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Using private social care services in Finland:

a free or an enforced choice for older people?

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ABSTRACT

The purpose of this study was to examine the reasons that influence older people to choose private services as an alternative source in the comprehensive tax-subsidized Finnish social care system. The study also aimed to analyse whether people use private services as a free choice or an enforced choice and to identify factors that contribute towards these choices. This paper used both quantitative techniques and qualitative content analysis methods. The results showed that people chose private care because of effortlessness to use, requirements for additional services, unavailability of public support and lack of information about public provisions. Most of the respondents performed a free choice to use private services but a considerable number were enforced towards this alternative service. People who lived in city center with a higher level of income and who needed more services are more likely enforced towards using private support. More research is required to understand deeply about the effects of the growing private care market on older people in Finland.

KEYWORDS: Older people, private service, free choice, enforced choice, Finland.

INTRODUCTION

Older people are the main consumers of health and social care services in Finland, as they are in most European countries. With population aging, need for care increases, however, often older people may not depend on a single source of support (family/public/private) but on a combination of several of them (Kröger & Leinonen, 2012). In Nordic countries, families have less obligation to take responsibility over the older people's economic and social welfare than in other European countries (Daatland, 1997; Haberkern & Szydlik, 2010). According to legislation, responsibility for care of older people has been comprehensively taken care by local authority. The municipality arranges tax-subsidized care for their residents either through producing the services themselves, through collaborating with neighboring municipalities or through purchasing services from the private sector. Local authorities also offer some choice for older people through tax deduction for domestic help and tax-funded service voucher to buy private care from the market.

Private social care services in Finland

Traditionally, the municipality offers social care services to their residents with some complementary support from non-profit organizations. Presently, alongside with the municipality, a larger number of for-profit and few not-for-profit organizations are actively involved in providing a wide range of care support for older people. Transition from publicly

produced services to privately produced or provided service can be observed from the early 1990s' recession. This can be seen as a new public management approach adapted by the Finnish public administration to overcome the overwhelming financial crisis and to expand service coverage for older people (Tynkkynen, 2009). As part of this approach, several municipalities started to share their care responsibilities with the private sector. However, overtime, favouring a mixed care economy and a strong prioritization of privatization in political agenda have steered a rapid expansion of the for-profit sectors. Thus, within two decades, privately produced or provided care increased in its quantity, whereas public coverage for older people reduced considerably (Anttonen & Häikiö, 2011). A report showed that the private sector produced in 2002 an estimated share of 16 % of health care and social care (Salonen & Haverinen, 2004). A recent study (Karsio & Anttonen, 2013) stated an increase in the number of private social care units from 3,018 units in 2002 to 4,350 units in 2010. Even though introducing the private sector in homecare started comparatively late in Finland, it currently appears larger than in other Nordic countries (Karsio & Anttonen, 2013). The private sector is estimated to produce of around one third of care support for older people (Ministry of Social Affairs and Health, 2013). Nowadays, national and local authorities consider private services as an acceptable solution for meeting older people's service demand (Rissanen & Sinkkonen, 2005; Rissanen et al., 2010; Karsio & Anttonen, 2013).

Choice in care process

Generally, choosing care services is a two stage process; initially an individual decides whether or not to use care services and later he/ she decides which provider to choose i.e. public or private or other available resource in the market (Scott 2000a). The second stage of the process is often crucial because it determines the service provider. Usually, people act rationally while choosing their care service and the provider (Anell, 1997; Scott, 2000b;

Fotaki, 2005; Robertson, 2009). However, rational thinking does not always support people's choice of providers; as rational choice requires adequate information about the service availability, mental ability to differentiate services and self-control to choose the service (Exworthy & Peckham, 2010; Kooreman & Prast, 2010). Older people find themselves often in a situation where they sense incapability of making rational choice (Albada & Triemstra, 2009; Victoor et al., 2012b). People's choice can also be influenced by other factors rather than just by rational thinking, such as acceptability, affordability, availability, accessibility and accommodation (Pechansky and Thomas, 1981; Exworthy & Peckham, 2010; Nordgren & Ahgren, 2011). Furthermore, individuals' socio-economic and health status also play an important role in determining the service provider (Stoddart et al., 2002, Burge et al., 2004; Mukamel et al., 2004; Lako & Rosenau, 2009; Exworthy & Peckham, 2010; Szebehely et al., 2012, Van Aerschot 2014). Hence, people's choice is often driven by multiple individual factor and collective factors.

