JYU DISSERTATIONS 128

Jiby Mathew Puthenparambil

Marketisation of Care within the Nordic Context

Private Care Provision for Older People in Finland

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF HUMANITIES AND SOCIAL SCIENCES

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ABSTRACT

Mathew Puthenparambil, Jiby
Marketisation of care within the Nordic context: Private care provision for older people in Finland
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This dissertation focuses on the ongoing development in the use of private social care services for older people in Finland by asking the following questions at two levels. (1) At the municipality level, to what extent do municipalities involve private providers in organising care services for older people, and what are the determining factors that are associated with the outsourcing of publicly funded care services? (2) At the individual level, to what extent do older people use private care services, and how do people who use private care services differ from people who use traditional public care services? (3) Also at the individual level, why do older people choose to use private care services, and is this a free or a forced choice? Quantitative data from the Sotkanet Indicator Bank and Statistics Finland was used to examine the municipality-level research questions. The data covers all 311 municipalities in Finland for the period 2001–2015. A two-wave longitudinal survey 'Arki, apu ja palvelut' was used to answer the individual-level research questions. The data was collected from people aged over 74 years in 2010 and 2015 in the cities of Jyväskylä and Tampere.

The results show that the share of outsourced public home care visits and service housing have increased considerably. An increase in care needs (i.e., demand for care) among the ageing population in a municipality is one of the main influencing factors behind outsourcing, particularly for service housing. At the individual level, one third of respondents utilised private care services, and these users had significantly higher incomes and educations as well as better health than those using public services alone. Older people chose private services because of the services' are easily accessible, and their own additional needs for services. Although the majority of users used private care out of free choice, a substantial number of users used private services out of forced choice. Overall the findings show that private care provision is no longer a marginal phenomenon in Finland. There has been a steep and steady growth in the use of private provision for older people at the municipality level (i.e., through outsourcing) as well as among older people. In short, it is apparent that social care services for older people in Finland have been clearly affected by the marketisation of care.

Keywords: Marketisation, private services, older people, service use, municipality, Finland.

TIIVISTELMÄ (FINNISH ABSTRACT)

Mathew Puthenparambil, Jiby
Hoivan markkinoistuminen pohjoismaisessa kontekstissa: vanhusten yksityiset hoivapalvelut Suomessa
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Tämä tutkimus tarkastelee yksityisten sosiaalipalvelujen kasvua suomalaisissa vanhuspalveluissa. Sen tutkimuskysymykset kohdentuvat yhtäältä kuntatasolle ja toisaalta yksilötasolle. (1) Kuntatasolla tässä tutkimuksessa tutkitaan, missä määrin kunnat käyttävät yksityisiä palveluntuottajia vanhojen ihmisten hoivapalvelujen tuottamisessa ja mitkä tekijät selittävät julkisesti rahoitettujen hoivapalvelujen ulkoistamista. (2) Yksilötasolla tutkitaan, missä määrin vanhat ihmiset käyttävät yksityisiä hoivapalveluja ja missä suhteissa yksityisiä palveluja käyttävät eroavat julkisten hoivapalvelujen käyttäjistä. (3) Yksilötasolla tutkitaan lisäksi myös sitä, miksi vanhat ihmiset käyttävät yksityisiä hoivapalveluja ja onko siinä kyse vapaasta vai pakotetusta valinnasta? Sotkanet-indikaattoripankkia ja Tilastokeskuksen kuntatietoja käytetään kuntatason tutkimuskysymysten tutkimuksessa. Nämä tilastoaineistot kattavat Suomen kaikki 311 kuntaa ajanjaksolla 2001–2015 Yksilötason tutkimuskysymyksiin vastaamisessa tämä tutkimus käyttää ”Arki, apu palvelut” -kyselyn aineistoa, joka on kerätty yli 74-vuotiaiden parissa Jyväskylässä ja Tampereella vuosina 2010 ja 2015.

Tulokset osoittavat, että ulkoistettujen julkisesti rahoitettujen kotihoitokäyntien ja palveluasumisen määrä on kasvanut huomattavasti. Hoivatarpeiden kasvu eli palvelujen kasvava kysyntä ikääntyneen väestön joukossa on tärkeimpiä kuntien palvelu-ulkoistuksia selittäviä tekijöitä, etenkin palveluasumisen osalta. Yksilötasolla kolmannes vastaajista käytti yksityisiä hoivapalveluja ja heillä oli selvästi korkeammat tulot, korkeampi koulutustaso ja parempi terveys kuin vain julkisia palveluja käyttävillä. Vanhat ihmiset käyttivät yksityisiä palveluja etenkin niiden helppokäyttöisyyden vuoksi ja koska heidän tarvitsemiaan palveluja ei ollut saatavilla kunnalta. Vaikka suurin osa yksityisiä palveluja käyttäneistä teki niin vapaasta tahdostaan, monet vanhat ihmiset olivat valinneet yksityiset palvelut pakon edessä. Yleensä ottaen tutkimuksen tulokset osoittavat, että yksityiset hoivapalvelut eivät ole Suomessa enää marginaalinen ilmiö. Yksityiset palvelut ovat lisääntyneet nopeasti ja jatkuvasti niin kuntien palvelu-ulkoistusten johdosta kuin vanhojen ihmisten omien palveluostojen seurauksena. On selvää, että hoivan markkinoistuminen on vaikuttanut merkittävästi Suomen sosiaalipalvelujärjestelmään.

Avainsanat: markkinoistuminen, yksityiset palvelut, vanhuspalvelut, palvelujen käyttö, kunta, Suomi.

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LIST OF ORIGINAL PAPERS

1. Mathew Puthenparambil, J. (2018). Outsourcing within the Nordic context: Care services for older people in Finland. *Journal of Aging and Social Policy*, *30*(5), 440–457.

2. Mathew Puthenparambil, J., Kröger, T., & Van Aerschot, L. (2017). Users of home-care services in a Nordic welfare state under marketisation: The rich, the poor and the sick. *Health and Social Care in the Community*, *25*(1), 54–64.

3. Mathew Puthenparambil, J., & Kröger, T. (2016). Using private social care services in Finland: Free or forced choices for older people? *Journal of Social Service Research*, *42*(2), 167–179.

AUTHOR'S CONTRIBUTION

Article I: Mathew Puthenparambil, J. (2018). Outsourcing within the Nordic context: Care services for older people in Finland. *Journal of Aging and Social Policy*, *30*(5), 440–457.

Sole authorship

Article II: Mathew Puthenparambil, J., Kröger, T., & Van Aerschot, L. (2017). Users of home-care services in a Nordic welfare state under marketisation: The rich, the poor and the sick. *Health and Social Care in the Community*, *25*(1), 54–64.

The first author took the main responsibility for developing the research ideas, analysing the data and writing the first version of the paper. The second and third authors commented on and supplemented the paper. During the process towards publishing this article, all authors contributed to the revision of the paper, but the first author took the major responsibility.

Article III: Mathew Puthenparambil, J., & Kröger, T. (2016). Using private social care services in Finland: Free or forced choices for older people? *Journal of Social Service Research*, *42*(2), 167–179.

Both authors contributed their time to this paper. The first author developed the ideas, analysed the data and wrote the first version of the paper. This initial version of the manuscript was later commented on and supplemented by the second author.

LIST OF ACRONYMS

ADL	Activities of Daily Living
AR(1)	Autoregressive Correlation
IADL	Instrumental Activities of Daily Living
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Cooperation and Development
VIF	Variance Inflation Factor

FIGURES

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1 INTRODUCTION

Providing adequate and quality care for older people is one of the challenges faced by many countries. This challenge is mainly due to demographic changes (e.g., ageing population), lack of care professionals, shrinking informal care support, and the overall effect of the recent financial crisis, both nationally and globally. In 2016, out of the total Finnish population of 5.5 million, people aged 65 years and above comprised 20.9% (Sotkanet, n.d.). The population group aged 75 years and above, which requires more care services than the group of 65–74-year-olds, represents 9.1% of the total population. Interestingly, this particular group shows a projection of 13.9% in 2030, 15.8% in 2040 and 17.0% in 2060 (Sotkanet, n.d.). This projection indicates that this particular group will almost double in number and will encompass almost one fifth of the total Finnish population in the next 40 years.

As the population ages, the demand for care increases, and these demands are met through either informal care (e.g., family, friends) or formal care (e.g., public, private or NGO care services). In Finland, municipalities are responsible for organising tax-subsidised care for older people by providing services themselves, collaborating with neighbouring municipalities, or outsourcing services to private providers (for-profit and non-profit organisations). Additionally, municipalities are responsible for generating a major share of the funds to finance care services (Häkkinen, 2005). However, during the last three decades, several changes have occurred in the social care sector, particularly in care for older people.

First of all, a coverage drop is evident in all types of public care provision for older people. Until 1990, the coverage of the home care services organised by municipalities was exceptional in the international standards (Kröger & Leinonen, 2012). However, during the economic recession of the early 1990s, central government took extensive measures and reduced many public expenditures, including central grants to municipalities. This action affected local governments severely, and consequently they downsized many of their expenditures – especially in health and social care for older people, which was previously heavily subsidised by central grants (Kröger, 2011). In 1990, about 31.5%

of older people aged 75 years and above were covered by home care services; however, the coverage decreased to 20.4% in 2010, and further dropped to 18.4% in 2017—a total coverage drop of 13.1 percentage points in the last three decades (Sotkanet, n.d.). Additionally, a coverage drop was also noticeable in long-term residential homes (National Institute for Health and Welfare, 2013).

Second, local governments have taken extensive measures to integrate home help and home nursing into a single home care service, in order to simplify care arrangements and save on administrative expenses. In addition, local governments are arranging care services more strictly by tightening the eligibility criteria (needs assessment) for tax-financed care services. Local governments also employ means assessment, although in principle at least, means assessment should not be prioritised in the Nordic welfare state context. However, in the wake of these approaches, municipalities quickly shifted the focus of home care from care of the home to care of bodily and medical needs (Kröger & Leinonen, 2012). As a result, people with basic needs (e.g., for cleaning or shopping) received less priority from the municipality. Although this integration was intended to simplify care arrangements and target the neediest group, the policy of retrenchment (transferring some of the care responsibilities to users themselves and their families to reduce care costs) cannot be ignored as a motivation.

Third, the integration of informal care with formal care and a strengthening of refamilisation have taken place (Anttonen & Karsio, 2016; Bäckman, 2016; Burau & Kröger, 2004; Häikiö & Anttonen, 2011; Kröger & Leinonen, 2012). No specific legislation for informal care support existed until the introduction of the Act on Support for Informal Care in 1993, amended in 2005 (937/2005). Under the Social Welfare Act (1984), municipalities provided informal support in the form of a home care allowance to family members who took care of older persons. Municipalities were not legally obliged to provide this home care allowance, but most of them did so (Niemelä & Salminen, 2006, p. 17). With the implementation of the Act on Support for Informal Care, support for informal caregivers who provided care on a continuous basis expanded. Informal caregivers are now entitled to receive a care allowance, days off from caring, holidays, eligibility for care-related training, and free health check-ups. To receive a care allowance, a person needs to sign a care agreement with the municipality. The amount of care allowance is often tied to the demanding nature of the caregiving (how much and how often), and also depends on the budgetary allocation of the municipality. The integration of informal care with formal care has transferred several care responsibilities from the state to users' families, thus inducing a significant increase in family care support (Anttonen & Häikiö, 2011; Henriksson & Wrede, 2008).

In the recent Finnish political discourse, there has been a stronger emphasis to increase informal care support. For example, "Home care for older people and better informal care for all age groups will be developed" was one of the key targets of Juha Sipilä's government (2015–2019). The quote "better informal care for all age groups" gives a clear indication of a shift towards neo-familial

care policies in Finland, hinting that families should assume more responsibility in taking care of older people.

