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THE IMPACT OF PRIVATIZATION ON THE SOCIAL WELFARE STATE

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The delivery of “cradle to grave” services is a hallmark of Swedish social welfare policy, but changes in the political and economic climate of Sweden since the early 1990’s have created a demand for reform to improve efficiency and responsiveness of public services. This article analyzes the context in which privatization has been introduced in Swedish elder care. Particular aspects of Swedish social policy moderate the benefits commonly attributed to the privatization of public services in other countries, such as cost-savings, efficiency gains, and consumer choice. In addition, there are also potential negative consequences, such as decreased access to and quality of services. Moreover, privatization does not fit neatly into the existing bureaucratic and regulatory structure of the Swedish social service sector. If Swedish policymakers pursue further privatization of elder care and other social services, they must recognize the necessary trade-offs with regard to changing traditional social welfare policy

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I. INTRODUCTION

As one of the most studied social welfare states, Sweden is often recognized for its strong social insurance programs. These programs guarantee income support, generous unemployment benefits, and a universal pension system, including its large public sector that provides social services “from the cradle to the grave.” Although these public sector programs seem to be an inevitable consequence of establishing a comprehensive welfare state, they were established incrementally and continue to undergo changes in their implementation. The passage of national social welfare legislation in 1956 gave municipal governments (*Kommuner*) the responsibility of providing home help for the elderly (Swedish Institute 1999). Municipally provided childcare was not introduced until the late 1960’s (Szebehely 1998). In recent years, private organizations have begun to provide publicly financed services in both the childcare and elder care sectors. For example, parents who advocated for alternative choices to municipal day care centers organized their own childcare cooperatives and eventually the development of the current public subsidy to private childcare providers. The entrance of the private sector in the central functions of the social welfare infrastructure has created an enormous debate in Sweden on what implications this privatization of social services will have on social policy. This article analyzes the context in which the privatization of elder care has been introduced in Sweden, compares and examines the impact that the privatization of the public has had in Sweden with other countries. The results commonly attributed to privatization of services in other countries must be reexamined in light of particular aspects of Swedish social policy. The paper identifies the tradeoffs that the privatization of elder care services in Sweden requires and outlines several possible policy directions for the future organization of elder care services.

II. METHODOLOGY

The paper’s analysis of the Swedish context for privatization is based on literature in both Swedish and English, including journal articles, books, and Swedish government reports. These sources are supplemented with Swedish newspaper articles from 2000-2001 and interviews conducted during that same time period. In order to gather information on how the privatization of elder care has been implemented in city districts in Stockholm, I interviewed

eldercare administrators at three city districts who have had at least one year's experience in contracting with private eldercare providers. Earlier research suggests that administrators have the most first-hand experience with the problems and solutions that privatization has presented (Fridolf 1996). Two interviews were conducted at the administrative offices of the city districts, and one interview was over e-mail. All communication was in Swedish.¹

III. THE RISE OF PRIVATIZATION

Swedish municipalities are privatizing the provision of social welfare services for both political and economic reasons. In the case of elder care services, municipalities are contracting with private companies or individuals to provide home care and institutional health care for the elderly in the municipality. As discussed in this article, elder care can include health care (*vård*), personal care and assistance with activities of daily living such as bathing, walking, eating, and toileting, as well as other "social" care (*omsorg*) such as light housework, meal preparation, companionship in recreational activities like walks outdoors, and shopping (Trydegård 2000). In 2002, private companies or individuals provided home care services to nine percent of individuals eligible for public home care, and to twelve percent of individuals in publicly-funded special housing (Lindström and Nilsson 2003). This figure represents a small percentage of care provided in Sweden, but privatization is most concentrated in the large cities. For example, *Dagens Nyheter* reported on 16 November 2000 that in Stockholm, 57% of public elder care has been turned over to private producers. Before examining the impact that this type of privatization has on clients, municipalities, and policy, it is first necessary to consider why some municipalities consider employment of private providers as an attractive alternative to public provision of care.

Changes in Sweden's economy and politics in the early 1990's are the main reasons for the rise of privatization. First, the financial "crisis" of the 1990's is often named a critical period in Swedish history, during which the government and citizens began to closely examine the high costs of welfare state services. Public elder care, the focus of this study, became a candidate for policy reform as the increasing demand of an aging population and decreasing financial resources forced politicians to discuss the feasibility of maintaining social welfare services at

¹ Copies of the relevant interview notes and the exact references to Swedish sources available only in Sweden are available with the author.

their current level. In 1993, public spending in Sweden reached 67.5% of the GDP, while the economy shrunk by 5.2% between 1990 and 1993 (The Economist 2003). Additionally, the increasing unemployment in Sweden during the 1990's meant that the government was providing more benefits, even as income tax revenues diminished (Johansson 1997).