Free choice, enforced choice and negative choice: In this study we conceptualized 'choice' into three categories: free choice, enforced choice and negative choice. The term 'free choice' is often discussed in the health and social care policy. Free choice is generally considered as an approach to initiate users' autonomy as well as to encourage users' active participation in the care process (Greener, 2003; Dixon et al., 2010; Victoor et al., 2012a). Many scholars consider this approach as a way to increase provider's responsibility, to increase consumers' value and to promote care quality (Christensen & Hewitt-Taylor, 2007; Greener, 2007). Based on a general free choice definition, here, for this study, we conceptualized 'free choice' as a situation where an end-user of service has the flexibility to select a private care service based on different options concerning quality, availability and personal preference. The term 'enforced choice' is not frequently debated or researched in the social care setting.

Dhar & Simonson (2003) quoted that a consumer is usually forced to search for an alternative resource when there is delay in existing service or there is an urgent need for service. Grounding on this explanation, we conceptualized 'enforced choice' as where the end-user of services chooses a private provider because of the inefficiency or the inaccessibility of public provisions. Likewise, 'negative choice' is where end-users do not choose a private provider for various reasons such as receiving support from the public sectors, skepticism towards the private sector or personal preferences.

Based on the conceptualized definitions, we grouped different variables to explain the core question of how older people choose private services. Even though several studies had explored the use of formal social care in Finland (e.g. Blomgren et al., 2008; Kehusmaa et al., 2012), a lack of knowledge still persists concerning how older people perceive private social care. Therefore, the research questions of this study are (1) to examine why older people choose private care as an alternative source in a comprehensive tax-subsidized Finnish social care system, (2) how people's choice are made, that is, whether the choice is based on free choice or on enforced choice and (3) to identify factors that contribute towards these choices.

METHODS

Sample and Source of Data

This study used a survey dataset from the "Care, help and everyday life" (in Finnish: "Arki, apu ja palvelut") research project which was conducted in 2010 jointly by the University of Jyväskylä and the University of Tampere, Finland. The aim of this project was to collect information about everyday life situations among people aged over 74 years, living independently at home or in sheltered housing (that is, people residing in institutional care were excluded from this study) in the two cities of Jyväskylä and Tampere. These middle

sized cities were selected in a view that they both share almost similar features concerning the number of aged population, the number of service consumption and the number of private service units (National Institute for Health and Welfare, 2013). Based on the conventional 95 % level of probability used in social science (Guthrie, 2010), a sample of a thousand participants from each city was considered as adequate to represent the total population. We collected participant addresses from population registries of the cities of Tampere and Jyväskylä. These addresses were randomised by the population registry through a computer-generated method (which was beyond the control of the authors). A personalized covering letter about the study, a consent form, and a 12-page self-administered questionnaire were sent to the participant addresses, asking the participants to return the form after completion, using the attached prepaid envelope. Initially, we received a total of 959 questionnaires, but after sending reminders to the non-respondents, 477 questionnaires were added. Thus, we obtained a total of 1436 completed questionnaires corresponding to the response rate of 71.5 % (Jyväskylä 69.0 % and Tampere 74.1%). The whole process of data collection was carried out between May and August 2010. Two-third of the respondents were women and the remaining one-third were men with a mean age of 81.93 (±4.75). Among the private service users', 47 % bought service through out-of-pocket payment, 31 % used tax deduction and tax-funded service voucher and the rest mixed both options to purchase private service.

Researchers did not apply for an ethical committee approval because of the minimum participants risk emerging from the project. In Finland, researchers are required to have an ethical committee approval only if the study involves an intervention in the physical integrity of subjects or deviates from the principle of informed consent or is otherwise sensitive like studies involving under aged children or concerning violence (Ethical review in human sciences, 2009). We followed the principle of informed consent; participants were well

informed about their rights (including the right to discontinue in the project). We followed all ethical guidelines proposed in the Helsinki Declaration and National advisory board of Research ethics throughout the study.