Finally, the promotion and strengthening of market practices in the public care sector has been another major trend in Finland. Although new public management-oriented reforms—which adopt market principles and business management techniques in the public sector (Siltala, 2013)—were introduced in Finland from the late 1980s onwards, they strengthened during and after the early 1990s economic depression. The promotion of the marketisation of care was strongly emphasised on the political agenda as well as through policy frameworks (Anttonen & Häikiö, 2011; Gawel & Toikko, 2014; Jutila, 2011; Tynkkynen, 2013). Marketisation here refers to a process where market rationalities and practices are introduced into the public care sector (Anttonen & Meagher, 2013). The argument for the marketisation of care starts with the idea that competition between providers helps to build an economically efficient and effective service delivery system by reducing service costs, improving care quality and increasing consumer choice. Marketisation has been shaped in various forms, but in the Nordic countries (Finland, Sweden, Denmark and Norway) it can be categorised mainly into two forms: (1) *outsourcing* of public services to private providers, whereby public authorities take responsibility for financing, regulating and monitoring the services; (2) *choice*, whereby people have the possibility to choose services from different providers, mainly private (for-profit) providers (Petersen & Hjelmar, 2014).

In recent years, marketisation has not only been transforming the traditional care delivery system but also shaping a new role for older people. Under marketisation, the perspective of 'care' itself is changing from the core value of welfare services to its market-oriented perception as a 'commodity', while the role of older persons has been changing from 'users' to 'consumers' (Meagher & Szebehely, 2013). As a result of marketisation, there has been fast and substantial growth in the private care sector. A recent report by the Ministry of Social Affairs and Health (n.d.) showed that in Finland, the private sector produces a quarter of all health and social care services. Karsio and Anttonen (2013) reported in their study that the number of private social care units increased from 3018 units in 2002 to 4350 units in 2010. Although the introduction of the private sector into the care of older people started comparatively late in Finland, it currently appears to be on a larger scale than in the other Nordic countries. A recent report on care workers comparing the four Nordic countries (Norway, Sweden, Finland and Denmark) showed that Finland had the highest percentage (20%) of care workers working in the private sector compared with the other countries (Kröger et al., 2018). Nowadays, national and local authorities strongly consider private care services to be a solution for meeting older people's service demands. However, only limited research has been conducted in Finland to describe the trends in older people's care service usage or the changes in publicly organised care services.

With the recent transformation of care, it is important to understand how municipalities organise care services for older people. Increasing service de-

mands and limited central government grants to municipalities have influenced several municipalities to adopt marketisation in their social care delivery system. In Finland, municipalities are not obliged by law or any other policy framework to outsource their services to private providers unless they decide to do so; therefore, the degree of intensity and the methods used for outsourcing can vary significantly between municipalities (see Karsio & Anttonen, 2013). However, these local differences have not been studied comprehensively in Finland, which means that there is only limited understanding of the number of municipalities engaged in outsourcing their in-house services, or of the trends associated with the use of private social care services. There is limited knowledge about how older people are using private care services within the ongoing marketisation of care. Moreover, the austerity measures have influenced several municipalities to organise services only for people in the greatest need, while those in need of certain support services (e.g., cleaning, shopping) are required either to purchase services from private providers or to depend on informal care support. As a result, people in need of support services have ended up purchasing private services, either by paying for them entirely out of their own pockets, by utilising tax credits for domestic help, or through service vouchers (which can be either income-related or flat-rate). Most often, a large proportion of users end up paying entirely out of their own pockets for the services they have purchased from private providers (Anttonen & Häikiö, 2011). Previous studies in Finland have concentrated on the use of public services, and less attention has been given to private services, although private services is a fast-growing phenomenon. In particular, research focusing on self-financed private services has been limited.

1.1 Research questions

The above-mentioned research gaps are addressed in this study through three published scientific articles. This dissertation summarises the results from these three articles. For this purpose, I have formulated three sets of research questions, where each set of questions is addressed by one article. A brief description of all the articles and how they are positioned in this dissertation is presented after this section. The research questions in this dissertation are:

(1) To what extent do municipalities involve private providers in organising care services for older people, and what municipal factors (care needs of older people, population size, economic situation, political ideology) are associated with the outsourcing of publicly funded care services?
(2) To what extent do older people use private care services, and how do people who use private care services differ from those who use traditional public care services?

(3) Why do older people choose to use private care services in the context of a Nordic welfare state where there is a tradition of universal public care provision? And is this a free or a forced choice?

Summarising the findings helps us to understand the trends in the Finnish care system, to discover the influence of the marketisation of care services on older people, and also to add to knowledge about ongoing developments in a Nordic welfare state.

1.2 Position of articles in the dissertation

To answer the research questions above, I summarise key results from the three articles, each set of research questions representing one article. For the first set of research questions, I compile results from Article I: 'Outsourcing within the Nordic context: Care services for older people in Finland'. This article addresses trends in the outsourcing of care services for older people in Finnish municipalities by asking: how much growth has there been in the number of municipalities involved in the outsourcing of home care services and service housing with 24-hour assistance, and what has been the quantity and intensity of this outsourcing? In addition, the article investigates whether and how municipal factors (the care needs of older people, population size, economic situation and political ideology) are associated with the outsourcing of these two key care services. The development of outsourcing in municipalities is examined between 2001 and 2015 in home care services and service housing with 24-hour assistance. These two services were chosen because they are considered to be the most important elements in older people's long-term care, especially from an 'ageing in place' perspective, and also because these two services are the most outsourced forms of social care for older people.

The second set of research questions is addressed by Article II: 'Users of home-care services in a Nordic welfare state under marketisation: The rich, the poor and the sick'. This article examines the use of formal care services among older people aged 75 years and above by asking: who uses private care services, who mixes them with public services, and how do these two groups differ from those who use only public care services in the more traditional way? Additionally, the article also examines the (socio-economic, demographic and health-related) factors associated with the use of only public services, only private services, and both public and private services. The article explains the use of private care services at the individual level.

The third set of research questions is studied in Article III: 'Using private social care services in Finland: Free or forced choices for older people?' This article aims to understand why older people choose private care in a comprehensive tax-subsidised social care system. There are several reasons (e.g., affordability, availability and accessibility of care) that motivate older people to

choose private services, but these have been under-studied in the Finnish context and was examined in this article. Additionally, the article analyses whether people choose private services as a free choice or a forced choice, and what factors contribute to their making those choices. Forced choice is conceptualised as 'when the end user of services chooses a private provider because of the inefficiency or the inaccessibility of public provisions', while free choice is conceptualised as 'operating in a situation in which an end user of service has the flexibility to select a private care service from among different options that concern quality, availability, and personal preference' (Mathew Puthenparambil, p. 168).

2 THE STATE OF THE ART

This chapter first briefly discusses the social care system for older people in Finland, and then presents the development of the private care market in Finland. The development of private care provision within the universal welfare state has previously been studied using different concepts such as commercialisation, the quasi-market and privatisation. However, in this dissertation the development of private care is studied using marketisation as the analytical lens. Here the key focus is to examine the use of private care provision in municipalities and among service users, rather than to look at the marketisation mechanism as such.

2.1 Social care services for older people in Finland

Care services for older people in Finland have their roots in poor relief legislation (Bäckman, 2016; Kröger, 2003; Topo, 2011). Until the end of the Second World War, families took responsibility for caring for their aged family member(s), while local parishes and municipal poorhouses supported older people without families. The modernisation of the care of older people started during the post-war period, when the Finnish government strengthened older people's economic and social care support through various policy amendments, e.g., the Social Allowance Act of 1956, the National Pensions Act of 1956 and the Municipal Home Help Act of 1966. Thus, by the end of the 1970s, families were no longer legally obliged to take care of older family members. Consequently, these acts enhanced independence among older people. Later, the Social Welfare Act of 1982 ensured care services and benefits to enable older people to live independently. The period of the 1980s is considered a golden era for older people in terms of the adequacy and quality of care (Kröger, 2003). However, this period was short-lived thanks to the arrival of the 1990s global economic recession, and welfare reforms followed during and after the recession.

The governance of care for older people in Finland follows a three-tier system. Central government (the Ministry of Social Affairs and Health), the top functionary, is responsible for developing and defining legislation and policies, and for the supervision and allocation of state subsidies. Six state administrative agencies at the regional level provide the direction, licensing and oversight of healthcare, supervise healthcare professionals and ensure quality management. At the local level, municipalities hold responsibility for organising social welfare and healthcare services for their residents. The primary responsibilities of each municipality include providing adequate and quality home care services, housing-related services, financial support, and support for informal care for older people.

There is no unified understanding of social care (see e.g., Anttonen & Sipilä, 1996; Daly & Lewis, 2000; Knijn & Kremer, 1997). However, a general definition can be found in the book *The Young, the Old and the State: Social care systems in five industrial nations* by Anttonen et al. (2003, p. 7): social care means 'giving informal or professional attention to whole person who need help in their everyday lives'. Social care includes a range of activities related to personal or practical assistance to help a person maintain their everyday activities. Presently, the social care of older people in Finland comprises (1) home care services, (2) residential care services and (3) support for informal carers (Karsio & Anttonen, 2013). Home care services comprise an integration of several services such as home help, home nursing and support services. Home help refers to services related to activities of daily living (ADL), e.g., bathing and dressing, while home nursing refers to services associated with the performance of medically related tasks, e.g., medical tests, rehabilitation tasks, and the cleaning and dressing of wounds. Support services refer to tasks related to instrumental activities of daily living (IADL), e.g., cleaning and shopping.

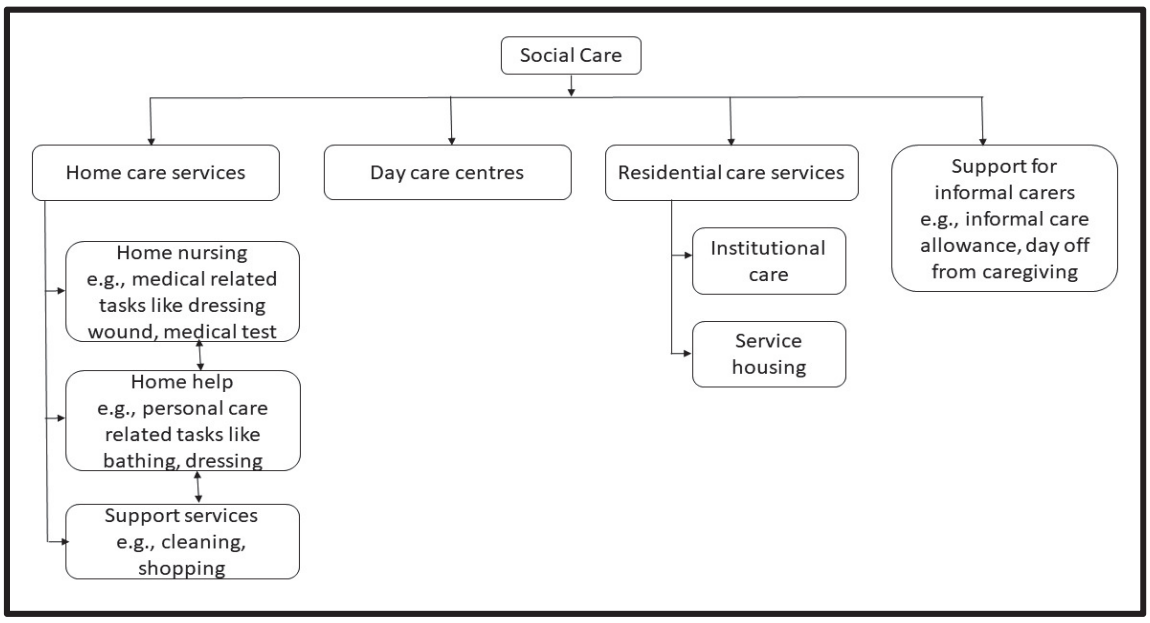

FIGURE 1 Social care services for older people in Finland.