Economic conditions were especially bleak from the point of view of the municipalities. A 1992 social service reform consolidated responsibility for a wider range of elder care services at the municipal level, even as the national government decreased its contributions to local budgets, particularly during the years between 1990 and 1996 (Halvarson et al. 1999). In this way, "the fiscal crisis of the state was exported to local governments" (Montin and Elander 1995, 26). Instead of making budget cuts, locally elected officials favored the development of a more efficient way of producing public services that would cut costs without reducing social services that their constituents consider to be an entitlement.

Consequently, politicians and public administrators in Sweden pursued a range of government reform strategies categorized as "New Public Management" that developed throughout northern Europe in the mid-1980s. The philosophy of New Public Management promises greater efficiency through a reorganization of the public administration that both introduces management techniques of private corporations to the public sector, and encourages public entities to use market forces in accomplishing their service goals (Bäck 2003). The primacy of management principles over bureaucracy became a driving force behind reorganizing the public administration of care and facilitated the transition to the private provision of welfare services (Wise and Amnå 1993).

Second, while the demand for reorganizing the public sector may have been in response to an economic necessity felt by local politicians, a growing Conservative party in Swedish politics popularized the concept of privatization in order to challenge traditional Social Democratic policy. The Conservative party (*Moderaterna*) hailed privatization as a reform necessary to change the social welfare state by expanding the number of service providers for individuals. Indeed, "Free Choice in Care" was a winning slogan in 1991 for the Conservatives who won the majority of seats in Parliament that year for the first time in nearly sixty years (Johansson 1997, Bäck 2003). Even by the time the Social Democrats regained control in 1994, it had become politically pragmatic to address long-standing critiques of the welfare state, which argue that the public sector is bureaucratic, inefficient, paternalistic, and discourages personal

and civic responsibility (Daatland 1997). The movement towards greater privatization of services continued through the 1990s.

The Conservative party's slogan may have resonated with a more fundamental change in Swedes' political values. Papadakis and Taylor-Gooby (1987) suggest that changes in the welfare system are to be expected, since the post-WWII conditions under which the current welfare state was built have changed. For instance, citizens who demanded security in the post-war era now demand autonomy and individual choice in their service providers that is unavailable in a government-controlled monopoly of health and welfare services (Rosen 1996). In the 1970s, Ronald Inglehart identified the emergence of these values as a move towards "post-materialism," and included a greater preference for freedom and an higher quality of life, which a growing middle class in Sweden could support (Fridolf 1996).

A confluence of economic and political conditions in the 1990s made the private provision of elder care services a desirable policy direction for some municipalities, even though prior to its implementation in Swedish municipalities, privatization had been tested largely in other countries and service sectors. However, did the implementation of privatization in Sweden have the expected results?

IV. CONCURRENT CHANGES IN SWEDISH ELDER CARE

Concurrent with privatization, other changes in the provision, organization, and financing of municipal elder care services make it difficult to isolate the impact of privatization independent of other trends. For example, the total percentage of elderly people receiving publicly financed care had been decreasing long before any municipality had employed private elder care providers. For those aged 65-79, the proportion of home care recipients decreased from 11% in 1980 to 4% in 1997; for those over age 80, the proportion decreased from 34% to 20% in the same time period (Szebehely 2000). Additionally, the content of care has shifted; in 1987, 80% of all publicly-funded caregiving hours were devoted to "homemaking" activities, like meal preparation and household chores, as compared to personal care, while in 1993 only 48% of time was spent on "homemaking" activities (Sundström and Malmberg 1996).

What explains these trends? There is evidence that municipal caseworkers (*biståndsbedömare*), who determine which individuals receive care and how much care they receive, are now using more restrictive eligibility criteria to assess needs. Elderly with "lesser"

needs are being pushed out of the system, and care is becoming more focused on helping clients with the primary activities of daily living. “Focusing,” “targeting,” and “rationing” are all terms used to describe the changes in elder care that have occurred since the early 1980’s, indicating that the decision to prioritize spending on some individuals over others is being made by municipal elder care administrations, not private providers (Sundström and Malmberg 1996).