Dependent Variables

This particular study included only those respondents who reported to have used public or private care services (n=679; 47.2%) and excluded other respondents (n=757). We decided this exclusion since our research objectives focused on the users of care support. Although this exclusion criterion reduced the sample size to half, the acquired sample size remained still sufficient (Guthrie, 2010). Based on the conceptualization of choice described in the introduction chapter, the dependent variable was constructed as a nominal variable with three groups (1) free choice (2) enforced choice (3) negative choice. The dependent variable was assessed from the following question "why do you use private service?". Following answers were computed into the "free choice" group: (a) private services are of better quality; (b) it is effortless to use private services; (c) personal preference towards private services. In the "enforced choice" group, the following answers were included: (a) services are not granted from the municipality; (b) services are not fast enough from the municipality; (c) need for additional services which the municipality does not provide. In the "negative choice" category we included those respondents who gave an answer to the following question "why do not you use private service?", thus expressing that they have chosen not to use private care services.

Independent variables

The independent variable include: age, number of children, number of IADLs limitation (shopping, cleaning, house maintenance, transportation, managing medication) and number of social care service uses (as continuous variables). Area of residence (city centre vs suburb/partially populated), marital status (married/living together vs single/independent), education (no vocational vs vocational/higher) and regular contact with children (yes vs no) were coded into dichotomous variables. Self-reported health status was classified into a three categorical variable (very good/good, fair and poor/very poor). Household income was a categorical variable with ten groups. To standardize income for household size, the middle value of the each group was transformed into individual household income, after which, using modified OECD equivalence scale, the income variable was measured into equivalised household income by dividing the monthly income with equivalence factors (value of 1 to the first adult in the household, value of 0.5 to other adults, and value 0.3 to children aged under 13). Equivalised income was coded into quartiles (with the cut-off points 850, 1125 and 1500 euros).

Data Analysis

To address the research questions, variables were analyzed using multiple response frequency test (Table 1) and cross tabulations with chi-squared test (Table 2). Multinomial regression analysis (Table 3) was included because this method was identified as a suitable statistical tool to answer the third research question. In addition, this regression model had the advantage of not assuming linearity, normality and homoscedasticity but the assumption of multicollinearity need to be satisfied (Hosmer & Lemeshow, 2000). However, there is no predefined technique for testing multicollinearity when using categorical variable (Petrucci, 2009). One way of testing multicollinearity is through a collinearity diagnostic test with tolerance values < 0.1 and VIF value > 10 (Field 2009). We followed this technique to

identify any collinearity between independent variables; the outcome showed a negative result. In the multinomial analysis, “free choice” and “enforced choice” were considered as dependent categories and “negative choice” as the reference category. The model results were presented as odds ratios (OR) with their confidence intervals at 95%. The data was analyzed with IBM SPSS version 19 and all missing data in the regression model was deleted using list wise approach.

Additionally, qualitative content analysis was performed to explore other reasons contributed towards the use of private service. For this specific purpose, the open-ended question “why do you use private service, other reason?” from the survey questionnaire was coded into two main categories free choice and enforced choice with three sub-categories in each main group. References to price, trust and autonomy were grouped under free choice and, on the other hand, themes of availability, information and income were annexed with the enforced choice. Themes unable to be coded under the above categories (e.g. reference to bureaucracy) were placed under a different sub-category ‘other issues’ in each main category. Of the total 95 open-ended responses, only 48 were included as the other responses were excluded due to irrelevant answers (e.g. “I don’t need private services”; “I do not use”). Out of selected responses, 23 were grouped into free choice under different themes and others in enforced choice. The author translated the open-ended responses from Finnish to English with the help of a translator and also crosschecked with a research colleague to ensure all textual analysis was consistently applied under each theme.

FINDINGS

Table 1 describes how three categories of the dependent variable ‘choice’ were constructed. This table also shows the different reasons the respondent gave for using/not using private

services. Effortlessness to use private service (34.8 %), additional need for service (18.6 %) and better quality (14.3 %) were reported as the main reasons for using private social care support. Reasons stated for not using private services were their expensiveness (42.3%), personal preferences towards public service (24.2%) and extensive support received from the public sector (22.2 %).