Residential care consists of two settings: (1) service housing with or without 24-hour assistance; (2) institutional care, which is mainly designed for older people who need constant care during their daily activities. In service housing, people receive services based on an individual care and service plan signed between the user and the local government. However, in this type of housing, users need to pay separately for their accommodation and also for all the services they use. In traditional institutional care too, people receive accommodation and a regular care service, but both are included in the income-based user fee. It is still unclear how these two settings – i.e., institutional care and service housing with 24-hour assistance – differ from each other. One possible differentiation can be made based on user fees and social security benefits for service users. That is, people living in institutional care are not entitled to receive care allowance, housing allowance or compensation for medical treatment from Kela (the public social insurance institution). However, people in institutional care can retain 15% of their income, even if the costs of their care provision exceed twice or three times their income. The payment practice differs for people living in service housing, and varies from one municipality to another. Older people may be required to pay an overall fee of 85% of their income, or they may need to pay for every service they use. Although there is no legislation that sets how much a person can retain for personal expenses after paying their user fees, it varies from €108 to €250 per month (see Hetemaa et al., 2018).

Informal care generally refers to any kind of support provided by family members, relatives or friends for an older person who needs help in order to maintain everyday activities. Support for informal carers in Finland through public funding is organised in various forms. The main form of support is the informal care allowance, which is granted to a family member who takes care of an aged family member (e.g., spouse or parent) with higher care needs. To be eligible for this grant, caregivers need to formulate an informal care agreement with the municipality of residence. However, each municipality sets its own eligibility criteria and allowance figures for informal support. Other forms of support to which informal caregivers are entitled are: days off (three per month) from their caring duties; substitute services (e.g., from the municipality or private providers) during their absences; training in caregiving; annual holidays; free health check-ups; and other related services, such as short-term care in an institution, day care centres for older people, and foster homes. This dissertation focuses only on the first two types of social care service, i.e., home care services and service housing with 24-hour assistance. Although support for informal carers does not fall within the scope of this study, it is worth mentioning the different forms of social care arrangement for older people in Finland.

Generally, the municipality has responsibility for organising statutory services for older people, but it also has the freedom to use other methods, such as collaborating with neighbouring municipalities to co-produce care services or to purchase care services from non-profit or for-profit organisations. Until the early 1990s, the services purchased from private providers, especially for-profit providers, were minimal, but this practice started to gain importance in munic-

ipalities following the strengthening of the marketisation approach (Anttonen & Häikiö, 2011; Szebehely & Meagher, 2017).

2.2 The Finnish model of care for older people: A universal model?

Finland belongs to the universal welfare state or Nordic welfare model, with the principle of universal public services and benefits (Anttonen & Sipilä, 1996; Esping-Andersen, 1990; Sipilä, 1997; Van Aerschot & Zechner, 2015). The main features of universalism are comprehensive public responsibility, decentralised organisation, basic income security, equality in the use of services, and legislation that guarantees benefits and services for all people who need them (Anttonen & Sipilä, 1996; Cox, 2004; Esping-Andersen, 1990; Greve, 2007; Kvist, 1999; Sipilä, 1997). Universalism is considered one of the main pillars of social policy in the Nordic welfare state (Anttonen, 2002; Anttonen & Sipilä, 1996; Cox, 2004; Sipilä, 1997), which aims to promote equality of status where citizens/residents enjoy similar rights irrespective of differences, e.g., in class or market position (Esping-Andersen, 1990, p. 25). Universalism is seen as a grand idea in care policy to reduce inequality (e.g., class) and prevent social risks (e.g., poverty).

Discussions of universalism and the welfare state can be found in the literature from the 1970s onwards but these are mainly from the perspective of social security, with less attention paid to the dimension of social care. As social care has emerged as a main focus of research since the 1990s, several researchers have analysed universalism within different welfare regimes using the dimension of social care as a main conceptual and theoretical framework (Andersen, 2012; Anttonen, 2002; Anttonen & Häikiö, 2011; Cox, 2004; Kröger, 2003; Vabø & Szebehely, 2012). Anttonen (2002) discussed universalism from the Nordic perspective as basic social benefits and services based on compulsory legislation designed uniformly throughout the country for all citizens (irrespective of class difference), where citizens hold rights to and equal access to the tax-financed benefits and services. Andersen (2012) pointed out that the dimension of 'adequacy of service' was neglected in Anttonen's (2002) work, and so he introduced it as one of the features of his own conceptualisation. 'Adequacy of service' is often critiqued in relation to the degree to which it is achievable in care settings, especially in the care of older people, because of increasing care needs and decreasing care resources. There are other conceptualisations of universalism too (e.g., Cox, 2004; Vabø & Szebehely, 2012); but overall, universalism is a context-specific and multidimensional concept, which makes it hard to achieve a firm definition of it (Anttonen, 2002; Anttonen et al., 2012). With different definitions and interpretations available, the main idea behind universalism in the welfare service context is to provide publicly funded benefits and services to all residents according to their needs, with no discrimination.

Thus, in theory, the Finnish model of care for older people can be associated with a principle of universalism that encompasses certain features: (1) legislation that guarantees the uniform provision of benefits and services throughout the country for all residents, without discrimination (e.g., no class differences); (2) comprehensive public responsibility for the organisation of care, which also means that care provision for older people is more public-centred than private-centred or family-centred; (3) a sufficient amount and quality of care provision for older people to enhance their independence (Anttonen, 2002; Kröger, 2003; Van Aerschot & Zechner, 2015).

Universalism approach in the care of older people started slowly in Finland compared with other Nordic countries. Although various policies (e.g., the Social Allowance Act of 1956, the National Pensions Act of 1956 and the Municipal Home Help Act of 1966) were introduced in the post-war era, Finland has not really achieved its goal of comprehensive universal care for older people. This is mainly because of the lack of adequate resources to cover the increasing care needs of older people. Financial support for social care services is not particularly generous compared with other services, e.g., childcare. Care services for older people are often controlled by needs assessment to maximise the limited resources, thus making services available only to those in greatest need (Kröger et al., 2003). Other services, such as childcare and healthcare services, however showcase stronger universalism in their delivery system compared with social care for older people (Kröger, 2003). Furthermore, various reforms in institutional and home care services during and after periods of recession (i.e., the early 1990s and 2008) have weakened the care model's existing universalistic approach, for example by tightening up eligibility criteria and promoting marketisation.

It is quite challenging to measure universalism, because it represents different meanings in different contexts and places. Additionally, all welfare programmes or models include a somewhat universalistic approach in their structure. Therefore, measuring it dichotomously – i.e., asking whether a service model represents universalism or not – is theoretically invalid. At least to an extent, universalism can be measured in degrees, i.e., whether a service model represents strong or weak universalism based on different criteria, e.g., service coverage or quality of care (Kröger, 2003; Moberg, 2017; Szebehely & Meagher, 2017). Studies related to Finland have shown that universalism in the care of older people has weakened continuously in several respects due to various reforms (Anttonen & Häikiö, 2011; Kröger, 2003; Moberg, 2017). This situation is not unique to Finland, but is also reflected in other Nordic countries to different degrees. A cross-national study by Szebehely and Meagher (2017) concluded that universalism in the care of older people continues to weaken in the four Nordic countries (Denmark, Finland, Norway and Sweden) in relation to six features of universalism: (1) a clearly defined right to services; (2) the same rules defining the right to services applied to all citizens or residents; (3) tax-financed services; (4) services used by those who need them; (5) good quality services; (6) publicly provided services. Overall, the findings from earlier stud-

ies show that universalism in the care of older people in Finland and other Nordic countries has weakened in several respects, and is continuing to be transformed due to the changing economic situation, social requirements and welfare policies.

2.3 Development of private care for older people in Finland from the marketisation perspective

In recent years, Finland has witnessed the accelerating growth of the private care market, especially in social care services for older people. Currently, the private health and social care service sector produces one quarter of all care services (Ministry of Social Affairs and Health, n.d.). Compared with other Nordic countries (except Sweden), Finland emerges as an eager promoter of the care market (Meagher & Szebehely, 2013). The opening up of the care market can be traced to the early 1980s, when the Finnish government introduced Social Welfare Act 710/1982. Through this act, municipalities acquired the freedom to organise and produce their social care services, with more options to outsource services to for-profit and non-profit organisations, using central government grants. Before the economic recession of the early 1990s, Finnish municipalities produced almost all such services themselves, with some exceptions in residential care, where several municipalities outsourced such services to non-profit organisations. However, the active promotion of the care market started in the late 1990s and continued in the 2000s.

2.3.1 Marketisation of care

During the economic recession of the early 1990s, the Finnish government promoted liberalist care market ideas to build an economically efficient and effective public service delivery system. Since that time, marketisation has become a dominating trend in the social care setting. Marketisation is a context-bound concept with different understandings in different contexts, places and times. Marketisation commonly refers to a process where market rationalities and practices are introduced into the public care sector (Anttonen & Meagher, 2013). It also denotes a strong presence of private (for-profit) providers in the public care delivery system. The common forms of marketisation are, for example, the outsourcing of care to private providers with or without competition (especially to for-profit providers), the introduction of choice models (e.g., service vouchers), financial incentives for older people (e.g., tax deductions for domestic help), purchaser-provider splits, and benchmarking in the public care sector. Furthermore, deregulation policies that promote for-profit care providers, and even the acquisition of private care insurance, are considered part of the marketisation process (Brennan et al., 2012).

The main arguments for marketisation in the public care sector are that the introduction of the market (e.g., different for-profit care providers) or market

principles (e.g., competition) reduces service costs, decreases bureaucracy, improves care quality and increases consumer choice. For example, it has been argued that competition between care providers brings down the costs of services (Hefetz & Warner, 2011; Petersen et al., 2015), since providers need to compete with each other to attract customers, expand their market coverage and sustain their presence in the market. Furthermore, marketisation emerges as an attractive and reasonable solution when government mechanisms struggle to perform efficiently because of the monopolisation of state production and budget maximisation by public officials. Additionally, local governments may tend to outsource their in-house services in order to maintain a smooth flow of supply and demand if they struggle to produce sufficient care services due to an insufficient workforce or limited resources. In this scenario, local governments may decide to outsource, with or without concentrating on cost savings as their focus, in order to provide support for older people without interruptions.

Marketisation is often justified with the 'cost savings' argument. To some extent, governments have been able to (slightly) reduce service costs by outsourcing their in-house services (Petersen & Hjelmar, 2014). However, outsourcing does not always result in cost reductions, because of transaction costs that are closely associated with the outsourcing process and are often difficult to measure. Local governments need to allocate funds to build contracts and systems to control, monitor and follow up external providers, which may result in higher service costs than the previous costs of in-house municipal services (Brown and Potoski, 2003). In Nordic countries, the marketisation of care has produced mixed results, and research is still progressing in different areas, e.g., concerning the impact of marketisation on quality of care. Petersen and Hjelmar (2014) conducted a systematic review of research articles comparing Denmark and Sweden, and they found positive, negative and neutral effects of marketisation on home care. One study in their review showed a positive effect on meals-on-wheels services, i.e., outsourcing improved care quality and also increased satisfaction among service users; however, another study found that the choice model actually increased administrative costs. Lindgren (2009, cited in Petersen & Hjelmar, 2014) found that the fixed price system utilised by municipalities may reduce the quality of private care, since private providers are unable to modify prices in the long run. For example, travel costs may increase if the coverage area is relatively wide (e.g., in rural municipalities) unless such costs are anticipated and adequately presented in the budget.

It is often a question of interest how far marketisation can improve the productivity of welfare services. Meagher and Szebehely (2010) argued that the productivity of outsourced care services remains more or less the same because of the labour-intensive nature of welfare services. Welfare services cannot be treated as a product that is easily replaceable with something else. Although productivity might be increased with some innovations (e.g., technology), the quality of care and human involvement cannot be compromised. In the case of transferring public holdings (e.g., a nursing home) to private providers, the new

management may alter the modus operandi of the previous organisation but is less likely to change the existing workers. The local government may negotiate a deal with the new management for the smoother transition of existing workers, or the new management may find it easier to retain existing workers than to spend additional resources finding a new workforce. However, there is always a chance that some of the staff may be laid off as part of the new management's policies, whether to reduce human resource costs or to increase workforce efficiency (by removing unproductive workers).

Marketisation in the care sector is also criticised for creating rigidity among care managers, since they need to follow a profit-oriented rather than a service-oriented approach; the classic example is the tightening of needs assessments for those receiving care services, and the additional implementation of means-testing. There are other arguments too about why local governments outsource their services to private providers, which will be discussed in a later section.

