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Conclusions and summary

CONSEQUENCES OF COMPETITION

What is happening to the Swedish welfare system?

SNS Förlag

Introduction and conclusions

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The system for providing welfare services in Sweden has experienced a major political change over the past 20 years. The country used to have public welfare monopolies, but private, commercial actors are now being allowed to provide welfare services to an ever greater extent. Almost a fifth of all employees in the welfare sector currently work for private companies.

Although various aspects of this change have been debated, no public assessments of these reforms have been carried out. For the first time a group of the leading welfare researchers in Sweden have compiled information about the consequences of these changes – in a comprehensive study commissioned by SNS (Centre for Business and Policy Studies): *Consequences of competition. What is happening to the Swedish welfare system?.* The study looks at statistics and research for all the major welfare areas: pre-schools, schools, individual and family care, health and medical care, labour market policy, and services for the elderly and the disabled.

This document provides a summary of the most important observations and conclusions from this study. The full report (279 pages) can be downloaded at www.sns.se or ordered from SNS Förlag.

Major regional differences in the level of privatisation

The study shows that privatisation has so far developed differently in different parts of Sweden; competition clearly does not exist in every part of the country. It is mostly major cities, suburbs and large towns where private companies provide a high proportion of welfare services. The exception is individual and family care where competition can be seen in many different parts of the country. There are seven local governments that still do not have one single private service provider in any of the following areas: pre-schools, care for the elderly and the disabled, and individual and family care. There is no competition for elderly care in the majority of the local governments – this is true for as many as 151 of them. However, most local governments have private pre-schools, even though 56 local governments do not.

Schools is the area that has seen the most rapid change in the 21st century in this respect, with the number of local governments without free schools falling from 144 to 90 between 2002 and 2010. The difference in the level of privatisation between local governments also appears to have increased slightly for pre-schools and schools.

In the study the researchers have tried to identify the factors that are behind the differences in the level of privatisation in different local governments.

The results show that local governments that have a high number of employees working for private companies tend to have a high proportion of well-educated residents, although this is not the case for individual and family care. Local governments with a non-socialist majority have a higher proportion of private employees working for welfare services. However, the political bias of the local government only affects the level of privatisation in elderly care and pre-schools, and not the other activities.

It is also more common for local governments with a high number of private employees in elderly care, schools and pre-schools to have a high share of foreign residents. Local governments with a high number of employees working in the private sector for individual and family care and pre-schools tend to have a high proportion of young people living in the area. Local governments with a high level of privatisation in individual and family care also tend to have a high proportion of elderly people.

These results should be seen as a description and not a causal link. To gain a more in-depth understanding of the mechanisms behind these connections would require a more sophisticated analysis than is covered by the framework of this study.

Several major providers on the market

In the 21st century the increase in the number of private actors in all areas has been caused by the arrival of more and bigger profit-driven companies onto the market. But it was often non-profit organisations that were responsible for the initial expansion in the 1990s. These early actors were more different from the public providers because they specialised in a specific area: for example, schools for children with special needs. However, nowadays there are big companies in several areas that have a high share of the market.

The clearest example of this is the concentration in elderly care. This market is dominated by two big private providers that are owned by risk-capital companies: Attendo Care and Carema Care. Together they represent around half of the private market. The biggest growth in private pre-schools has also been pre-schools run by companies. There are three really big providers on this market. The biggest is Pysslingen, which also runs schools as well. In the schools area there are currently both profit and non-profit free schools operating on the Swedish market that have many different specialisations. However, most of these schools are run by private companies; 64 percent are set up as private companies, while non-profit associations and foundations represent 33 percent.

Ten major company groups account for 30 percent of all independent primary and lower-secondary schools. The concentration is higher among independent upper-secondary schools, and highest in densely populated areas. The main private company in the upper-secondary area is Academedia, while Kunskapsskolan is the largest in primary and lower-secondary schools.

Big companies also completely dominate the re-regulated pharmacy market. Private pharmacy chains are mostly owned by risk capitalists. In outpatient care the proportion of profit-run companies is also increasing, even though the owner concentration is relatively limited in this area. Profit-driven companies have been responsible for all of the increase seen in recent years. The national providers include Praktikertjänst, which is owned by its employees; this is the largest single provider on the market. Praktikertjänst owns more clinics than the next two biggest companies, Carema and Capio, which are both owned by risk-capital companies.