Table 1 around here

Of the total population (n=679), 24.6 % reported to have used private service as a free choice and 17.2 % as an enforced choice (Table 2). Most of the respondents were females (65.9 %). On an average, the respondents were aged 82.36 years, had 2.20 children, had difficulty in 3.39 IADL activities and used 2.08 services. The enforced choice group had a higher mean age (83.92±5.22), a higher number of difficulties in IADL activities (4.25± 2.83) and a higher number of service used (3.48±1.70) than the other two groups.

Table 2 around here

In both the free choice and the enforced choice groups, majority of the respondents lived in the city center, had vocational or higher education and had a similar level of income distribution. The respondents who used private services through free choice were largely in the good and fair health category. From the Figure 1, it can be observed that respondents in the free choice and enforced choice categories were overall highly satisfied with the price, quality and other components of private care. However, compared to the free choice group, the enforced choice group showed a higher level of disagreement in all five components, particularly in the price and the quality.

Figure 1 around here

Multinomial regression model (Table 3) was performed to investigate the relationship of socioeconomic and other variables with the dependent variable 'choice' (free choice and enforced choice as dependent categories and negative choice as reference category). The

results show many statistical similarities between the free choice and the enforced choice groups. In both, people living in city center and with higher income level had higher odds of choosing private care services compared to members of the negative choice group. The variables that differentiated the free choice group from the enforced choice group were self-reported health status and the number of services used. In other words, people were more likely to choose private social care services through free choice, if they lived in an urban area, had higher income and good or fair health. Correspondingly, enforced choice group used private care if they required more care services (OR=1.30; p=<0.01), along with other significant variables associated with the free choice group except self-reported health. Moreover, a new multinomial regression model was analyzed using free choice as the reference group (considering space limitation the results were not reported as table). The model presented a comparison between free choice versus enforced choice. The result showed a statistically significant association only in the number of service used (OR=1.24; p=<0.01) while all other variables remained non-significant (p= >.05). In other words, we could say that people in the enforced choice group are more likely to choose private care if they require more care support than free choice group.

Table 3 around here

Other reasons for choosing private services were further explored through a qualitative content analysis from the open-end question "why do you choose private service, other reason?" (Table 4). Respondents in the enforced choice category reported unavailability of public service as an important factor which influenced them to choose private service ("*I have not received the health service I need from the city"; "the only possibility").* Lack of information about public provisions appeared to be a significant issue for the enforced group, as well ("*I do not know whether it would be possible to receive services from the city...").* Personal income came out strongly in this analysis. It seemed that a person with higher

income, including persons with a higher pension were no longer entitled for public funded provision in practice *("Pension and that is why I will not receive support i.e. too high income"; "On the basis of income I do not get the service from the city").* In the free choice category, respondents gave an ample importance to the service cost and also to trust towards the provider when choosing service provider *("...the service was not very expensive", "The service person is always the same, in municipal there will always be different").*

Table 4 around here

Few participants thought that the private sector provided more autonomy than the public provider during and after the product selection *("I think the services are in order for me; when I order them myself I pay for them myself and I receive tax deduction. I will change the firm/ company if necessary").* Other reasons for using private services were related to reliability, place of residence *("I live in a private sheltered housing")* and information *("I have not been up to finding out about all the service. Tiresome / stressful...").* Only one person reported a high level of bureaucracy in the public sector as a reason for choosing private care.

DISCUSSION

Understanding why older people choose private care rather than public support has a crucial importance in the Finnish welfare state. Finding out these reasons will explain how older people perceive and access private service. This information is needed due to the rapid reconstruction of the Finnish welfare model of care for older people from a public centered model towards a dual mechanism of public and private partnership. Among the reasons, effortlessness to use private had the highest response in the quantitative analysis followed by need for additional service. These results are expected because from the early 1990s' onwards Finland has experienced a profound change, not only in coverage level but also the whole

concept of homecare (Kröger & Leinonen, 2012). Local authorities shifted their focus within homecare from taking care of home to taking care of bodily and medical needs (as cited in, Kröger & Leinonen, 2012). Thus, several municipalities cut homecare services from their care package, particularly cleaning and shopping service. Even in this study, the respondents who identified themselves as private care recipients are largely using less-intensive services like cleaning, shopping and home maintenance services. Quality of private service stands in the third position which indicates that for several respondents private services are of better quality. However, in the light of the current situation in the public and private sectors, we assume that there would not be any major difference in the quality of service they offer; a recent study showed a statistically non-significant association between the quality of service and the type of provider (as cited in Karsio & Anttonen, 2013).