As part of the marketisation process, the principle of 'user pays' may be introduced, strengthened or reframed (Meagher & Szebehely, 2013). In Finland, all services provided by municipalities are subject to a user fee, with some exemptions for people on low incomes. To receive such an exemption, older people need to take the initiative and inform care managers of their situation. Often older people fail to utilise the income exemption because they lack knowledge regarding their rights, and also because of the hassle they would face in the bureaucratic process. Most Finnish municipalities practise a dual assessment method, i.e., needs assessment and means assessment, although at least in principle, means assessment should not be prioritised.

Among the Nordic countries, Finland has the highest user fees (Anttonen & Häikiö, 2011): Finnish user fees cover 15–20% of the service cost, while the municipality covers the major share of 70% through public taxation, and the rest comes from central government subsidies (Karsio & Anttonen, 2013). There is a ceiling of €691 for one calendar year in healthcare services, after which care users do not need to pay the user fee. However, it is users' responsibility to inform the relevant agencies to activate the ceiling so that they receive a reduction or waiver of the user fee; otherwise, the fee will be charged. Moreover, the ceiling does not apply to services such as home care services, home nursing and long-term inpatient care, which means that older people need to pay user fees (usually up to 85% of their income) as long as they receive these services. All municipalities in Finland charge user fees for these services, but the fee structure varies a lot from municipality to municipality. Here is an example: in Helsinki, a person needs to pay a fee of €9.30 per visit for temporary home care service, and €14.70 per visit for a doctor; in Tampere, temporary home care service costs between €12 and €18.90 per visit. However, if the user receives a service regularly (at least once a week), the service charge is calculated based on the number of services received, the size of the family and the gross income of the household. Unfortunately there is no national-level data available in Finland to explore how much older people pay out of their own pockets to pur-

chase private care services separately or to top up service vouchers. An earlier study showed that one fifth of the total population used out-of-pocket payments to purchase private services (Anttonen & Häikiö, 2011). The assumption is that people use out-of-pocket payments to purchase at least some practical help (e.g., cleaning, shopping) from private providers.

2.3.2 Policies related to marketisation

This section discusses the main policies that have contributed to the expansion of the private care market. The Planning and Government Grants for Social Welfare and Health Care Act (733/1992) was one of the policies that promoted the private care market. The implementation of this act not only strengthened municipalities' autonomy, but also created an opening for market-based practices (e.g., the outsourcing of public care) in their care delivery systems. This act expanded municipalities' freedom to organise health and social care tasks at their discretion, by removing the previous system of earmarked state funding for welfare services, and by relaxing the strictly regulated outsourcing policy (Karsio & Anttonen, 2013). The Public Procurement Acts (1505/1992 and 1530/2001) were another important policy that promoted the private care market. These acts followed the European Union directive on competition neutrality, urging municipalities to promote fair competition in their outsourcing practices. Among the Nordic countries, Finland and Sweden fully implemented the competition neutrality principle, treating for-profit and non-profit organisations equally under their procurement laws (Meagher & Szebehely, 2013, p. 253). In response to the competitive neutrality practised by the municipalities, even non-profit organisations revamped their entire organisational structures, or some part of their structures (e.g., services for older people), to resemble profit-making organisations. Such organisational changes helped non-profit organisations to meet the eligibility criteria set by the municipalities for them to participate in procurement processes. As a result, some outsourcing practices (e.g., direct contracts awarded to private providers without competition) have become less significant. Nowadays, almost all Finnish municipalities favour an open tendering procedure, whereby interested and eligible private organisations submit a tender in response to the municipality's open call for competitive bidding. Lith (2013, cited in Karsio & Anttonen, 2013) reported that about 98% of publicly funded housing services in 2011 were outsourced through an open procedure.

Later, in the early 2000s, the tax credit for domestic help (2001/2006) was launched, supporting all Finnish residents with taxable incomes to purchase care services from private providers or to employ private domestic and care workers using tax deductions. This policy allows a person to deduct a maximum credit of €2400 per person per year. Following the introduction of the tax credit for domestic help, the usage of tax deductions increased from €32 million in 2001 to €359 million in 2014 (Finnish Tax Administration, 2016). In 2011, 14% of Finland's 2.5 million households utilised the tax credit system (Aalto, 2015).

However, there is no data available to show the quantity of tax credits used by older people, although this group may be the primary users of the tax credit.

The Act on Service Vouchers for Social Welfare and Health Care (2004/2009) was introduced to promote the purchase of private care services using service vouchers. This act enabled municipalities to provide service vouchers to the user to purchase private services, instead of providing municipal services. Here, users can choose a service from any municipality-approved private provider. However, if the user refuses to accept a service voucher, the municipality needs to provide the services itself or by other means, e.g., through outsourced services. The municipality decides the value of the service voucher, which may be primarily associated with the individual's household income (usually for regular home care) or based on a flat rate. However, users themselves need to pay the additional fee if the price assigned on the service voucher is exceeded. Interestingly, no regulation exists on how much a private provider can charge for the services they provide, but the final decision rests with municipalities as to whether or not to include the private provider if the service is quoted at a higher price (Moberg, 2017). Unfortunately, there is no data available to reveal how much user fees vary between different private providers, but in home care services, at least, the prices should be relatively similar. Service vouchers have attracted many users from different age groups, but among older people their usage has been modest and not on the level anticipated during the implementation period of the act (Kröger & Leinonen, 2012). Overall, the implementation of service vouchers opened a space for 'freedom of choice', and also encouraged the expansion of care markets.

The Act on Care for Older People of 2013 was implemented to ensure that older people would receive quality care according to their needs on an equal basis throughout the country. This act gives more importance to home care than to institutional care, promoting independent living and recommending institutional care only if it is medically justifiable. Although this act does not directly invoke marketisation, it opens up fertile ground for the market. For example, people living at home with care needs require regular home care services, and these care needs are supported through either formal (public or private) care or informal care. As the use of private service provision increased, the Act on Private Social Services (922/2011) was introduced to ensure that private providers maintained adequate and appropriate facilities, equipment and staff to ensure their high quality. This act provides regulations and guidelines related to the production, implementation and supervision of private care. However, the act has been criticised for shifting the responsibilities for monitoring and supervision from municipalities to private providers themselves, and partially also to users (Kotkas, 2015).

2.3.3 Current market situation

Even though the marketisation of care started slowly in Finland, the share of privately provided care has increased significantly in the 2000s (Anttonen & Häikiö, 2011). An earlier study showed that in 2002 the private sector produced

16% of total health and social care services (Salonen & Haverinen, 2003). A report compiled by the National Institute for Health and Welfare, which used private care units as a measurement to estimate private sector growth, found 4350 private care units in 2010, compared with 2700 units in 2000 (Väyrynen, 2011). Another national report on 'healthcare and social welfare personnel' in 2013, compiled by Ailasmaa (2015), found that the private healthcare sector employed 22% of care personnel in 2013, compared with 17% in 2000. In the social care sector, nearly a third of social service personnel were employed in the private sector in 2013, compared with a fifth in 2000; 40% of these personnel worked with older people. The report further found that the private sector employed 28% of all physicians in the country. There are around 1300 private firms (94% of them with fewer than 10 employees) in Finland, but among these, 10 companies cover almost 30% of the total share, and three of those companies (Attendo, Carema and Aleris) operate internationally (Meagher & Szebehely, 2013, p. 250). Due to the lack of available data, the share between for-profit and non-profit organisations in the social care sector is unclear. However, a report titled "Health and social care staff in 2014", compiled by National Institute for Health and Welfare (2018), showed that for-profit organisations employed 21% of the total staff working with older people.

In general, the market is not always perfect, being often vulnerable to fail. In the social care setting, this risk is even higher, because of several reasons, for example, lack of information among care users, inability of the supervising authorities to monitor the market and to make timely interventions before changes in care values i.e., private providers aiming to increase their profit-margin by reducing quality of care (through e.g., understaffing). This situation is somewhat true in Finland because of the recent scandals (in Spring 2019) that emerged in long-term residential care settings. For-profit Esperi Care nursing home in Kristiinankaupunki was suspended as a precaution measure to ensure the immediate safety of its residents. Some of the main issues found in that care home were understaffing and poor quality of medical care. Soon it was found out that this nursing home was not the only private institution that provided negligent care for its residents. Regional administrative agency, a public governing body that supervises health and social care institutions at the regional level, observed shortcomings in several other private nursing homes, owned by other for-profit companies (e.g., Attendo), as well. Some of the issues were related to staffing, i.e., understaffing, fatigued care workers, unrelated nursing duties (e.g., cleaning, laundry), unavailability of doctors. Other issues were related to poor quality of care (e.g., poor quality of food, service plans being not properly updated, residents being left to sleep in wet diapers), and medication (e.g., giving drugs without prescription, medicines being not correctly labelled, providing wrong medication). Though monitoring agencies have taken strict action on those nursing homes that showed care negligence, the residents of those homes have already suffered. Currently, Valvira (The National Supervisory Authority for Welfare and Health in Finland) is investigating suspicious deaths of older people in nursing homes.

2.4 Use of private care services: At municipality and user levels

The next section of this subchapter discusses how the outsourcing of care is theoretically and empirically understood, and how the outsourcing of services in municipalities is explained. Later sections of this subchapter deal with user choice, discuss from the older people's perspective whether their use of private care services is based on free or forced choice, and elaborate on how older people utilise care services.

2.4.1 Outsourcing of care

In Finland, municipalities employ different market-related practices while organising care for older people; the outsourcing of public care service is one among them. Outsourcing is often considered a marketisation instrument to implement market-like mechanisms in governance (Karsio & Anttonen, 2013). Researchers often refer to outsourcing as an independent concept, and also as a tool of marketisation and privatisation, but in this study, outsourcing is understood as an instrument of marketisation. Outsourcing refers to a practice where an external organisation is hired by a public agency to produce its in-house care services. However, the public agency takes care of the financial responsibility to produce the outsourced care services and of other duties such as commissioning, regulating and monitoring of outsourced services (Stolt & Winblad, 2009; Tynkkynen, 2013). This definition also applies to the Finnish context. However, the degree of outsourcing varies widely between Finnish municipalities because of the decentralised governance, and also because of the national legislative framework, which does not provide any step-by-step guidelines for municipalities on how to perform outsourcing in a uniform way (Karsio & Anttonen, 2013). Additionally, there is no legal obligation for Finnish municipalities to outsource their services unless they decide to do so. Therefore, in Finland, outsourcing methods practiced by municipalities may differ from each other and be complex. Furthermore, the outsourcing of public services can be practised by municipalities with or without competition. The open tendering procedure, whereby municipalities call for open competitive bidding and all interested parties are eligible to submit a tender, is the widely most favoured; other methods – e.g., restricted procedures, or direct awards without competition – still coexist, but are very minimal (see Karsio & Anttonen, 2013). Lith (2013, cited in Karsio & Anttonen, 2013) reports that about 98% of publicly funded housing services are outsourced through an open tendering procedure.

In this dissertation, outsourcing refers to the 'practice of municipalities employing for-profit or non-profit private organisations through different means (e.g., open tendering, service vouchers) to deliver public care services' (Mathew Puthenparambil, 2018, p. 441). The outsourcing of care is often considered a strategy to regulate economic pressure on the government, improve actual service coverage without losing quality, increase consumer choice and reduce administrative burdens (Geys & Sørensen, 2016; Green-Pedersen, 2002;

Karsio & Anttonen, 2013; Le Grand, 2006; Rostgaard, 2011; Stolt & Winblad, 2009). Municipalities often outsource services when their statutory services are inadequate to meet increasing demand and maintain a demand-supply flow. Although several scientific works have investigated the reasons for the outsourcing of public services in different service settings, limited research exists on the outsourcing of public care services for older people, and the results of these few studies vary greatly, with similarities and dissimilarities. Below I elaborate on these variations in more detail. The variations mainly arise because the indicators used to examine outsourcing differ across time, place and service contexts (Bel & Fageda, 2017; Petersen et al., 2015).