Although municipal caseworkers determine eligibility for elder care services based on need rather than income, the introduction of user fees may also limit access to services for some Swedes. Municipalities have been able to charge clients fees for elder care services since March 1, 1993, as long as the fees were small enough to allow clients a reasonable amount of money (*förbehållbelopp*) for other living expenses they or their spouse/domestic partner faced (Regeringens skrivelse 1999/2000). However, a 1996 study by the National Board of Health and Welfare (*Socialstyrelsen*) found that most municipalities have fees so high that after payment, some individuals are left with an income equivalent to the social welfare norm (the minimum guaranteed by state assistance), which is not adequate as a long-term income (Socialstyrelsen 1996a).

In a survey of home care clients across Sweden conducted in 1995, one out of every ten clients over age 75 said that they needed help but no longer sought municipal services because fees were too high (Svenska Kommunförbundet 1998). A public elder care system increasingly funded with user fees will have the most detrimental impact on access to services for low-income elderly, who depend on municipally-provided care to meet their needs more than elderly with higher incomes (Regeringens skrivelse 1999/2000). Again in this instance, the fee schedule for services is entirely determined by the municipality, not the provider, and thus is unrelated to the privatization of elder care in some municipalities.

Changing conditions in the work environment of caregivers in the elder care sector are having an impact on the quantity of workers available and the quality of care those workers can provide. The National Board of Health and Welfare and the County Boards, who have the responsibility to inspect health and care-related activities, as well as to investigate complaints of services provided by the municipalities, noted in 1999 that it had been increasingly difficult to maintain and recruit competent and experienced care workers. In the same report, these two oversight agencies observed that personnel are caught between the demand to stay within their budget and the demand to satisfy their client’s needs. They also pointed out that managers are

over-worked and have less time with which to influence and advise their staff (Socialstyrelsen and Länstyrelserna 2000). As municipalities choose to emphasize productivity and efficiency in care delivery in response to decreasing resources and increasing demand for services, care workers employed by the municipality face a dilemma. They cannot spend too much time with any one client, in order to heighten their “productivity.” However, in forgoing this time they may be forced to sacrifice any meaningful relationship with clients, a key feature of caregiving that originally attracted workers to this profession. These new conditions of elder care work – including heightened stress and diminished job satisfaction – have the potential to discourage individuals from joining the caregiving workforce and decrease the quality of care workers can provide (Gustafsson and Szebehely 2000). Yet, there is no evidence that the emphasis on productivity is any greater in companies aiming to earn a profit than in municipal care units that are facing budget constraints, removing privatization as a source of increased caregiver stress.

Perhaps the greatest change in municipal elder care since has been the emergence of a new organizational model in elder care administrations called the purchaser-provider (*beställare-utförande*) model. Under this model, municipal administrators become “purchasers” of care separate from the care providers. Caseworkers responsible for determining an elderly individual’s level of need are no longer the same municipal personnel that provide care. As of April, 1999, 233 out of 411 elder care administrations in Sweden had established a type of administrative organization, although in most cases the “provider” was a municipal agency (Socialstyrelsen 1999). This form of reorganization has facilitated privatization in some municipalities, because it requires caseworkers/needs assessors to enumerate the services required for their population, assign a cost to those services, and accept bids for contracts to provide necessary services. To date, there is no evidence that the impact of this model is observed differentially in municipalities with private versus public providers. The trends within elder care described above have developed amidst the same economic conditions that gave rise to privatization, and have had consequences that could be mitigated or exacerbated by privatization. The next section examines the features particular to Swedish policy and the implementation of privatization thus far that have influenced the effect of privatization on public elder care services.

V. THE IMPACT OF PRIVATIZATION

From the perspective of Swedish policy makers, privatization promised increased efficiency in the public sector, increased individual choice in services, and reduced political accountability for changes in services. This section will present evidence suggesting that privatization has indeed motivated changes in these areas, but that particular features of the Swedish welfare state have influenced how privatization has been implemented, as well as its results.

A. Cost

The Swedish Association of Local Authorities (*Svenska Kommunförbundet*) reviewed several studies conducted prior to 1998 on the effects of contracting between the public and private sector in elder care, and concluded that this form of privatization can have short-term cost-saving effects (*Svenska Kommunförbundet* 1998). In 1991, the Competition Committee organized by the Swedish National Board of Health and Welfare (*Socialstyrelsen*) concluded that introducing competition into service production could increase the possibility for cost-savings and efficiency within public services, although the Committee also acknowledged that it did not matter whether the private or public sector produced the services. The Committee also observed that while contracting may have lowered the cost of services initially, a “bottom has been reached” as to how cheaply services can be provided without reducing quality (*Socialstyrelsen* 1999). There is evidence that private providers in Sweden have offered bids lower than the cost of care to win a contract initially, in order to first establish a relationship with a municipality (*Socialstyrelsen* 1996b). However, the elder care administrators interviewed expressed concern about what will happen when private firms are no longer willing to cover the difference between the municipal contract award and the actual cost of providing quality care.