Apart from the close-ended answers, qualitative results (see, Table 4) provide additional insight to explore other reasons for choosing private care. Several end-users consider private care as a cheaper option due to the expensive user fees charged by the local authority. This is not surprising because user fees are usually defined based on the individual's income level (Karsio & Anttonen, 2013). Consequently, higher income earner need to pay higher fees for public services, but the same recipient can buy the private service cheaper from the market as there they need to pay only a fixed price (Kröger & Leinonen, 2012; Szebehely & Trydegård, 2012). Another outcome from the analysis was the meaning of personal income ("*pension and that is why I will not receive support i.e. too high income*"). This statement emphasises the inaccessibility of public support for a certain section, largely the higher income group in the society. Nevertheless, this finding goes against the notion of the universal welfare model where all social groups receive care in a uniform way without anyone being marginalized. In this context, we could argue that the Finnish welfare model is slowly drifting away from the

core idea of universalism, but such a conclusion would need support from future studies. Information is another theme that emerged from the analysis. Generally, information about services is always paramount, and conversely, lack of information creates unwanted consequences for the user (Dranove & Satterthwaite, 2000; Bent, 2009). Here, users' reports that they choose private support due to inadequacy of available information concerning public provision ("*I do not know whether it would be possible to receive services from the city...*"). This response raises some questions about the relationship between the local authorities and the service users: whether it is the authority that shows less interest in providing information to their residents or it is the users who lack interest in seeking information from the local authorities. It will be hard to give a correct answer, but usually, older people are not always an active consumer in the care market (Roberts, 2001). Either way, information about the service and the provider often plays a significant role in the users' decision making process (Lent & Arend, 2004; Fotaki et al., 2005). Another reason mentioned by the respondents is the possibility of autonomy. An earlier study conducted in Sweden showed that older people gave much importance to autonomy when they need to choose a health care support (Nordgren & Ahgren, 2011). Some of the reasons emerging from our quantitative and qualitative analysis are familiar from countries with a strong private market, but for Finland, these results are new because of very limited studies in this area. Thus, we could expect almost a similar results, if a similar study were conducted in other Finnish municipalities or even in other Nordic countries.

The second research question was to explore whether older people choose private service based on free choice or enforced choice. Although majority of the respondents perform free choice, a considerable number has chosen private service by enforced choice (see, Table 1). Common reasons described by the enforced group are the unavailability of public services

and delay in municipal support. Using private support even for a service like cleaning demands additional resources from both free and enforced choice groups, i.e. users need to pay out-of-pocket for the supplementary support. The enforced choice model cannot be ignored because of the rapid expansion of privatization in the care sector. For example, if people have to pay a considerable amount of money even after receiving some financial support from the public authority, then low-income people within the enforced group are more likely to end in a situation where income determines whether they can use the service or not. Furthermore, if having a good income becomes the only way to gain private support, then in a matter of time, the gap between social groups may widen bringing income-based health inequality in the society. The above described development cannot be proved from this study only but it requires further attention because several existing studies show an increase in income-based health inequality (Van Doorslaer et al., 2006; as cited in Wahlbeck et al., 2008; Van Aerschot 2014)

It is also necessary to examine why users apply free choice while purchasing private support. One of the main reasons mentioned in the analysis is that it is effortless to choose private service, rather than better quality or personal preference. This response might have surfaced because of longer waiting times or a higher level of bureaucracy prevail in the local authority. Hirschman (1970) and Le Grand (2006) in their notable work describe that when people experience dissatisfaction (e.g. delay, poor quality) with a product of an organization, they may either 'exit' by not buying the product or leaving the firm or look for other alternatives in the market. Here, the free choice group might not necessarily be dissatisfied with the municipal service, but could be directed by municipal care managers to use tax rebates for domestic help and service vouchers that are easily available for all social groups (as cited in Karsio & Anttonen, 2013). Furthermore, both the free choice and enforced choice groups

seem highly satisfied with the price, quality and other components of the private provision (Figure 1), though the enforced choice group shows more dissatisfaction than the other group in all components. This suggests that a considerable number of people are not happy with the present situation and the new model of choice. We cannot provide any clear explanation for this outcome but can suggest that the dissatisfied enforced choice group members may come from the less advantaged group. Therefore, more research is needed to understand and explore this finding further.