Development towards greater customer choice

At the beginning privatisation was mostly based on the contract model, with public contracting bodies and their financial backers (local governments, county councils and the state) buying services from private companies in accordance with contractual terms and conditions. Since then there has been a gradual shift towards customer choice models, where consumers themselves can choose between approved producers. This involves residents taking a ‘bag of money’ financed by the public authorities to their chosen producer.

The Act on Freedom of Choice in the Public Sector came into force on 1 January 2009 to strengthen customer choice; this was also designed to support smaller producers are on the market. The idea was for this reform to increase pluralism and promote small companies. Schools adopted this model from the very beginning, when the pre-school reform was introduced as a customer choice system. The freedom of choice system has now been introduced for healthcare and social services; this system is obligatory for county councils in primary care, but voluntary for local governments. As a result both models are used in parallel in the care for the elderly and the disabled.

However, labour market policy is still mostly run in accordance with the contract model. The exception is the provision of 'establishment guides' (people who help newly arrived immigrants to find work), where the freedom of choice system has been introduced. The care of young people and alcohol and substance abusers is run almost exclusively in line with a third model: *the purchase of services*. A private, profit or non-profit, organisation owns the operations, which is often some kind of institution/home. The local government then buys individual places, which is normally regulated in written framework agreements, following competitive tendering. Aspects of this model can also be seen in the care for the elderly and the disabled.

Benefits of competition are unclear – mostly knowledge gaps

Is it possible to draw any general conclusions about whether the provision of welfare services has been better or worse since the private actors entered the market? The anthology has gone through what research says about the consequences of open competition on quality, costs and efficiency. *The main conclusion is that the knowledge base is remarkably limited in many areas.* The anthology cannot therefore give any general conclusions about either gains or losses. But it does point out many interesting areas where further research should be carried out. The anthology also analyses the conditions for effective markets for welfare services, and this analysis provides guidance on what future studies should focus on.

To summarise, the consequences of greater competition are remarkably under-researched. The research results that exist do not reveal any clear-cut efficiency gains or losses, for example, in the form of lower public spending on welfare services. Although the private providers certainly have lower costs in several areas, these operations are not always comparable. In addition savings normally lead to higher profits for the provider, without reducing public spending. Neither is it possible to see any clear quality gains in most of the areas. The measurements that are available mostly indicate that the results have not changed or that change is going in different directions depending on the study.

One area that possibly deviates slightly from this general picture is primary care, where accessibility as a quality measurement appears to have increased. However, one comment that appears in all chapters is that it is problematic to define and measure quality. Most of the areas do not have objective measurements. The two areas that come closest are schools (pupils' test results) and labour market policy (transition into employment). Good care is a much more difficult concept. What is striking is that customers are slightly happier with the private providers in virtually all areas. However, it is problematic to interpret differences in customer satisfaction and quality. These differences could equally be due to the customer groups and their expectations differing between the providers. Customers of private providers are probably more likely to have made an active choice and they might want to legitimise this choice by saying that they are satisfied. Or maybe people who have made an active choice have higher expectations on quality and are more critical, which would mean that the customer satisfaction index *underestimates* the differences in quality.

In all areas, apart from health and medical care (and individual and family care services where there is a lack of information), groups that are socio-economically stronger seem at least slightly overrepresented as customers of private companies, which indicates that open competition can have segregating tendencies. There is a main difference in segregation between primary care and schools. In primary care, it is the groups with major care needs that have increased their use of care services, while in free schools they have more applicants than places; free schools can use waiting times as a criterion for the customers they accept, while private medical centres are not able to do this. In his chapter Jonas Vlachos says that when waiting time is used as a tool for selection, it can have a major impact on social segregation.

Why doesn't open competition produce clear benefits?

Open competition has not, at least so far, been the miracle cure that many people hoped would lead to higher efficiency and quality. Why is this not the case? There are two factors that need to be remembered here to understand this. *Firstly,* these markets are not 'real' markets but 'quasi-markets', where consumers only have limited power; for example because demand is mostly determined by the public budget and public authorities also regulate the range of providers to varying extents. There are also a number of other 'market failures' that can prevent competition from working.

Secondly welfare services are very special kinds of services as they are complex and linked to extensive 'externalities'. It is often impossible to change your mind once a decision has been made. The next section contains a discussion on each of these aspects.

The market for welfare services differs from a normal market

There is a well-developed theoretical framework for research into welfare economics that can be used to analyse the conditions that are needed for open competition and customer choice systems to work for welfare services.

In this report we have used the 'quasi-market theory' from Le Grand and Bartlett (1993). This theory describes the situation where a public monopoly is replaced by competing suppliers. Although this definitely results in a commercial market, it is not a normal market.