Svensson and Edebalk (1997) estimate that the cost to municipalities of contracting with private providers is an additional one to 2.5 percent of the amount paid to the contractor, accounting for the new overhead costs of overseeing the contractor and of creating an infrastructure for regulating services that are privately provided. Moreover, municipalities face the tradeoff between having frequent bidding periods, which push providers to constantly find ways to innovate and improve efficiency, and giving clients continuity of staff and care

providers. While long contract periods give firms an incentive to invest in recruiting qualified staff and to promote continuity of care, infrequent exposure to competition may undermine the original intent of privatization (Socialstyrelsen 1996b).

Two of the three Stockholm city districts studied, Spånga-Tensta and Kista, realized cost savings in the beginning of their contract with private elder care providers. One administrator interviewed attributed the cost-savings to changes that the private firm could make in staffing, including hiring only part-time personnel that worked a more demanding schedule. Eventually, the firms discovered that there were too many complaints from staff about being overworked, and this administrator finds that now some privately-provided services are more expensive than those under municipal administration (Hellid 27/04/01). In Kista, the only year that the city district saved money by contracting out was 1993, the first year of privatization (Rosenqvist 27/04/01).

One reason that the implementation of competitive bidding and privatization in elder care will not have the cost-saving gains that had been observed in other countries is that European Union and Swedish labor laws now prevent private providers from realizing cost-savings through wage reductions. For example, during the 1980's, contracting schemes in Britain allowed private contractors to hire less costly non-union employees to replace more expensive municipal employees (Ascher 1987). It was from this practice that privatization realized most of its cost-savings. Today, throughout the European Union, private contractors must first offer jobs to the municipal workers whom the contract "replaces" before they are allowed to hire other employees (Engström 25/01/01).

In Sweden, under workers' protection legislation, firms that take over municipal contracts must employ the workers for at least one year if workers choose to continue working in the same place but under different administration (Rosenqvist 27/04/01). Moreover, in Sweden elder care workers who are hired by either the municipalities or private firms belong to the same labor union. Thus, the context in which privatization is being implemented in Sweden is fundamentally different from the context in which privatization was declared a means to save costs. If the privatization of elder care services will solve the problem of the burgeoning cost of providing care to a growing elderly population, it is not necessarily because private providers produce the same services at a lower cost.

B. Competition

Under the principles of New Public Management, efficiency in public services will increase by forcing municipal providers and private firms to compete for business on the basis of cost and quality. However, in a case study of nine elder care administrations that had privatized elder care services, Fridolf (1996) found that administrators received too few bids from private providers to realize true competition. Even in Stockholm, where most privatization in elder care has taken place, the elder care administrators interviewed indicated that they each received two or three bids from private providers in their last contracting cycle.

The paucity of providers competing for municipal contracts in Sweden should not be surprising. Because municipal purchasers are granting contracts largely on comparisons of price, it is difficult for private providers to submit a bid that is low enough to win a contract yet high enough to make a profit, given the similarity in costs faced by both public and private elder care providers. Additionally, the traditionally comprehensive amount of elder care services financed and provided by the municipality has left little private demand for services, which has had two implications. First, access to a variety of private providers is greatest in wealthy regions where there is more likely to be a private market for services, second, private providers otherwise exist only when the public sector subsidizes them. A strategic planner for privatization at Stockholm City Hall asserts that the public sector has financially supported every private provider who has won a contract in elder care (Eriksson 26/02/01).

If competition among private and public providers is not sufficient to warrant a bureaucratic infrastructure to support privatization, Swedish policy makers must decide whether to subsidize private providers to promote a greater degree of competition, or eschew privatization altogether. Yet, the absence of a truly competitive market with many firms may not be problematic. The elder care administrators interviewed for this paper stated that even competition between two firms gives the municipality or city district more control over the price and quality of services received. [citation] If there is at least one alternative to the public sector, then the municipality or city district's elder care administration can compare the price and quality of municipal work with the private sector. If the purchasers in the administration determine that a private provider is performing poorly, the purchasers can put its contract out for bid. However, the question is how the existence of alternatives will be maintained in a country where the majority of care is still provided by the municipalities.