The third research question was to identify the attributes which explain membership in the free choice and enforced choice groups, and to explore how these two groups differ from each other. The multinomial regression analysis (Table 3) shows that people who live in city center and have higher level of income are strongly associated with membership in both free and enforced choice groups. These results are not surprising since often private providers are located in the urban areas and people with higher income have the higher probability of choosing private service (Burge et al., 2004; Mukamel et al., 2004; Lako & Rosenau, 2009; Exworthy & Peckham, 2010). Another outcome from the regression analysis (enforced choice vs negative choice and enforced choice vs free choice) indicates that with increasing service needs the people are more likely to be enforced to use the market-based care. We cannot pinpoint the exact reason but can suggest that this could be as a part of new public management approach to confront overwhelming service demand or rising costs or to reduce the scope of the state (Green-Pedersen, 2002). Further investigation is required to identify particular reasons behind privatization in these Jyväskylä and Tampere municipalities and also in other Finnish municipalities.

It is not surprising that people do not choose private service because of its expensiveness but, however, here it raises a serious question. If the municipalities are restricting their care

provisions (which is increasingly happening) and at the same time the alternative option seems too expensive for many, then this raises the question how people with limited incomes can meet their needs. This requires a rethinking at the policy level to redesign homecare in a more user-centered way and to increase coordination between the public and private partnerships to minimize the users' drop-out, which is often seen in the quasi market (Le Grand 2011). Moreover, it is also necessary to ensure that older people enjoy their constitutional rights to receive care without being marginalized merely on the grounds of their fiscal situation. Furthermore, policies need to be strengthened to provide adequate information and quality services in the market, for the reason that older people are not always an active consumers (Roberts, 2001).

Limitations

This study is limited in several ways. Firstly, this study includes only two cities in Finland that might not represent the entire country; secondly, the way free choice, enforce-choice and negative choice are defined can influence the result because variables included in the grouping might have some correlation with each other. Finally, the samples which represent private users are not sufficiently large to generalize the study outcome. Our survey data was collected from the general population, of whom the majority were non-user of services; therefore, further studies are required to be conducted with a higher representation from service users. Apart from these, some older people might have reported incorrectly their service usage, for instance, they might be using private service but have reported as public service or vice-versa. Therefore the findings of this study must be interpreted with some caution. Despite of these limitations, there are several strengths for this study. First, this study is among the few conducted in the Nordic countries, which has tried to examine the reasons influencing older people in choosing private social care services. Although the survey data

comes from 2010, the outcome is still relevant because of the continuing and increasing privatization and marketization in the Finnish health and social care sector. The qualitative findings from open-ended answer serve as an extra asset for this study by providing additional insight apart from the quantitative outcomes.

Conclusion

Private services as an alternative source of care have recently gained much more importance among older people in Finland. Reason for choosing private care provision include accessibility and availability of private services, additional needs of older people and lack of information from local authorities. The result of this study results not only uncover the reasons for using private services but also raise some questions about the efficiency of municipally organized public care services, requiring further evaluation. Especially, many non-users of private services considered private support as too expensive. This in turn raises some concern over service needs of the disadvantaged group because presently, several local authorities show more enthusiasm in promoting privately organized care provisions. Therefore, more studies are needed to identify the effects of privatization and marketization on older people and to understand more deeply how older people perceive this new source of care in Finland.

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Table1. Descriptive statistics of the dependent variable 'choosing private service'

Variables	n	%
A. Private service users		
Free choice		
Effortless to use private service	163	34.8
Private services are better quality	67	14.3
Personal preference towards private service	46	9.8
Enforced choice		
Need for additional services which are not available through the municipality	87	18.6
Services are not fast enough from the municipality	57	12.2
Services not granted from the municipality	48	10.3
Total Count	468	100
B. Non- users of private service		
Negative choice		
Private services are too expensive	234	42.3
Prefer public service rather than private service	134	24.2
Received all services from the municipality	123	22.2
Do not know how to access private services	42	7.6
Difficulty to obtain private services	13	2.3
Services not available from private providers	6	1.0
Total Count	552	100