- Firstly, not all suppliers are profit-maximising, despite the competition. For example, some of the actors can be non-profit organisations. This makes it difficult to predict how the service providers will react to incentives on the market.
- Secondly, demand on a quasi-market is determined by the public budget and not by the customer who consumes the service.
- Thirdly, the choice of supplier is not only always made by the customer who consumes the service, but by the public body that has procured the service on behalf of the consumer. The importance of the last two points differs slightly between the customer choice and contractor models. In a customer choice system, the consumer definitely has more power than in an adapted procurement system; but a central selection of suppliers has also been made in a customer choice system.

Le Grand and Bartett set out a number of key conditions that have to be met if a quasi-market is going to work effectively. The market structure must:

- be based on competition and prices,
- be characterised by correct and complete information,
- have limited transaction costs,
- not have any negative effects, for example the providers should not prioritise the most profitable customers.

Fixed payments, entry barriers and procurements requiring high competence

The first condition for a quasi-market to work effectively is that there needs to be a market structure that is based on competition and prices. The laws and regulations for procurements and framework agreements are intended to promote competition on the markets that work in line with the contract model, but the anthology has shown that these regulations can also distort competition.

The role of being the contracting party has often been demanding for local governments, county councils and the Swedish Public Employment Service. Local governments have moved over to competitive tendering using a combination of fixed price and quality as a criterion, because it has been difficult to specify exact quality requirements. Signing a contract for welfare services is much more complicated than signing a contract for services such as waste collection and school meals. Welfare services are often very complex and need to be adjusted to the individual. This is particularly true of work with socially vulnerable individuals. In addition, major procurement processes that require high amounts of resources benefit major actors at the expensive of smaller ones, and this could have contributed to the formation of oligopolies in some areas.

In the customer choice models there is a fixed payment per customer. In schools, pre-schools and health and medical care, it is forbidden to charge additional fees. This means that the actors cannot compete by offering high-quality services for higher prices; the only way they can generate profit is by keeping their costs down. If the costs are not followed up properly, lower costs will not necessarily lead to lower expenditure for the public authorities; instead the savings will go to the profits of the private provider.

There is also a limited amount of scope for quality improvements; except when the provider can specialise in groups that do not require as many resources, which allows it to keep its

costs down. In home care services, the private provider is able to offer additional services. However, home care services from the local government do not have this option. It is true that customers of home care services provided by the local government can buy additional services from a private actor. But customers really appreciate continuity, so it is better for them to receive all the services from the same provider.

Finally, if competition is going to be effective, the entry and exit thresholds on the market have to be low. But in the welfare market it is important for any providers that want to enter the market to be inspected carefully for the good of the citizens; this definitely slows down the entry process. There is also a clear value in not removing providers from the market as soon as they show a dip in their results, as customers appreciate continuity. In other words there are rational reasons as to why both entry and exist onto these markets are slow. However, this does restrict the benefits of competition.

The exit mechanism appears to work particularly badly in the schools area. Extremely few schools have closed down and as long as new ones are continually set up, there will be unnecessary overcapacity.

Information asymmetries

According to Le Grand and Bartlett, another requirement for an effective quasi-market is for there to be a limited amount of 'information asymmetries' (when some information is not available to all the parties involved). It is clear that this requirement has not been met very well on some of the markets that have been analysed. In fact the anthology indicates that customers are faced with considerable problems when trying to find relevant information about the content, costs and quality of the services. As a result they are not able to make well-informed decisions. It is also true that the authorities and local governments that are responsible for welfare services do not collect enough relevant statistics.

The information used to measure and follow up quality is based on data that is simple to collect – for example staff to customer ratios – instead of data that reflects the factors that the customers perceive, such as quality, or factors that actually lead to better results.

The chapter on healthcare, for example, shows that even when customers feel that they are given enough information, in practice they are hardly in a position to make a well-informed choice. The most important sources of information for them are the medical centre they already know and tips from friends and relatives. This means that they only have limited sources of information. It is also true that the person making the decision is often not the person who will consume the services and this makes it even more difficult to get relevant information. Parents find it difficult to form an understanding of the quality of a pre-school because it is their children, not themselves, who are there during the day. Similarly relatives of someone with dementia find it difficult to find out about the quality of the care home. It is even more difficult to know this kind of information in advance when the decision has to be made.