C. Freedom of Choice

Although consumer choice was a political slogan used to enhance the appeal of privatization in the early 1990s, it has been realized in only a few municipalities in Sweden. Moreover, even in those municipalities few elderly clients actually take advantage of their choice. In 1995, only four municipalities employed a voucher system, in which consumers could take their public care “voucher” to any private provider; that number had not changed by 1999 (Socialstyrelsen 1995a, Socialstyrelsen 1999). The voucher system in place is also quite limited. It is only valid for certain services, and providers must charge the same rates for the same services, thereby removing any competition among providers based on price. If the client is not interested in choosing among providers, the municipal social worker will choose for the client; the result in over 90% of the cases (Socialstyrelsen 1995a). In general, most of the “choice” that privatization affords is to the municipal committees responsible for purchasing care and who contracting with private providers.

D. Government Regulation

The introduction of private providers into the municipal care system means that the municipality is now responsible for activities that are produced by outside organizations. Municipalities’ evaluation and follow up of privately produced elder care is weak. A 1995 study of 39 municipalities with extensive privatization in elder care revealed that of the 39 audited, 21 reported that they had no documented follow-up or evaluation of the private providers with whom they contracted (Socialstyrelsen 1995b). In a case study of nine city districts in Stockholm that contracted with private elder care providers, Fridolf (1996) states that there is little control of the providers’ activities during the contract period, especially if the municipality does not receive complaints. However, a complaint-based survey of providers is problematic in elder care, because the elderly are typically reticent in voicing dissatisfaction with services.

There is a legal requirement for government oversight and control of publicly funded, privately provided activities. Since July 1, 1994, municipal law has mandated that municipalities must have ongoing and regular evaluation of the activities in question, as well as analyze the provider’s quality and efficiency (Socialstyrelsen 1995b). Moreover, the Swedish counties have investigative boards that check up on complaints and examine a percentage of municipal care activities annually. The municipality is then responsible for correcting the faults found

(Socialstyrelsen and Länstyrelserna 2000). However, the elder care administrators that I interviewed acknowledge that oversight in their own administrations has been informal and implemented slowly.

E. Quality

Despite the general lack of municipal regulation of elder care services, the shift from public to private provision has not worsened the quality of care. A publication of the National Board of Health and Welfare reported results from a study of elder care in six municipalities, of which some that had implemented privatization in elder care and some that had not. While the results may have been skewed because participation in the study was voluntary, the study authors concluded that private providers in elder care seemed to have the same or better quality than municipal providers (Socialstyrelsen 1996b). In a published review of literature on privatization, the Swedish Association of Local Authorities reports that few studies demonstrate that clients observe a decreased quality in their care provided by private contractors, and several studies show that clients have a high opinion of contractors' level of service (Svenska Kommunförbundet 1998). Finally, although the National Board of Health and Welfare and the County boards have expressed concern about the effect that worsening working conditions for elder care workers will have on quality, Gustafsson and Szebehely (2001) studied the working conditions in public and private elder care services in three municipalities, and found that although privately-employed workers were more negative about their working conditions, the difference in quality between the municipalities were found to be at least as great as the difference in quality between public and private providers.

F. Access to Services

Critics of privatization fear that when private companies or individuals provide publicly-funded care, they have an incentive to reduce access to care among individuals with a high amount of care needs. In the United States, for example, Medicare finances medical care and services for eligible individuals that is provided by certified entities that are often private and for-profit. As the *New York Times* reported (21/04/00), these providers have incentive to "cream" from the group of clients who seek services, and take healthier cases over others, so that they can still profit from the fixed-rate government reimbursement. In Sweden, however, the system of municipal gate-keeping prevents any such "creaming" to occur. In this system, caseworkers determine the amount and type of publicly financed care services the elderly receive

based on their level of need. Private providers play no role in selecting individuals to whom they will provide care. As long as the municipality assures that private providers are fulfilling their contract, all eligible clients will have access to care. However, decreased access to services may be occurring as a result of other changes in the municipal administration of elder care, such as the implementation of the purchaser-provider model, which divides the municipal purchasers from the entity that provides care. Under this model, purchasers are involved in assessing client needs but are separate from the task of providing care. As a result, a direct care worker cannot react to a client's new needs as they arise, but rather must wait for the purchase of more services from the municipality after the caseworker (part of the purchasing unit of the municipal administration) completes his or her assessment. In a study of eight municipalities, Szebehely (2000) found that the amount of home care granted to clients had decreased most in municipalities with a purchaser-provider model. Szebehely concludes that specialized needs-assessors had become more restrictive in determining the level of client need, probably as a result of the distance they have from the actual care work (Szebehely 2000). As further evidence that privatization has not affected access to care, Trydegård and Thorslund (2000) found that historical coverage rates for home care in a municipality from 1976 to 1997 better predict a municipality's current coverage of home care, which ranges from five to fifty-two percent of elderly over age eighty across all 290 municipalities in Sweden, than whether it employs private providers in home care or not.