Table 2. Descriptive statistics of choice

Variables	Total N=679	Free choice N=167 (24.6)	Enforced choice N=117 (17.2)	Negative choice N=395 (58.2)	*p* value
	M±SD or %	M±SD or %	M±SD or %	M±SD or %	
Age in years	82.36±4.93	82.17±4.59	83.92±5.22	82.45±4.94	**
Number of children	2.20±1.47	2.12±1.56	2.38±1.36	2.18±1.47	*NS*
No of IADL limitation	3.39±2.81	2.65±2.47	4.25+2.83	3.44±2.86	***
Number of services used	2.08±2.46	1.84±1.82	3.48±2.99	1.77±2.39	***
Gender					
Female	65.9	66.9	65.8	65.6	*NS*
Male	34.1	33.1	34.2	34.4	
Area of residence					
City center	48.4	59.8	56.0	41.4	***
Suburb/ partially populated area	51.6	40.2	44.0	58.6	
Marital status					
Married/living together	41.2	40.1	37.1	42.8	*NS*
Single/independent	58.8	59.9	62.9	57.2	
Education					
No vocational education	42.0	29.7	42.1	47.2	**
Vocational or higher education	58.0	70.3	57.9	52.8	
Regular contact with children					
Yes	82.0	78.4	87.2	82.0	*NS*
No	18.0	21.6	12.8	18.0	
Self-reported health					
Good	21.9	27.5	19.6	20.2	**
Fair	47.7	52.7	40.2	47.8	
Poor	30.3	19.8	40.2	32.0	
Equivalised household income					
Quartile (4^{th}/lowest)	33.4	24.3	20.4	41.0	***
Quartile (3^{rd})	21.7	20.7	30.6	19.4	

Quartile (2nd)	28.5	23.6	27.7	20.8
Quartile (1st/highest)	16.4	31.4	21.3	8.8

*p< .05; ** p<.01; *** p< 0.001; *NS=Non Significant; M=Mean; SD= Standard Deviation.*
Note: Numbers within categories within a variable might not add up to total because of missing values. Missing data in the following variables (% of the total sample (n=679)): Age, 3.1%; Number of children, 2.8%; Self-reported health, 1.9%; Equivalised household income, 11.8%. Missing value less than 1 % in the variables were not reported.