Boyne's (1998) framework for understanding outsourcing in local government is notable. He comprehensively reviewed the literature over two decades, and grouped the different explanatory factors associated with outsourcing into four categories: (1) fiscal stress: to verify whether local governments facing severe financial pressure tend to outsource their services; (2) scale and market structure: to examine whether cost savings through economies of scale and the competitive market are the reason for outsourcing; (3) public preferences: to examine whether local political systems outsource services in response to public demand; (4) the power of public employees: to verify whether local government employees influence outsourcing. The results were mixed. Some studies showed a positive effect of fiscal stress as an influential factor behind outsourcing, while others showed a negative or non-significant relationship. Even though Boyne found a positive association between population size (as a measurement of market structure) and outsourcing, he warned about the inefficiency of population size as a measurement to capture market structure. In the last two categories, Boyne found little empirical evidence to answer his questions. Boyne's categorisation has been widely used in scientific literature, since he tried to capture different theoretical assumptions in a comprehensive way. His study found two main drawbacks in the previous literature: he argued against not including variables that represent the 'service needs' of a certain outsourced provision; and he also highlighted the importance of a longitudinal approach, since cross-sectional research cannot capture changes in local government outsourcing decisions, and thus yields less valid results. Boyne's work is still considered a core framework, although additional dimensions – e.g., administrative professionals, political orientation, reform variables, and leadership and policy diffusion (Bel & Fageda, 2017; Bhatti et al., 2009; Brudney et al., 2004; Green-Pedersen, 2002; Pallesen, 2004; Petersen et al., 2015; Stolt & Winblad, 2009) – have been added to expand the framework theoretically as well as practically (in terms of the availability of data). However, studies related to the outsourcing of care services of older people are rare. Even among these studies (Petersen et al., 2015; Stolt & Winblad, 2009), the important factor of the care needs of older people is largely missing, although this dimension should be considered a reason for outsourcing, based on the theoretical assumption that increasing care demand leads to outsourcing. Therefore, in this dissertation, 'care needs of older people' is used as a dimension of municipal factors. Other mu-

nicipal dimensions included in this study are population size, economic situation and political ideology. A longitudinal methodological approach is used to understand the development of the outsourcing of care services in Finnish municipalities.

2.4.1.1 Care needs of older people

The demand for increasing care due to the ageing population should be seen as a significant factor associated with the growth of the private market in the social care sector. A few studies have used 'share of aged population' as an indicator to examine the relationship between care needs and the increasing likelihood of outsourced public services (Petersen et al., 2015; Stolt & Winblad, 2009), based on the hypothesis that an increase in the percentage of older people will likely increase long-term care needs in the population. The theoretical notion is that an increase in the ageing population pressurises local governments to maintain a steady flow of care services for their residents. Local governments may search for alternative solutions to maintain a demand-supply flow. As a consequence, municipalities may seek support from private providers to complement care provision and regulate increasing care demands (Meagher & Cortis, 2009; Rostgaard, 2011).

It is evident from previous studies that municipalities often tend to outsource their services to private providers at times when their statutory services are inadequate to support increasing demand. In earlier studies, the percentage of older people was used as a measurement to reflect the increasing demand for care in the population (Petersen et al., 2015; Stolt & Winblad, 2009). However, this type of single measurement does not fully represent the actual care demands of the population. To unpack care demands more thoroughly, one needs to find a measurement which is close enough to specify actual care needs, for example, limitations in the ADL (e.g., eating, toileting) of older people. Most often, the availability of such data at national and local levels is limited. Due to the lack of data regarding ADL, this study includes five proxy measurements to represent care demands in the population: the proportion of people aged 65 years and older; the proportion of older people receiving pensioners' care allowance; the proportion of older people living alone; the number of people receiving regular home help; and the number of people living in residential care. A brief description of these variables is provided in the methods chapter.

2.4.1.2 Population size

The population size of the municipality is considered as an important indicator for explaining the outsourcing of public services. The theoretical argument behind this is that municipalities with a higher population density create more market opportunities for external providers; therefore the number of external providers will be higher in such municipalities. Additionally, competition between providers in the larger municipalities reduces service costs, which encourages municipalities to outsource more services (Hefetz & Warner, 2011; Petersen et al., 2015). In addition, larger municipalities might have adequate resources (e.g., finance and administration) to organise outsourcing more effi-

ciently than smaller municipalities (Pallesen, 2004). However, in the case of municipalities with a lower population density, the availability of private providers is minimal, because of the higher expenses involved in organising care or inadequate market capacity in the region. For example, distances between users of home care services discourage private providers in sparsely populated or rural municipalities because longer distances between users increase operating costs and reduce the profit margin (Stolt & Winblad, 2009). Although population size as a measurement is often criticised for its inability to reflect the original market capacity (Boyne, 1998; Petersen et al., 2015), it is still used in this study due to the absence of other reliable variables.

2.4.1.3 Economic situation

The economic situation of the municipality is an important explanatory factor concerning the outsourcing of public services. The theoretical argument for considering the economic situation is that when municipalities experience fiscal stress, they tend to outsource their services to private providers (Bel & Fageda, 2007; Bel & Fageda, 2017; Geys & Sørensen, 2016; Joassart-Marcelli & Musso, 2005; Zullo, 2009). According to this argument, outsourcing of public services helps municipalities to save care costs and to retain the same level of public taxation without increasing it to cover the care expenditure. Additionally, outsourcing is also expected to helps municipalities to maintain the existing level of service coverage without having to eliminate any of their care provisions. However, a counterargument suggests that affluent municipalities may have adequate financial and administrative resources to implement outsourcing effectively and efficiently (Bhatti et al., 2009; Pallesen, 2004). Therefore, affluent municipalities are likelier to outsource their services to private providers compared to other municipalities. Measuring the fiscal stress of a municipality is not a simple task, because there are various factors that can have a direct or indirect effect on fiscal stress. Boyne (1998) considered the ratio of local taxes to local income, local tax levels, and local spending to be essential indicators reflecting economic reasons for outsourcing. Other researchers have used similar indicators to represent economic conditions, such as the municipality's total revenue, total expenses or total debt (Geys & Sørensen, 2016; Häkkinen, 2005; Stolt & Winblad, 2009; Warner & Hebdon, 2001). The theoretical rationale for including these indicators is that, for example, if the collected tax revenue is higher, a municipality is considered to be in a stronger economic condition. However, as mentioned, these earlier studies produced mixed results, i.e., some studies found a negative relationship between outsourcing and economic conditions, while others showed a positive relationship or no relationship at all. Therefore, this study used four variables to analyse the relationship between the economic situation of the municipality and the outsourcing of public care services, and also to compare the results to those of previous studies. The variables representing the economic situation are: (1) the percentage of tax revenue; (2) the percentage of health and social care expenditure; (3) the percentage of central government grants to local government; (4) the annual contribution margin of the municipality. The annual contribution margin is measured by

calculating the difference between the revenues (e.g., taxes) and running costs of the municipality (Fredriksson et al., 2010).

2.4.1.4 Political ideology

The growth of the private care sector can also be seen as a politically driven factor. In general, political parties with right-wing ideologies are considered to be promoters of the free market, whereas left-wing parties are seen as promoters of public provision. This general claim has been supported by earlier studies (Green-Pedersen, 2002; Plantinga et al., 2011; Sundell & Lapuente, 2012), i.e., market-oriented reforms are favoured by the countries with right-wing governments, whereas left-wing governments have backed public provision. However, there is little research on the relationship between outsourcing and political ideologies in the Nordic countries, and among these few studies the results are somewhat mixed. A study from Sweden (Stolt & Winblad, 2009) and a cross-national study (Zehavi, 2012) from five countries— England, Australia, New Zealand and two Nordic countries: Norway and Sweden —showed a positive relationship, while a study from Finland did not reveal any positive or consistent relationship (Fredriksson et al., 2010).

In Finland, until the end of the 1980s, the private (for-profit) care market was considered an extreme right-wing idea, but this perception changed over time. During the early 1990s, the then ruling right-wing central government implemented many market-oriented reforms in the public sector as a strategy to tackle the financial crisis. Later, even parties belonging to the moderate left supported 'market economy' principles in their political agendas. For example, since the 1990s in Finland, the Social Democrats have undergone an ideological transformation by accepting the basic principles of the market economy (e.g., Marttila, 2016; Jutila, 2011). It has become challenging and complex to draw a distinction between right-wing and left-wing parties according to which of them favours the outsourcing of public services. For example, local politicians who are themselves local government employees show weaker political affiliations (in terms of right-wing or left-wing ideology) than their colleagues who are not employed by a municipality (Fredriksson et al., 2010). Additionally, the organisational structure and the rationality of governance may also influence the outsourcing practices of a municipality (Yliaska, 2014). Nevertheless, recent political debates concerning the strengthening of marketisation and privatisation in health and social care services have motivated the inclusion of political ideology as an explanatory variable, for comparison with previous results.

2.4.2 User choice

Choice is often considered an essential component of marketisation. In care policy debates in many European countries, 'choice' is placed at the centre of the discussion in an attempt to frame policies according to the needs and wishes of older people. Choice is viewed as 'an appealing strategy as it appears to offer the possibilities of both introducing more user empowerment and signalling political innovation and responses to criticisms of a lack of equality and indi-

vidualism' (Rostgaard, 2011, p. 5). The basic assumption is that choice empowers service users, increases users' voice and control, and improves efficiency and quality in the care delivery system (e.g., by reducing waiting times). Another important assumption is that choice empowers users to 'exit' from their care arrangements if they feel dissatisfied. Hirschman's (1970) work *Exit, Voice, and Loyalty* argued that when users experience dissatisfaction (e.g., delay or poor quality) with a particular product of an organisation, they may exercise their right to 'exit' from the firm by not buying the product or finding alternatives on the market. This leads the company's clientele and revenue to decline, which in turn induces the management to develop a new approach (e.g., improving quality) to regain market share. Choice is also seen as an opportunity for all social groups to receive similar services from a service provider, without discrimination. Overall, the idea from the policy perceptive is that choice will empower users, increase users' voice and control, promote efficiency in the care delivery system, improve service quality and bring diversity into the care setting.

In reality, the outcomes of choice models have been mixed. Previous studies have found that for some users, choice gives them more control in their care arrangements, but for others, choice brings more responsibilities (Clarke et al., 2004; Glendinning, 2008; Schmidt, 2018; Rostgaard, 2011). A Swedish study (Vamstad, 2016) found that older people failed to see the purpose of choice, and often made poor choices while using social care services. Most often, older people prefer to find an easy solution to support their care needs, rather than engage in a complex process (e.g., collecting and processing information, comparing different services and providers) for choosing care services. Meinow et al. (2011) found that the majority of older people who could benefit most by exercising 'choice' do not have the capacity to act as a consumer because of cognitive and physical limitations. It is a well-known fact that health-related problems and fragility increase as humans advance in the ageing process. So the argument of exercising 'choice' by all age groups is problematic. Even the argument in the choice models that 'exit' is an option has little effect for older people, because only a small number of users change their service providers (Szebehely, 2011, cited in Brennan et al., 2012). For older people, receiving regular and good quality care is more important than having an opportunity to exit from a caring relationship. Often, user choice would cause more inconvenience to older people because of the personal responsibility attached to the process, e.g., gathering information about services and service providers, and managing financial responsibilities, which older people often prefer to avoid. Additionally, choice might bring new risks of social exclusion or increase the risk of inequality (Glendinning, 2008). This is because people who are active, well informed and well off find it easy to navigate through the different options for care and care providers, leaving inactive and less privileged people at the mercy of others. Choice will become unattractive if older people experience frequent changes in care workers or predetermined dates and times (including short-duration visits) for daily care provision (Eichler & Pfau-Effinger, 2009). Nowadays, predeter-

mined dates and short-duration visits are a common phenomenon in almost all Nordic countries. A study conducted in Norway with different age groups reported that older people in lower economic strata tended to make adverse consumer choice decisions, even though this group generally did not fall into the category of vulnerable consumers (Berg, 2015). This result implies that choice is an unappealing strategy for this specific group.