VI. RECOMMENDATIONS

The privatization of elder care services has not decreased cost, increased efficiency, or increased choice, as proponents of privatization predicted; nor has it decreased quality or access, as opponents have argued. Given current social policies and bureaucratic practices in Sweden that have mitigated the results of privatization observed in other countries, how should Swedish policymakers proceed with regard to the implementation of privatization in public services? What tradeoffs in policy direction does privatization require?

A. Focusing the use of public funds for elder care on clients that have the most severe needs can realize more cost-saving than privatization.

If a political decision is made to reduce the budget for elder care services, it must mean that fewer clients receive services or all clients receive fewer services. There is no evidence that

private providers can produce the same amount of services for lower cost than municipal providers, or that the introduction of competition among providers can elicit efficiency gains in the service sector. Therefore, municipal politicians cannot avoid their budget crisis by squeezing the private sector and forcing private companies to risk their financial solvency, or else the private sector will not develop. Instead, politicians may have to trade their short-term popularity gained from preserving the current level of elder care services in order to create a long-term strategy for maintaining levels of spending on elder care at a reasonable proportion of the municipal budget, even if it means that municipally funded elder care services cannot be provided as comprehensively as before.

B. National policy must recognize the tradeoff between maintaining competition in the elder care sector and reducing its cost.

If a political decision is made to move forward with privatization, maintaining competition among providers in a country without a tradition of extensive private enterprise in the social service sector will incur its own cost, without a net reduction in cost of providing services. This additional cost may be borne by government agencies that invest in and/or subsidize private providers in order to ensure that municipalities have a choice among contract bids.

In a perhaps more dire scenario, this cost may be borne by clients who are left without services when private providers leave the market because they cannot earn a profit and the municipal care services unit has been dismantled. The risk of incurring these costs may only fall on municipalities or city districts that choose to pursue privatization of elder care services, but the benefits of preventing these costs by enlarging the pool of private providers could eventually accrue to other municipalities who also privatize. The development of tax paying for-profit elder care companies also has implications for government revenue at a local and national level.

Therefore, the national government should consider a role in promoting the development of private providers as long as municipalities privatize services. However, this policy direction will probably not be cost-neutral, and will require discussion at a national level as to the implications of allowing local government the choice to privatize or not.

C. Privatization requires the development of new regulatory policies.

Administrations that have privatized elder care services have traded internal quality control within municipal care units for external oversight of private providers. Although there is

no strong evidence that private companies or individuals provide lower quality care than the public sector, elder care administrations still have the legal responsibility for assuring the care that is delivered to elderly clients. There is evidence that municipal purchasers have not yet designed or implemented a system to audit private providers. Having different systems of regulation across municipalities or city districts that privatize may be even more problematic than having a weak system because it burdens private providers that are contracted by elder care administrations with varying rules and standards. Again, there is a role for national government, in this case to promote a level of uniformity with which municipalities implement external oversight systems of providers. Additionally, local elder care administrations that are contracting out elder care services must be held accountable by a county or national agency for assuring the services delivered by private providers. The potential cost of regulation for municipal, county, and national government highlights the fact that privatization cannot just be considered a local issue, but has broader implications that Swedish policymakers must address on a national level.

D. Freedom of choice in the elder care system will require that privatization be implemented differently.

One of the strongest arguments for privatization is that by having a choice in the company or individual from whom they receive services, clients may be able to choose the care provider that best meets their needs. It may be becoming more difficult for the public sector to meet the needs of the population given that residents in Sweden are far less ethnically homogeneous than they used to be. Aging immigrants living in Sweden may prefer caregivers that speak their native language and understand their cultural customs.

