fact that the percentage of municipalities that hire private providers is still less than half.

6 Results

Table 2. Elderly assessment of care as a function of several independent variables for the years 2008 and 2011.

	2008		2011	
Variables	Model 1	Model 2	Model 3	Model 4
Constant	54,520*** (1,667)	71,580*** (0,354)	31,730*** (1,664)	70,637*** (0,345)
Treatment	0,040 (0,043)		0,205*** (0,027)	
Influence	0,134** (0,039)		0,059* (0,022)	
Security	-0,054 (0,039)		0,191*** (0,028)	
Food	0,068* (0,028)		0,025 (0,016)	
Outdoors	0,094* (0,034)		0,086*** (0,022)	
Activities	0,156*** (0,027)		0,090*** (0,018)	
Privatization	-0,043** (0,013)	-0,083*** (0,018)	-0,012* (0,006)	-0,052*** (0,14)
Adjusted R^2	0,609	0,71	0,817	0,48
N	256	256	256	256

Note: Multicollinearity is not a problem according to the test. None of the VIF values are greater than 2.8. Standard errors in parentheses. All regressions are ordinary least squares. $^{***}p < 0.01$, $^{**}p < 0.05$, $^{*}p < 0.10$.

This study compares the performance of the selected variables for the years 2008 and 2011. Table 2 presents the estimates for four models, where 2008 includes models 1 and 2, and 2011 includes models 3 and 4. Models 1 and 3 include all variables, while models 2 and 4 only consider the variable privatization. In this way we can analyze for each year the effect of privatization on the perception of the service by users between 2008 and 2011.

The first model includes all the variables. Except for Treatment and Security, all variables are statistically significant and show positive correlation with the dependent variable, with the exception of Security and Privatization. It is worth mentioning that the Privatization variable shows a very weak negative effect, which means that the perception of quality decreases slightly when increasing the rate of privatization. The results show a good degree of explanation (adjusted $R^2 = 0.609$) and a negative correlation for variable Privatization ($-0,043$); that is, however, statistically significant at five percent. This result shows that privatization has a weak negative effect on the overall perception of service. The weak effect of privatization is not consistent with the idea that privatization will lead to improvements in the quality of service thanks to increased competition.

The second model examines how the Total perception variable is affected when using only the degree of privatization as an explanatory variable. The degree of explanation differs from the previous model by about 10 percent. Indeed, the coefficient of determination is adjusted $R^2 = 0.71$. Meanwhile, the variable privatization shows a negative correlation (-0.083); that is, however, statistically significant at one percent. This result again shows that the privatization level has a very weak negative effect on how older people feel about elderly activity in its entirety.

The third model includes all the variables analyzed in 2011. In this model, all variables except for Food are statistically significant, and only the Privatization variable shows a negative correlation. In general, the

results obtained in 2011 are more significant when compared with 2008, and the coefficient of determination is greater (adjusted $R^2 = 0.817$). The privatization variable is statistically significant at 10 percent and shows a negative correlation ($-0,012$). The weak negative effect implies that the perceived quality decreases slightly when the rate of privatization increases.

The fourth model excludes all variables except Privatization. The degree of explanation differs markedly from previous models (adjusted $R^2 = 0.48$). The variable privatization shows a negative correlation (-0.052); that is, however, statistically significant at one percent. This result, like all previous models, records little effect of privatization on the perception of the service by users.

Note that the participation of private actors involved in elderly care works in different environments. This reasoning indicates that stating the exact effects of privatization is a difficult task. There are certainly a number of background variables such as information to customers, budget constraints, size of the municipality, and municipal political leadership that may in some way correlate with privatization.

7 Conclusions

This study analyzes the effect of privatization on the perception of quality experienced by users in elderly care. The effect of privatization on the dependent variable Total Perception of Service Quality is low in all models analyzed. At the same time, in all models, the degree of explanation is relatively high. These results indicate that in some way the effect on the dependent variable can be attributed to the quality variables defined in Table 1.

Regression analysis did not show a direct relationship between privatization and the dependent variable that measures the overall perception of quality. This result is not consistent with the expectations generated by privatization in the context of a quasi-market. However, we note that quality variables such as Outdoors and Activities have a significant effect on the overall perception of the quality of service experienced by the user.

Recall that the performance of these variables is closely associated with the quality of staff. Therefore, this result indicates a sound personnel policy will generate positive effects on the operation of nursing homes.

From the above discussion it is clear that it is not possible to note positive effects from privatization in the nursing home social welfare sector. It should also be added that we cannot draw firm conclusions because the models used do not capture important secondary variables such as ideological and budgetary constraints.

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