These difficulties are closely related to the complexity of the problems around customers making their voice heard (*voice*), being able to leave the service (*exit*) and loyalty (*loyalty*). In practice, 'exit' seems to be a distant alternative in many of the areas covered in the anthology, particularly for healthcare services.

This means that customer loyalty is strong. As has already been mentioned, one probable explanation is the fact that studies into customer values shows that continuity itself is one of the most important factors in creating quality. The chapter on primary care clearly shows this: there are very few individuals who choose a different medical centre after they have made their initial choice.

The lack of systematic follow-up and evaluation, and of sufficiently accurate quality comparisons means that customers have to rely on customer satisfaction indices too often, which is problematic as these indices are mostly based on subjective expectations.

One example that illustrates this is the falling levels of customer satisfaction in elderly care since the 1990s. It is difficult to know whether this trend is due to a general drop in quality or higher expectations (maybe because open competition has made us more aware of quality) or whether quality has not changed. Although quality is genuinely difficult to measure, this should not be an obstacle or an excuse not to try. A good place to start is to collect and distribute detailed information about the content of the services based on research about the factors that create quality.

Costs of creating an effective market

The third condition for an effective quasi-market is, according to Le Grand and Bartlett, for there to be limited transaction costs for setting up and maintaining a market. The anthology has revealed a number of problems for this condition as well. Supervision and inspection have shown to require a lot of resources. There are examples that show that competition for an attractive workforce has created an upward pressure on salaries in pre-schools and schools, though only to a limited extent. This in itself can also be positive for quality in the long term. In general there is no comprehensive information about transaction costs, but it is reasonable to assume that there are high costs involved in starting up and closing down these kinds of operations. There is also a cost involved in marketing that competing actors, particularly in the schools area, use to attract customers.

Motivations in customer selection

This anthology shows that the private providers in schools, pre-schools and elderly care are over-represented among socio-economically advantaged customer groups. There is also evidence to show that this applies to supplementary providers in labour market policy as well.

This would indicate that Le Grand and Bartlett's fourth criterion can be difficult to meet. The private providers should not be motivated to target the 'cream' of the customers, i.e. the most profitable ones, and leave the more demanding ones to the public sector.

The causes of these segregation tendencies are not completely evident or clear-cut. But this pattern can be seen mostly clearly in the schools area, where freedom of choice has had the strongest impact; the market is relatively unregulated and the private providers (but not the state schools) can choose their customers. There is a slightly different pattern in primary care, where the market is more regulated and no provider can use waiting times as a criterion for selecting customers. In this area the groups with the greatest care needs have increased their use of care services the most.

In other words there is cause for stricter regulation to counteract this kind of segregation. Interestingly enough there is nothing to indicate that the level of innovation would be much higher on the unregulated school market; an argument that is normally used, at least in theory, against greater regulation.

Focus on the wrong kind of quality

Le Grand and Bartlett also talk about the importance of having the right motivation structure to ensure that quasi-markets work well: a structure that enables the actors on the market to streamline and improve their quality. The reason why this is not always the case in reality can be said to depend on information asymmetries: when the 'true' quality is difficult to measure, the 'wrong' quality measurements are used instead. What *can* be measured is normally what is measured and reported rather than what *should* be measured.

Operations tend to be managed based on the follow-up that will be carried out, i.e. services are guided towards the targets that are actually going to be measured, which means that they do not produce the optimum results. One example that has already been mentioned in the section on information asymmetries is that assessors focus on 'input measurements', for example staff to customer ratios, instead of 'output measurements', i.e. the results that the service provides in terms of pupil knowledge, healthy patients, the level of well-being of disabled people, etc. The wrong kind of output measurements can also have problematic consequences.

Grade inflation is a good example to illustrate this: if you follow up and report grades, the main motivation is to generate good grades – instead of the motivation to generate good knowledge. However, it must be remembered that focusing too much on the wrong kind of quality can be a problem for the public providers as well.

Social value and 'externalities'

Schools, healthcare and nursing do not only offer welfare to an individual but to society as a whole. It is in everyone's interest to have a healthy and well-educated workforce that creates growth and therefore welfare for everyone. If vulnerable children are not looked after properly, this can result in huge costs for society in the long term, not only in moral and human terms, but also in economic terms. If every citizen has access to high-quality welfare services, this can also contribute to an effective democracy and constitutional state.

But it is very doubtful that an individual recognises or takes into consideration these general and long-term values – which are known as 'externalities' – when they make their choices. By definition the nature of externality means that the individual does not take them into consideration when choosing pre-schools, schools or medical centres.