Although choice is now at the centre of the discussion in Finland, it is not a new concept. Since the late 1980s, people have exercised choice to some extent (i.e., the opportunity to choose services from a private provider) in healthcare settings with some financial assistance from public health insurance (Aalto et al., 2018; Tynkkynen et al., 2016). The present extension of the choice model into the social care setting is limited to service vouchers, although people can also purchase services from external providers separately through out-of-pocket payments or the tax deduction.

While the Finnish government intends to bring 'choice' to service users by promoting private (for-profit) providers as an answer to the criticism of lack of diversity (due to the public monopoly), the question here is whether people use private care services out of free choice or forced choice. In this dissertation, choice is not examined on the basis of any specific model (e.g., service vouchers); rather, the dissertation looks at *how* older people choose private services. Private services can be obtained through service vouchers (only a few respondents reportedly used a service voucher in the data collected for this study, see Article II), by paying out of one's own pocket, or through economic incentives, e.g., tax deductions

Not every service is chosen on the basis of free choice. Users are often forced to choose a certain service or service provider. For example, a delay in receiving services, or a need for an urgent service, forces consumers to search for alternative resources (Dhar & Simonson, 2003). Forced choice is conceptualised here as 'when the end user of services chooses a private provider because of the inefficiency or the inaccessibility of public provisions', while free choice is conceptualised as 'operating in a situation in which an end user of service has the flexibility to select a private care service from among different options that concern quality, availability, and personal preference' (Mathew Puthenparambil & Kröger, 2016, p. 168). It is essential to discuss choice from the perspective of older people, since it is they who exercise the choice. In the next section, the utilisation of care services by older people and the factors associated with people's choices are discussed.

2.4.3 Utilisation of care services

Market-oriented welfare reforms in the care of older people have resulted in the increasing use of private care services among older people. Research conducted on the use of care among the older Finnish population has focused mainly on universalistic tax-funded public services, although private provision has emerged as a fast-growing phenomenon. So far, less attention has been paid to the actual use of private care provision among older people in Finland. This

section discusses the socio-economic and health variables that potentially either facilitate or interfere with individuals' utilisation of formal social care services.

In care research, individuals' economic situations, educational levels, age, gender, living arrangements and health are considered key indicators that determine the use of care services among older people (Blomgren et al., 2008; Evashwick et al., 1984; Kadushin, 2004; Kehusmaa et al., 2012; Kemper, 1992; Houde, 1998; McAuley et al., 2009; Redondo-Sendino et al., 2006; Roos & Mustard, 1997; Sandberg et al., 2012; Vadla et al., 2011; Wolinsky & Johnson, 1991). From an individual life course perspective, education and income determine one's employment, health, lifestyle and access to care in later life. Education is considered an important asset for a person, enabling and maximising one's potential to understand, negotiate and seek appropriate health and social care services. It has been well documented that well-educated and well-off individuals often find themselves in an advantageous position because of their ability to take preventive measures and to seek appropriate health and social care interventions. Additionally, this group is more actively involved in the decision-making and informed choice process when using care provision (Anell et al., 1997). Earlier studies on the use of formal services have often not separated private care provision from public provision. The few studies that have focused on the use of private care services (Geerlings et al., 2005; Pappa & Niakas, 2006; Rostgaard & Szebehely, 2012; Stoddart et al., 2002; Szebehely & Trydegård, 2012; Ulmanen & Szebehely, 2015) suggest that a good economic situation and a high educational level have a positive association with the use private services.

In Andersen's behavioural model of healthcare utilisation, which is a widely used model to understand the use of healthcare, individual income is considered an enabling factor, based on the argument that income facilitates a condition where one can obtain care services (Andersen, 1995). Furthermore, income enhances individuals' purchasing power and gives them control over their care arrangements. Andersen developed this model in 1960 to investigate the underlying factors associated with the use of healthcare, and he has updated the model frequently with new perspectives (Aday & Andersen, 1974; Andersen, 1995). In the model, Andersen (1995) proposes three dimensions to be examined when explanations for the use of healthcare are sought: (1) predisposing factors, which include individual sociocultural and demographic characteristics that existed before the illness (e.g., age, sex, education, occupation, family status), and which he sees as major determining factors in healthcare use; (2) enabling factors, including the resources found within the family and community that enable one to obtain care (e.g., access to services, income, a regular source of care, travel times, waiting times, the availability of healthcare personnel and facilities); (3) need factors, which include the variables that have an immediate effect on the use of health services (e.g., disease, illness, disability). Although this model studies the utilisation of care services without separating different sources (e.g., public or private) of support, from a general perspective it has helped us to understand the potential variables that determine the use of care.

In the Nordic context, all socio-economic groups in the population in principle are equally entitled to universal public care services and benefits, and should receive services without discrimination. However, studies have shown that the use of social care services is not equally accessible to all social groups (Kröger et al., 2019; Szebehely & Trydegård, 2012; Van Aerschot, 2014). Social care services in Finland are strictly targeted through the provision of services to the smaller group with higher care needs and the exclusion of the larger group with lower care needs. This excluded group with lower care needs is expected to purchase services from private providers, with or without partial public support (e.g., tax deductions), to seek support from their families, or to live without care services. People with adequate resources manage to find alternative care solutions, but those without resources often struggle to meet their own care needs. A study conducted in Sweden showed a class-related difference in the use of home care services, i.e., people in higher socio-economic strata purchased more private services from the market compared with those in lower socio-economic strata (Szebehely & Trydegård, 2012). Studies conducted in Finland have reported similar results (Enroth et al., 2018; Van Aerschot, 2014).

As part of the marketisation approach in Nordic countries, older people are entitled to benefit from tax deductions for domestic help. Often well-off people are eligible for a higher tax deduction, as their earnings-related pension is higher than the national pension. A Swedish study reported a clear income-based difference among older people: people with a higher pension income more often claimed a tax deduction to purchase a private care service as a supplementary or complementary service to public provision (Szebehely & Trydegård, 2012). It is also well documented that people with lower socio-economic status are likelier to rely on family care than on formal home care; they are also likelier to have poor health and to end up in institutional care, and they have higher mortality rates (Nihtilä & Martikainen, 2007; Szebehely & Trydegård, 2012; Tarkiainen et al., 2011).

Residential status, i.e., housing ownership, is considered an additional proxy measurement of socio-economic status, based on the argument that owning a house represents an individual's accumulated wealth (Connolly et al., 2009). Living in rented and poorly equipped housing increases the probability of admission to institutional care (Nihtilä & Martikainen, 2007), whereas homeowners are less likely to be admitted to institutional care (McCann et al., 2012). This is mainly because people who live in owner-occupied housing can allocate more money for care services than people in rented housing, as the latter pay rent, which limits their scope to seek care services.

Living alone increases the use of formal care services; at the same time, living with someone (i.e., a spouse or partner) reduces this use significantly. People who live with someone also have later admissions to residential care, since the other person often acts as a provider of informal care (Døhl et al., 2016; Hammar et al., 2008; McCann et al., 2011; Portrait et al., 2000). In Finland as well as other Nordic countries, multigenerational households are rather uncommon. Older people in these countries often prefer to live alone rather than to cohabit

with their adult children, contrary to the situation in many southern European countries (e.g., Italy, Spain). People's preference to live alone in Nordic countries is highly correlated with the publicly funded care services and benefits granted by legislation. A study reported that the proportion of older people (aged 80+) living alone is higher in the Nordic countries than in other Organisation for Economic Cooperation and Development (OECD) countries, mainly because of the home-centred public provision (Rodrigues et al., 2012). Furthermore, living alone is promoted through different policy guidelines in Finland (and is present in other European countries' guidelines too) that aim to develop a home-centred care model as an alternative to the traditional nursing home as part of the 'ageing in place' approach. However, there is a strong market-oriented approach influencing this change: for example, through service housing (which is counted as living at home), care responsibilities can be transferred from the state to the individual and the market. The 2008 and 2013 national policy frameworks 'Quality recommendation to guarantee a good quality of life and improved services for older persons', and the 2012 Act on Care Services for Older People, emphasise that older people should live at home for as long as possible, and thereafter in service housing with 24-hour assistance rather than in traditional institutional care. In 2016 in Finland, 57.7% of people aged 75 years and above lived alone (Sotkanet, n.d.).

It is a well-known fact that as humans advance in the ageing process, their health-related problems and fragility increase. However, the age at which a person's health deteriorates to the point where s/he starts to require care cannot be definitively determined because it depends on various factors, e.g., the individual's lifestyle, living conditions and social support. Generally, it is assumed that people aged 75 and above require more frequent care compared with those aged 60–74. The former group experience various health problems that require regular support, and they may find it difficult to live independently (Bravell et al., 2008), while the latter group are healthier and more often manage their day-to-day activities with minimal or no care. However, categorisations of age mainly depend on the research focus, availability of resources, locality and time.

Women are likelier than men to use care services (Blomgren et al., 2008; Kadushin, 2004; Roelands et al., 2003; Suanet et al., 2012). Women often receive less or no support from their spouses/partners, and also often outlive them, which may accelerate the use of regular care services. A study found that across Europe women often tend to live alone, while men live in a household with a partner or spouse (Rodrigues et al., 2012). When we look at gender while analysing the use of different types of formal care service, the results are mixed. Guerriere et al. (2008) and Stoddart et al. (2002) found that females' spending on private care was higher than that of their male counterparts; but at the same time, other studies have found a non-significant association between gender and privately financed care (Brega et al., 2003; Hawranik & Strain, 2001; Jenkins & Laditka, 2003). Even though most of the literature supports a positive association between female gender and the use of care services, other factors may in-

fluence the association. Living arrangements, information about services, service availability, access to public services, quality of care, the need for extra services and a lack of informal support may all influence people's use of private care services (Levesque et al., 2013; Propper, 2000; Rissanen & Sinkkonen, 2005; Tountas et al., 2005).

Health is a multidimensional concept. It is defined by the World Health Organisation as a complete state encompassing not only the physical condition of an individual but also the social, emotional and mental conditions. The deterioration of health is a natural phenomenon that happens with ageing. This cannot be stopped, but it can at least be managed to some extent with an active lifestyle and timely health and social care interventions. In Andersen's (1995) healthcare utilisation model, health is considered a need factor that has an immediate effect on the use of health services and determines whether individuals need care or not. It is clearly evident from previous literature that people in poor health are likelier to use all forms of available care resources (Blomgren et al., 2008; Evashwick et al., 1984; Kadushin, 2004; Kehusmaa et al., 2012; Houde, 1998; Redondo-Sendino et al., 2006; Roos & Mustard, 1997; Sandberg et al., 2012; Vadla et al., 2011). Self-reported health has been widely used as a measurement to predict functional limitations and mortality among older people (Burström & Fredlund, 2001; Sutton et al., 1999; DeSalvo et al., 2005), and also to assess income-related inequalities between users as well as between countries (Clarke & Ryan, 2006). A comparative study between Finland and Norway found that self-reported health was a reliable indicator to examine the use of care services (Suominen-Taipale et al., 2004). Since health is a multidimensional concept, different proxy measurements are used, such as physical disability, ADL, IADL, and the number of illnesses or chronic conditions. Døhl et al. (2016) reported that physical disability was a strong predictor of the quantity of services used by older people. A Swedish study showed that need indicators such as ADL and IADL were strong predictors of hours of home care (Meinow et al., 2005).