While this could be accomplished within the public sector by hiring a diverse workforce, allowing clients choice of providers could match them with caregivers more efficiently. However, privatization as it is currently implemented allows municipal elder care administrators to choose providers with which to contract, while clients remain voiceless in the process of determining their own provider. Instead, municipalities that choose to privatize elder care services should trade away bureaucratic control of assigning providers to clients, and implement in its place a mechanism like a voucher system that allows eligible clients to choose a caregiver from whom they receive municipally funded services.

VII. CONCLUSION

Elder care in Sweden underwent a number of changes in the economic and political climate of the 1990s. The privatization of elder care services in some municipalities is one attempt to reorganize social services in order to increase efficiency and responsiveness of the public sector. However, as it was implemented, it accomplishes neither of these goals. Instead, privatization requires investment to develop private enterprise in the social service sector and new regulatory mechanisms to oversee private providers, even as it fails to directly solve the problem of growing elder care costs and dissatisfaction with lack of choice in providers. Swedish policymakers face important tradeoffs in deciding whether to pursue privatization more widely, to maintain decision making and control over privatization in the hands of local government, or to prevent its implementation altogether.

References

- Ascher, Kate. 1987. *The Politics of Privatization: Contracting Out Public Services*. London: Macmillan Education.
- Bäck, Henry. 2003. Party politics and the common good in Swedish local government. *Scandinavian Political Studies*. 2:93-123.
- Daatland, S.O. 1997. Welfare policies for older people in transition? Emerging trends and comparative perspectives. *Scandinavian Journal of Social Welfare*. 6:153-161.
- Engström, Bo. Researcher at the National Board of Health and Welfare (*Socialstyrelsen*). Personal interview, 25 January 2001.
- Eriksson, Urban. Strategic planner for privatization at Stockholm City Hall. Personal interview, 26 February 2001.
- Fridolf, Marie. 1996. Konkurrensutsättning inom äldreomsorgen i Stockholms stad. [Competitive tendering in elder care in Stockholm.] In *Förnyelse av kommuner och landsting : slutbetänkande*. [Renewal of municipalities and county councils: final report.] SOU 1996:169/Bil 4. Stockholm : Fritze.
- Gustafsson, Rolf, and Marta Szebehely. 2000. Women's health and changes in care for the elderly. In *Gender and Health Inequalities*, Östlin P., Danielsson M., Diderichsen F., Härenstam A., Lindberg G., eds. Cambridge: Harvard University Press.
- Gustafsson, Rolf, and Marta Szebehely. 2001. *Arbetsvillkor och välfärdsopinion inom äldreomsorgen – en enkätsbaserad fall studie bland personal och politiker* [Working conditions and welfare opinion in old-age care – a survey-based case study among politicians and staff]. Stockholm: Arbetslivsinstitutet.
- Halvarson, Arne, Kjell Lundmark, and Ulf Staberg. 1999. *Sveriges Statsskick: fakta och perspektiv* [Sweden: facts and perspective]. Stockholm: Almqvist and Wiksell.
- Hellid, Anica. First home care inspector and administrator responsible for managing the competitive tendering process in elder care in Spånga-Tensta, Stockholm. Written correspondence, April 2001.
- Johansson, Lennart. 1997. Äldreomsorg på entreprenad fortsätter att öka [Contracting in elder care continues to increase]. *Äldre i Centrum*. 4:22-26.
- Lindström Irene, and Josephine Nilsson. 2003. *Swedish Elder Care Today* [online]. Stockholm: Svenska Kommunförbundet. [cited 12 April 2004] Available at: (<http://www.svekom.se/ward/aldre/publicerat/lastips.htm>).

Montin, Stig, and Ingemar Elander. 1995. Citizenship, consumerism and local government in Sweden. *Scandinavian Political Studies*. 18:25-51.

Nilsson, Ann-Kristin. Administrator for elder care in Liljeholmen, Stockholm. Personal interview, 27 April 2001.

Papadakis, Elim, and Peter Taylor-Gooby. 1987. *The Private Provision of Public Welfare*. Sussex: Wheatsheaf Books.

Pear, Robert. "Medicare Spending for Care at Home Plunges by 45%," *The New York Times*, April 21, 2000.

Regeringens skrivelse [Government communication]. 1999/2000. Utvecklingar inom den kommunala sektorn [Developments within the municipal sector] [online]. No. 102. Available at: (<http://www.regeringen.se/propositioner/skrivelser/skr19992000.htm>).

Rosen, Per, 1996. Frihet, jämlikhet, kunskap – patientinflytandets villkor [Freedom, equality, knowledge – the conditions of patient influence]. In *Valfrihet och jämlikhet i vården* [Freedom of Choice and Equality in Care], Anders Anell and Per Rosen, eds. Stockholm: SNS Förlag.