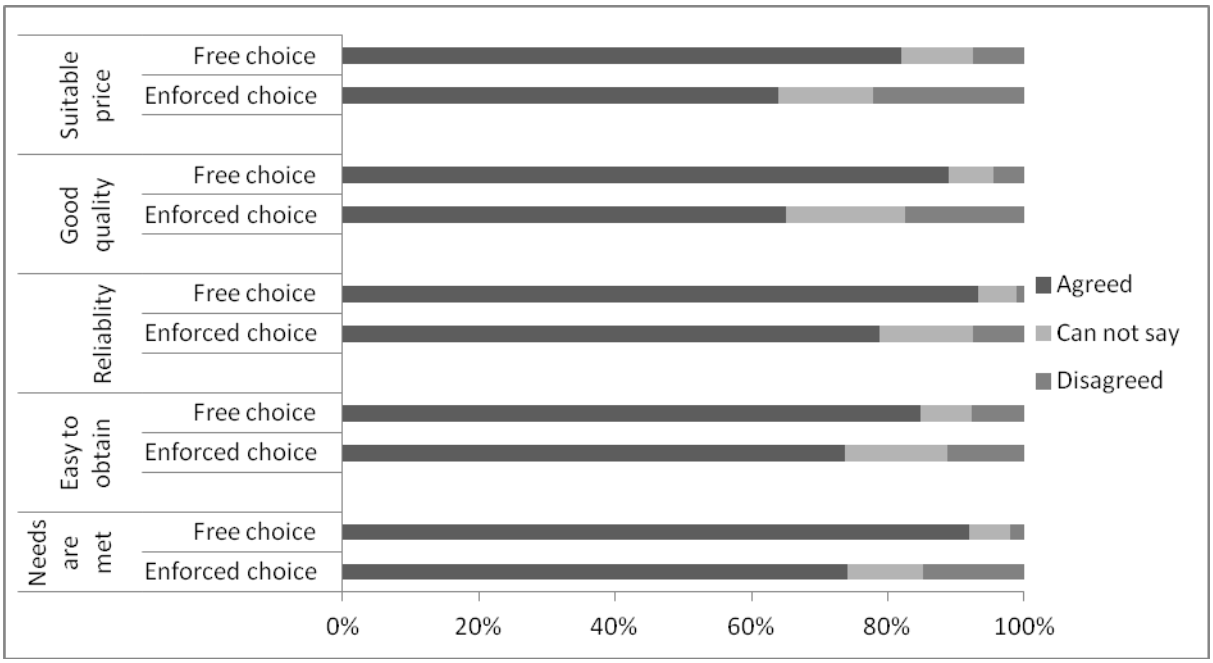

Figure 1. Level of agreement towards private care services

Table 3. Multinomial logistic regression on the variables associated with choosing private social care services (N=562).

Variables	Free choice		Enforced choice	
	Estimate (*SE*)	***OR***	**Estimate (*SE*)**	***OR***
Age	-0.00(0.02)	0.99	-0.00(0.02)	0.99
Number of services used	0.02(0.05)	1.02	0.24(0.05)	1.27***
Gender (ref: male)				
Female	0.49(0.27)	1.63	0.06(0.29)	1.06
Marital status (ref: single/ independent)				
Married/living together	-0.16(0.27)	0.84	-0.07(0.31)	0.93
Area of residence (ref: suburb/partially populated area)				
City center	0.65(0.22)	1.92**	0.66(0.24)	1.94**
Education (ref: vocational or higher education)				
No vocational education	-0.24(0.23)	0.78	-0.05(0.26)	0.95
Self-reported health (ref: poor)				
Good	0.72(0.32)	2.07*	0.05(0.35)	1.05
Fair	0.55(0.27)	1.74*	-0.06(0.27)	0.94
Equivalized household income (ref: 1^{st}/ highest quartile)				
Quartile (4^{th}/ lowest)	-1.84(0.33)	0.15***	-1.61(0.40)	0.20***
Quartile (3^{rd})	-1.27(0.35)	0.28***	-0.63(0.39)	0.53
Quartile (2^{nd})	-1.39(0.32)	0.24***	-0.91(0.37)	0.39*
Intercept	-0.34(2.22)		-0.51(2.29)	
-2 Log Likelihood	954.690			
Chi-Square (χ^2)	113.773			
Degree of freedom (*df*)	22			
Nagelkerke R^2	0.214			

*p< .05; ** p<.01; *** p< 0.001

Note: *OR*=adjusted odds ratio; *SE*= standard error of estimate. Goodness-of-fit statistics indicate the model is adequate (deviance = 938.055, degree of freedom (*df*) = 1050, value/ degree of freedom (*df*) =

0.89, p =0.99). 'Negative choice' was used as reference category in the analysis. Reference groups for categorical variables listed in parentheses.

Table 4. Qualitative findings from the open-end question: Other reason for choosing private care services (N=48)

Free choice (N=23)	**Enforced choice (N=25)**
Price:	**Availability:**
Advertisement just came in the right time and the service was not very expensive.	*I have not received the health service I need from the city*
Expensive city services.	*The only possibility*
Cheaper.	*I do not expect to receive the service I desire from the city*
	Cleaning is not a municipal service
	Changed over from the city of Tampere to the private sector
Trust:	**Information:**
The service person is always the same; in municipal services there will always be different.	*I do not know whether it would be possible to receive services from the city…*
Home-based worker will change almost every day.	*I do not know all the possibilities.*
An old familiar cleaner. A neighbor friend of another.	*Have been forced to pay for yourself when no one has explained the position, who gets what*
I have a reliable cleaner for 2 years.	
Autonomy:	**Income:**
I think the services are in order for me; when I order them myself I pay for them myself and I receive tax deduction. I will change the firm if necessary.	*….discussing with the supervisor of the home care service we came to the conclusion that with my income their services would be more expensive*

You get to choose.	*compared to private services because one cannot receive domestic help tax credit from them…* *Pension and that is why I will not receive support i.e. too high income* *On the basis of income I do not get the service from the city*
Other issues: *I have not been able to find out about all the service. Tiresome / stressful……* *I have heard bad things about public services* *I live in private sheltered housing*	**Other issues:** *Lot of bureaucracy.*