2.4.3.1 Choice in care for older people

The discussion above describes socio-economic and health factors and their association with the use of private care services. However, it is essential to discuss the key question of what – apart from socio-economic and health status – makes a user choose a private service. Choice can be understood as a two-stage process (Scott, 2000a). The first stage determines whether an individual needs care services or not, based primarily on the individual's health and social requirements. The second stage decides the source of support, i.e., whether to choose formal care (from public or private providers, or other resources available on the market) or informal care support. This choice is usually but not always based on the individual's socio-economic status, health status and family support, and the welfare regime (country) in which the person lives. Studies grounded on rational choice theory have argued that people often act rationally when choosing their service provider (Anell et al., 1997; Fotaki et al., 2005; Robertson & Dixon, 2009; Scott, 2000b). This is based on the argument that people act rationally by weighing costs and benefits, and that they choose the most

suitable option that brings the greatest personal satisfaction. Most often people act cautiously to gain benefits, but they do not always succeed in the process. To make a rational choice, one needs to have adequate information about the service and its availability, and cognitive skills are also required to compare the different services (Exworthy & Peckham, 2010; Kooreman & Prast, 2010; Meinow et al., 2011). People often end up in a situation where they feel unable to make the right choice (Albada & Triemstra, 2009; Schmidt, 2018; Victoor et al., 2012).

Adequate information is a necessary criterion for making a proper decision, but sometimes excessive or redundant information may constrain older people's decision-making. Older people may not always act independently, but rather depend on family members, friends or professionals to help them to make a proper choice. Therefore, choice cannot be understood simply through the rational choice framework. Eichler and Pfau-Effinger (2009) argue that choice is not determined by a single factor, but is influenced by different factors such as traditional cultural values, moral responsibilities between family members, attitudes towards the characteristics of good care, and economic independence. Additionally, information about the service, trust, and expectations about service personnel, social values and social support also play an important role (Levesque et al., 2013). As discussed earlier, the socio-economic and health status of users may have positive or negative effects on their choice-making (Burge et al., 2004; Exworthy & Peckham, 2010; Lako & Rosenau, 2009; Lent & Arend, 2004; Levesque et al., 2013; Stoddart et al., 2002; Szebehely & Trydegård, 2012; Van Aerschot, 2014). For example, people in lower economic strata tend to make more negative consumer choice decisions than people in higher economic strata (Berg, 2015). To sum up, the individual's choice-making depends on a combination of many factors, rather than on a single factor.

3 MATERIAL AND METHODS

The first set of research questions (Article I) in this dissertation explores the involvement of private providers in the organisation of care services for older people, especially in public home care services and service housing with 24-hour assistance. For this purpose, I collected secondary quantitative data from the Sotkanet Indicator Bank and Statistics Finland. Both statistical banks offer key population data for all Finnish municipalities starting from the year 1990. The study included all 311 municipalities (recorded in 2015) in Finland for the period 2001–2015. This period was considered optimal for this study, because after the year 2000 Finland witnessed a significant growth in the marketisation of care. The data was downloaded from the banks' websites and exported to statistical software (IBM SPSS version 22.0). During the export process, the data was cross-checked to ascertain that no municipalities were dropped out or mixed in with information from other municipalities. Secondary data from these banks is considered valid and reliable; several studies have been conducted using these databanks (Aaltonen et al., 2013; Anttonen & Häikiö, 2011; Kröger & Leinonen, 2012; Pulkki et al., 2015).

The other research questions (Article II and III) were answered using data from the project 'Everyday life, support and services' (in Finnish, 'Arki, apu ja palvelut'). This project was an independent pooled cross-sectional survey conducted in 2010 and 2015 in a collaboration between research teams from the University of Jyväskylä and the University of Tampere. The data was collected through a postal questionnaire survey to people aged over 74 years who were living at home or in service housing in the cities of Jyväskylä and Tampere. People residing in institutional care were excluded from the study. These two cities closely resemble each other in several ways with respect to their aged populations, home care use and numbers of private service units (see National Institute for Health and Welfare, 2013). To determine sample sizes in a population, researchers often follow the rule of thumb that a minimum sample size for a population of 100,000 is 386 respondents, using the conventional 95% level of probability in social science research (Guthrie, 2010). However, the decision regarding sample size heavily depends on various factors, such as the availability

of the sample population, and the time and money involved in the data collection. With survey methods, non-response rates and missing values are higher in surveys conducted among older people, due to memory problems or other health-related issues. Therefore, a sample of 1000 people from each city (Jyväskylä and Tampere) was selected in both survey waves to overcome some of these issues. The respondents' addresses were collected from the Jyväskylä and Tampere population registers. Staff in the population registries generated the addresses using a randomised computer-generated method in which the researchers had a limited role. Both surveys utilised a self-administered questionnaire – a common tool for data collection in survey methods — which had been prepared using Swedish and Finnish national survey questionnaires as examples (e.g., the HYPA survey; see Moisio, 2007). The same questionnaire was also used in the 2015 survey, with a few modifications. The questionnaire covered a range of topics, including socio-economic and demographic background, self-reported physical and mental health, management of everyday life, provision and receipt of support to and from others, and the use of social care services. Additionally, a new section related to housing was included in the 2015 questionnaire. The questionnaire included different question types, such as dichotomous questions, rating scale questions, Likert-type scales, and open-ended questions. The questionnaire was pretested in Tampere with 12 people in 2010, and six people in 2015 (due to a few modifications in the existing questionnaire), to check the validity and reliability of the questions. The feedback was carefully examined, and changes were made accordingly before the survey questionnaire was finalised.

The first wave of the 'Everyday life, support and services' survey was commenced in May 2010 and completed in August 2010. A total of 2000 questionnaires, along with covering letters, were posted to the addresses collected from the population register. Following this, a total of 959 respondents returned the questionnaire. Reminder letters with survey questionnaires were sent to non-respondents to increase the response rate. A total of 477 questionnaires were received from the second mailing round. Thus the total response rate from both cities increased to 71.5% (n=1436), where the response rate from Tampere was 74.1% (n=742) and from Jyväskylä was 69.5% (n=694). The second wave of the 'Everyday life, support and services' survey was conducted after a five-year gap. The survey approach was similar to the previous wave. From the initial mailing round, a total of 1166 questionnaires were received, but after reminders were sent to non-respondents, 308 additional questionnaires were added. A slightly higher response rate (73.7%; n=1474) was achieved in the 2015 survey compared with the 2010 survey. The response rate from Jyväskylä was 74.9% (n=749), and 72.4% (n=724) from Tampere.

Since the second and the third sets of questions focused mainly on service users, respondents who had reported the non-use of formal care services were excluded from the analyses. Often, the exclusion of any information from the original data set will reduce the total sample size, which can affect the inferences. However, in this study, the sample size remained sufficient to produce

meaningful and generalisable inferences, even after the exclusion of non-users of care services from the analyses. It is always worth comparing the 'excluded group' with the 'included group', to understand the variation between the two groups. A comparative analysis was performed using an independent sample t-test and a chi-squared test. The analysis revealed statistically significant results in the health-related variables, which indicated that the excluded group had very minimal health-related problems and could manage their day-to-day activities with no need for services. Therefore, the exclusion of the non-user group was considered reasonable to capture the real focus of the research.

3.1 Ethical approval

In Finland, researchers need ethical committee approval only if the study involves intervention in the physical integrity of participants, deviates from the principle of informed consent, or is otherwise sensitive, such as studies involving underage children or concerning violence (Ethical Review in Human Sciences, n.d.). Therefore no ethical committee approval was needed for this study. The data used for the first research question (Article I) was freely available for research purposes from the Sotkanet Indicator Bank and the Statistics Finland webpage. For the other research questions (Articles II and III), data was collected through a survey method using a self-reported questionnaire. Nevertheless, my study followed the 'Responsible conduct of research' guidelines governed by the Finnish Advisory Board of Research Ethics. For example, for the first article, special attention was given to integrity and accuracy when recording, evaluating and presenting secondary data. As part of the original survey method, participants were clearly informed about the research project in the covering letter, and were briefed that all information collected would be kept strictly confidential and anonymous.

3.2 Variables

3.2.1 Dependent variables

The first set of research questions (Article I) examined the extent to which municipalities involve private providers in the organisation of care services for older people, and the determining factors behind public outsourcing. For this purpose, the study focused on two crucial long-term services for older people, that is, home care visits (in Article I, the term 'home help visits' is used, but the definition is the same for both terms in this dissertation) and service housing with 24-hour assistance. 'Home care' refers to services performed in the users' homes in order to maintain users' personal hygiene and daily activities. For example, services such as bathing, dressing, toileting and sometimes home nurs-

ing (e.g., medical tasks, such as dressing wounds and performing medical tests) are considered home care. Service housing refers to the type of housing that includes accommodation and related services (e.g., personal care). In service housing, people receive services based on an individual care plan arranged with the local government. However, in this type of housing setting, users pay separately for their accommodation and also for all the services they use. Ordinary rental flats and housing without daily or regular home care services do not come under the definition of service housing.

To answer the research questions, both services were coded into dichotomous variables. For home care visits, the value 1 was given to municipalities if they reported having purchased home care services from private providers (including both for-profit and non-profit organisations), and the value 0 was allocated to municipalities that had not purchased any home care services from private providers. The same logic was applied to service housing, i.e., the value 1 was assigned to municipalities that used private services, and the value 0 to those that did not use private services. The dichotomous coding was necessary for two reasons: first, the research interest was to examine whether municipalities outsourced their services or not; second, the dependent variables were not normally distributed and contained extreme values. For example, some municipalities had outsourced fewer than 20 home care visits, while other municipalities had outsourced more than 500 visits. There are other statistical methods which can handle extreme values, but my research interest did not fit well with those methods. I therefore decided to code the dependent variables dichotomously. However, this type of coding explains only the existence of outsourcing (i.e., whether a municipality outsources or not) and not the intensity of outsourcing. To overcome this limitation, this study included some diagrams to examine the quantity and intensity of outsourcing in municipalities.

The second set of research questions (Article II) examined the extent to which older people use private care services, and how people who use private care differ from those who use public care services in the more traditional way. For this purpose, a number of social care services were listed, such as meals on wheels, shopping, cleaning, safety phones or bracelets, taking saunas or bathing, assistive devices (e.g., hearing devices), transport, home conversions, day care centres, nursing services and service housing. Based on the source of support received for the services mentioned above, the dependent variable was constructed as a nominal variable: (1) using only public services; (2) using only private services; (3) using both public and private services. The group 'using only public services' included respondents who reported having used at least one public care service from the list of services specified above; the 'using only private services' group encompassed respondents who used private services alone; the 'using both public and private services' group comprised respondents who reported having received at least one service from a public provider and at least one service from a private provider.

For the third set of research questions (Article III), the dependent variable was constructed as a nominal variable with three categories: (1) free choice; (2)

forced choice; (3) negative choice. This categorisation was based on the question 'why do you use private services?' Three possible answers – (a) private services are of better quality, (b) it takes no effort to use private services, (c) personal preference for private services – were all grouped under 'free choice'. The answers (a) services are not offered by the municipality, (b) services from the municipality are not offered fast enough, and (c) need for additional services which the municipality does not provide were clustered under 'forced choice'. The 'negative choice' category included those who answered the question 'why do you not use a private service?', thus expressing that they had chosen not to use private care services.

3.2.2 Independent variables

The independent variables that answered the question 'what municipal factors are associated with the outsourcing of publicly funded care services?' were organised under four themes – i.e., care needs of older people, population size, economic situation, and political ideology of the municipality – based on the theoretical framework discussed under 'Outsourcing of care' in subchapter 2.4.1. The dimension of care needs of older people included five proxy indicators: (1) percentage of people aged 65 and above; (2) percentage of people aged 65 and above receiving regular home care, meaning people who received care at least once a week or who had a valid care plan; (3) percentage of people aged 65 and above living in residential care, i.e., people who lived in either institutional care or service housing; (4) percentage of people aged 75 and above living alone at home or in residential settings (generally, people aged 75 and above require regular care more often than the group aged 60–74, because of the various health problems they face (Bravell et al., 2008)); (5) number of pensioners' care allowance recipients per 1000 inhabitants ('pensioners' care allowance is a tax-free benefit paid to older people who need support in daily functions to supplement extra costs due to illness or disability' basis' (Mathew Puthenparambil, 2018, p. 443). To be eligible for this allowance, an individual's ability for self-care needs to be impaired and require care on a daily. Due to skewness in the municipalities' population sizes, the data was converted into a natural log. This is because, for example, 68% of Finnish municipalities have fewer than 10,000 residents.