Rosenqvist, Ann-Cristin. Administrator for elder care in Kista, Stockholm. Personal interview, 27 April 2001. – old sources – any newer!

Socialstyrelsen. 1995a. Alternativa styr- och driftsformer i äldreomsorgen: Valfrihet [Alternative forms of administration in elder care: Freedom of choice]. No. 11. Stockholm: Socialstyrelsen.

Socialstyrelsen. 1995b. Alternativa styr- och driftsformer i äldreomsorgen: Uppföljning, utvärdering och avtal [Alternative forms of administration in elder care: Follow-up, evaluation and contracts]. No. 17. Stockholm: Socialstyrelsen.

Socialstyrelsen. 1996a. Äldreomsorgens avgifter [Elder care's fees]. In *Socialstyrelsen följer upp och utvärderar* [The National Board of Health and Welfare follows up and evaluates], No. 6. Stockholm: Socialstyrelsen.

Socialstyrelsen. 1996b. Alternativa styr- och driftsformer i äldreomsorgen: Äldreomsorg på entreprenad [Alternative forms of administration in elder care: Elder care under contract]. No. 8. Stockholm: Socialstyrelsen.

Socialstyrelsen. 1999. Konkurrensutsättning och entreprenader inom äldreomsorg [Competition and contracting within elder care]. *Äldreuppdraget*, No. 6. Stockholm: Socialstyrelsen.

Socialstyrelsen and Länsstyrelerna. 2000. *Social tillsyn 1999* [Social supervision 1999]. Stockholm.

- Sundström, G., and B. Malmberg. "The Long Arm of the Welfare State Shortened: Home Help in Sweden," *Scandinavian Journal of Social Welfare*. 5:69-75, 1996
- Svenska Kommunförbundet. 1998. *Förändring av kvalitet och produktivitet I barnomsorg, skola, och äldreomsorg [Changes in quality and productivity in child care, schools, and elder care]*. Stockholm: Mixi Print AB.
- Svensson, Marianne, and Per Gunnar Edebalk. 1997. Privata entreprenörer inom svensk äldreomsorg [Private contractors within Swedish elder care.] *Aldring och Eldre*. 4:24-31.
- Swedish Institute. 1999. *The Care of the Elderly in Sweden*. Fact sheet FS 8 o Ohfe.
- Szebehely, Marta. 1998. "Changing Divisions of Carework: Caring for Children and Frail Elderly People in Sweden," *Gender, Social Care and Welfare State Restructuring in Europe*, Jane Lewis, eds. England: Ashgate.
- Szebehely Marta. 2000. Äldreomsorg i förändring – knappare resurser och nya organisationsformer [Elder care in transition – shrinking resources and new forms of organization]. In *Välfärd, vård, och omsorg [Welfare, health care, and social care]*, No. 38:171-224 [online]. Stockholm: Socialstyrelsen. Available at: (<http://www.regeringen.se/propositioner/sou/sou2000.htm>).
- Tell, Ketty. Administrator for elder care in Liljeholmen, Stockholm. Personal interview, 27 April 2001.
- The Economist*.. "Krybb to Grav, Dancing to a New Tune: A survey of the Nordic Region." 14 June 2003.
- Thorslund, Mats, Å. Bergmark, and M.G. Parker. 1997. "Difficult Decisions on Care and Services for Elderly People: the Dilemma of Setting Priorities in the Welfare State,," *Scandinavian Journal of Social Welfare*. 6:197-206.
- Trydegård, Gun-Britt. 2000. *Traditions, Change and Variation: Past and Present Trends in Public Old-Age Care*. Stockholm: Stockholm University, Department of Social Work.
- Trydegård, Gun-Britt, and Mats Thorslund. 2000. "Explaining Local Variation in Home-help Services: The Impact of Path Dependency in Swedish Municipalities 1976-1997," *Tradition, Change and Variation: Past and Present Trends in Public Old-Age Care*, Gun-Britt Trydegård, ed. Stockholm: Stockholm University, Department of Social Work.
- Ungerson, Clare. 2000. "Thinking about the Production and Consumption of Long-term Care in Britain: Does Gender Still Matter?" *Journal of Social Policy*. 29:623-641.
- Wise, Charles, and Erik Amnå. 1993. "'New Managerialism' in Swedish Local Government," *Scandinavian Political Studies*. 16:339-358.