Similarly, competing pre-schools, schools and medical centres do not necessarily take into consideration how their actions affect society as a whole. This can result in general inefficiencies. A public monopoly can, at least in principle, include and take into account the interests of society in their operations. But of course a public monopoly can also manage their operations wrongly, for example due to fear of conflicts, a lack of interest or pure ignorance. The reason why these operations were opened up to competition in the first place was because of the extensive inefficiencies that welfare services had suffered for decades.

One good example of inefficiencies that competition can lead to is the grade inflation that has been seen in recent years. Individual pupils want to have good grades. Schools want to report a good development in their grades to attract intelligent pupils. As long as the grading system is only weakly linked to the pupils' actual performance, it will result in a spiral in which grades rise and rise, without the level of knowledge rising.

International comparisons show that the level of knowledge among Swedes has got significantly worse. A well-designed customer choice system must aim to build the interests of society into its customers' preferences, or at least include rules and incentives to prevent the results from being too far away from what is best for society. A results-based grading system and national tests that are not marked by the pupils' teachers would be a step in the right direction.

Choices often cannot be changed

Finally, choosing a school or a hospital is not the same as choosing a hairdresser or a waste collection company. As well as all the differences that have already been discussed – for example, welfare services are more complex and quality is more difficult to define – the choices are almost impossible to change afterwards. As it takes time to form a perception of the quality of a service, it can often be too late to change it when you have found out about the alternatives. It is hardly an attractive alternative to repeat a year in school, if the first choice appears to be wrong or not as good. It is normally not possible to correct a wrong choice that a person makes in healthcare or get back the time spent on long-term sick leave that was a result of incorrect or negligent care.

It is also difficult to hold a provider to account when the service is complex or there is a lack of established or evidence-based knowledge about what is 'good care' or 'good education'. Healthcare is definitely something of a role model here, as it is increasingly becoming based on well-known evidence. However, it is unclear to what extent evidence-based practice can be transferred to other areas.

Conclusions

We have commented on a number of problems on the Swedish quasi-markets for welfare services. However, the empirical evidence shows that open competition does not seem to have resulted in the clear-cut benefits that many people had expected. Should we therefore conclude that open competition is doomed to failure and that we should only offer public services? Or can open competition in the long term still give the efficiency and quality gains that the reforms aimed to achieve?

The purpose of this anthology is not to offer views on these issues; it is the first step in a multi-year research programme on the transformation from a welfare state to a welfare society. The anthology aims to highlight knowledge gaps and provide decision data on how the market for welfare services should be designed to work more effectively. Although it is uncertain what the exact consequences will be, it is clear that these markets are not yet fully developed. But it does seem that several of the central conditions for an effective quasi-market have not been met. This chapter ends with a few aspects that need to be focused on in order to improve these conditions.

Firstly, it is important to find the *right balance in the level of regulation*. Rules are needed because of all the market failures that have been discussed above. However, caution must be shown to ensure that the markets are not regulated too much – innovations are not born on markets that are strictly regulated. On the other hand, this anthology shows that innovations are not automatically born on unregulated markets either. One important question for future research is what can create good conditions for innovations.

One solution could be to offer greater customer choice by encouraging more (smaller) providers, which would strengthen competition; but a customer choice system needs to have rules as well. The case of free schools in this anthology has shown a number of problems that can occur in a mostly unregulated customer choice system. For example, there could be reason to re-examine the principle that free schools – but not state schools – can use waiting times as a method for selecting pupils.

Secondly, it cannot be stressed strongly enough how important relevant and high quality *supervision and inspection* are. These are essential for guaranteeing a high minimum level that would ensure that irresponsible providers are removed from the market as quickly as possible. ‘Relevant’ means that this supervision focuses on relevant quality criteria. As supervision is also what guides operations, it is very important for these criteria to be carefully selected.

Thirdly *follow-up and evaluation* are completely crucial in order to provide politicians and citizens with the decision data they need to ensure an effective and successful model. Politicians need to know which models work best and the citizens need information about quality to make a well-founded choice. High priority should therefore be given to better systems for collecting statistics and investments in open quality comparisons. When introducing new regulations, an experimental programme should be considered – for example using regional limitation – to make sure that the reforms can be evaluated.

This is how SNS wants to contribute to the knowledge base

SNS is planning to carry out further studies into how the Swedish freedom of choice model can be improved. We will bring together leading representatives from local governments, county councils and private providers who can talk to leading welfare researchers to define where the need for decision data is the greatest. This will ensure that SNS can contribute to a more factual debate on the Swedish welfare model.