The economic situation dimension included four proxy variables: (1) tax revenue in euros per capita i.e., total taxes collected in the municipality from various sources such as income, profits and other taxes; (2) total health and social care expenditure of the municipality in euros per capita; (3) central grants to the municipality in euros per capita (central grants are provided to equalise the financial conditions of weaker municipalities). This variable is important because most of the municipalities in Finland have experienced a budget deficit from 2009 onwards. Adding a 'budget deficit' indicator could have provided additional strength to the analysis of economic dimension of the municipalities but, unfortunately, the author could not manage to gather that information; (4) annual contribution margin, which measures the difference between the munic-

ipality's revenues and running costs (a negative value indicates the municipality's inability to cover operational costs). All the economic situation variables were reduced to smaller units (measured in thousands of euros) to overcome the skewness in the data.

The political ideology of the municipality was measured by the strength of 'right-wing parties', calculated by counting the total percentage of municipal council members affiliated with the following five political parties: the National Coalition Party, the Christian Democrats (Finland), the Swedish People's Party of Finland, the Centre Party of Finland and the Finns Party. Even though the Centre Party of Finland does not fall right away under the 'right-wing' categorisation, the 2015–2019 government headed by Mr. Juha Sipilä from the Centre Party was clearly a right-wing government and showed a strong preference for marketization in social and health care services.

The socio-economic, demographic, health-related and informal care variables used in Articles II and III are described below.

Age, gender and city: Age was analysed as a dummy variable (75–84, and 85 or over) in Article II, but was considered a continuous variable in Article III. No theoretical reasoning lies behind these two different codings. The gender variable was categorised into a dichotomous variable (male and female). Since the 'Everyday life, support and services' survey data was collected from two cities, city was coded in Article II as a dichotomous variable (Tampere and Jyväskylä).

Living arrangement and area of residence: Living arrangements were categorised in Article II as living alone or living with someone, based on the marital status of the respondents. However, in Article III the term 'marital status' was used instead of the term 'living arrangement'. People who reported being single, widowed or divorced were grouped as living alone, while people who were married, cohabiting or in a registered relationship were grouped as living with someone. The area of residence was coded into a dichotomous variable: city centre was one group, and suburban or sparsely populated area another group.

Education and income: In Article II education was categorised into four groups (no vocational education, vocational course, vocational degree, university degree), but in Article III it was measured as a dichotomous variable (no vocational education and vocational/higher education). In Article III, the dichotomous variable was motivated by an interest to find the difference between service users who had at least a vocational education and those whose educational level was lower, and also to increase the 'n' value in the latter category. In the original data set, the household income variable was measured in 10 categories — from the first group including €0–500 monthly income, to the last group ranging from €5000 upwards. The income variable was standardised by household size to produce more meaningful results. The middle value of each income category was transformed into an individual income, and these values were then divided by the respondent's household size using the modified OECD equivalence scale (OECD, n.d.). In line with the OECD equivalence scale, the

value of 1 was allocated to the first adult in the household, and the value of 0.5 to other adults. After the standardisation of income, the income variable was grouped into quartiles with the cut-off points of €850, €1125 and €1500; this was used in Article II and Article III.

Health-related factors and informal care: In Articles II and III, self-reported health was used as a variable to measure the health status of older people, categorised as a nominal variable (good health, fair health, poor health). In Article III, the number of IADL limitations (e.g., shopping, cleaning, house maintenance, transport, managing medication) and the number of social care services used were measured as continuous variables. In Article II, informal care received was coded as a dichotomous variable, i.e., daily, weekly and monthly informal care was coded into the 'yes' category, while less frequent and no informal help were coded into the 'no' category.

3.3 Data analysis

Different methods were used to answer the research questions, such as multiple response frequency tests, cross-tabulations with chi-squared tests, bar diagrams, line diagrams, the multinomial logistic regression model and the generalised estimating equations (GEE) model.

In Article I, a logistic GEE model was applied to answer the specific question: what municipal factors are associated with the outsourcing of publicly funded care services? Since the data had been collected longitudinally for a period of 15 years from 2001 to 2015 with two-year interval gaps, GEE was considered a suitable technique to answer the research question. GEE is a population average estimation model where measurements are assumed to be nested within subjects, but measurements between subjects are assumed to be independent (Heck et al., 2013, p. 198). In longitudinal data, an underlying assumption is that measurements made of individuals are dependent and positively correlated (Von Eye & Schuster, 1998). This is because the measurements are collected repeatedly from an individual at several intervals. Additionally, it is assumed measurements are highly correlated when they are close in time, and uncorrelated when they are further apart. Therefore, a correct correlation matrix needs to be specified beforehand to generate a correct parameter estimate in the GEE model. For that purpose, within-subject correlation structures for dependent variables were performed using GEE to identify a suitable correlation matrix. The results pointed toward autoregressive correlation (AR(1)) as a suitable matrix—in the output, correlation coefficients decreased whenever the time interval between measurements increased, which indicates AR(1) (Heck et al., 2013). AR(1) assumes that the correlation decays over time. To maintain a constant inference from the analyses, robust estimates for the standard error were included in the GEE model. By doing so, a constant inference can be produced even if the working correlation matrix was selected wrongly (Heck et al., 2013). Another advantage of this model is that the results are not limited to explaining

the difference between subjects, but can also examine changes over time within subjects. The results were presented using the coefficient at the logic scale, as the interest of this study was to find the relationship between the variables and its direction, i.e., whether it was a negative or positive relationship.

In Articles II and III, the relationship between the variables was measured using a multinomial logistic regression model. This model is appropriate when the dependent variable is measured in nominal categories, as the model helps to predict the membership by comparing the categories. However, a baseline category needs to be specified before the analyses, so that the other categories can be compared with the reference category. The advantage of this model is that it does not assume linearity, normality or homoscedasticity (Hosmer & Lemeshow, 2000). However, there should not be any multicollinearity issues between independent variables. There is no test or techniques which are predefined to examine the multicollinearity issue in the categorical variables (Petrucci, 2009). A collinearity diagnostic test is one of the suitable options to test multicollinearity, where the results of the tolerance value should not be under 0.1 and the variance inflation factor (VIF) value should not be over 10 (Field, 2009). Here, in the study, independent variables were checked manually for redundancies, and later checked with a collinearity diagnostic test. The results of the multicollinearity test showed that the values (e.g., VIF<2.5) were within the acceptable range. This output confirmed that no multicollinearity issue existed between the independent variables. The data was analysed using IBM SPSS version 19 and the results were presented in odds ratios. A listwise deletion approach was used to handle the missing data in the regression model. In addition, qualitative content analysis was performed on the open-ended responses from the survey questionnaire to explore other reasons contributing to the use of private service.

Limitations: The survey data collected in 2010 and 2015 did not include older people living in institutional care. This exclusion limited the scope for examining the more fragile group who require constant care. The sample collected from the general population under-represented care service users, because the majority of the respondents were non-service users. Additionally, some users may have wrongly answered the question regarding which service providers they used. For example, older people may have reported using public services even though they were actually using private services via a tax deduction. About 12% of respondents reported significant memory problems; this may also have affected the way older people answered the question about care utilisation. Finally, the clustering of services into public and private services in order to examine the use of different care providers, and also the definitions and clustering of free choice and forced choice, must be taken into account when we examine the results, because these issue might have had some influence on the results. However, these limitations did not prevent me from answering the research questions.

4 RESULTS

This results chapter is organised as follows. First, each set of research questions based on the three scientific articles (see Appendix I) is discussed in detail in turn. Then the discussion of all three is concluded with a summary table to highlight the main results of this dissertation

4.1 Trends in the organisation of care services for older people

To answer the first set of research questions – 'to what extent do municipalities involve private providers in organising care services for older people, and what municipal factors (care needs of older people, population size, economic situation, political ideology) are associated with the outsourcing of publicly funded care services?' – I will now summarise the key findings of Article I: 'Outsourcing within the Nordic context: Care services for older people in Finland'.

The results showed that the number of municipalities using private service housing with 24-hour assistance increased from 113 municipalities in 2001 to 191 municipalities in 2015, representing a growth of 69% in 15 years. However, the number of municipalities using private home care services (68 municipalities outsourced their care in 2001) remained almost constant throughout the 15-year period, except in 2015, when 89 municipalities outsourced their home care services compared with 62 municipalities in 2014. The total number of outsourced home care visits increased steeply over the 15 years, along with the total number of people living in outsourced service housing and the number of people receiving service vouchers. In 2015, a total of 2 million home care visits were outsourced to the private sector, compared with 0.6 million in 2006, while the number of people living in service housing with 24-hour assistance increased from 6000 in 2001 to 19,000 in 2015 (Article I, Figure 2). An especially rapid growth in private home care services was seen in the period from 2013 to 2015. The results from the scatter plots (Article I, Figure 3) showed that municipalities outsourced their housing services with no population size differences.

However, the distribution pattern in home care services showed a slight difference between highly populated municipalities and smaller municipalities. Less than one 10th of municipalities outsourced more than 25% of their total home care services. Interestingly, a few municipalities, including some sparsely populated municipalities (with fewer than 10,000 residents), outsourced their entire home care services to private providers.

The GEE statistical technique was used to examine the associations between the municipal-level factors and the outsourcing of public home care services and service housing for older people. In the service housing model (Article I, Table 1), the time variable had a positive association with the outsourcing of service housing, which indicated a growing pattern in the outsourcing of public service housing over the period. However, in the other categories of municipal factors, only the factors of care need (except the share of older people and people receiving regular home care) and population size (β=2.40, $p<.001$) revealed a significant association, while in the home care services model only three variables – i.e., recipients of pensioners' care allowance (β=0.02, $p<.01$), population size (β=0.73, $p<.001$), and health and social care expenditures (β=0.06, $p<.05$) – showed positive associations. In both the home care and service housing models, the variable representing right-wing parties did not display any significant results ($p>.05$).

In a nutshell, privately produced services – both home care and service housing with 24-hour assistance – increased continuously in Finland between 2000 and 2015. However, in the case of home care services, not many municipalities were actively involved in outsourcing, although the share of services purchased from this sector nevertheless rose considerably. Increase in the share of outsourced home care was evident mostly in the bigger municipalities and nearby regions. The care needs of older people were the main influencing factor for outsourcing, particularly for service housing. The overall trends show a clear pattern of the strengthening marketisation of care in Finnish municipalities.

4.2 Use of private care services among older people

To answer the second set of research questions – 'to what extent do older people use private care services, and how do people who use private care services differ from those who use traditional public care services?' – I will now summarise the key results from Article II: 'Users of home-care services in a Nordic welfare state under marketisation: The rich, the poor and the sick'.

The findings showed that among the total respondents (n=1436), about half (n=681) reported having used some social care services. Among service users, 50% (n=338) had used only public services, 24% (n=164) had used only private services, and the remaining 26% (n=179) had used both public and private services (Article II, Table 1). The descriptive analysis provides a picture of the distribution of the data. People in the 75–84 age group used only private or only public services, whereas people in the 85 years and older category used a mix of

public and private provision. This outcome is not surprising, since the oldest age group were likelier to need regular care services than the younger age group. The respondents who used solely private services reported that they lived alone (57%) and in owner-occupied housing (87%), and had good or fair health (82%). The data was further analysed using multinomial logistic regression to predict group membership. The multivariable analysis results (Article II, Table 2) showed that those who were female, living in a city centre, in owner-occupied housing, in fair or good health, with higher education and a higher household income had higher odds of using only private services compared with only public services. The results showed a clear pattern of socio-economic difference between the users of only private services and only public services.

Furthermore, the use of different types of public and private service was examined using a bar diagram (Article II, Figure 2). Support services such as cleaning, home conversion and shopping services dominated among the services obtained from the private sector. Figure 2 below shows the utilisation of different private services, providing additional insight into whether any changes took place between 2010 and 2015. The results show similar patterns in the 2015 data and the 2010 data. The use of private cleaning services dominates in both surveys, although a slight increase (5%) is evident in home conversion (small home repair) services. Other services such as nursing and service housing also display some growth in the 2015 data. It seems that private providers have already made their presence felt in many of the social care services.

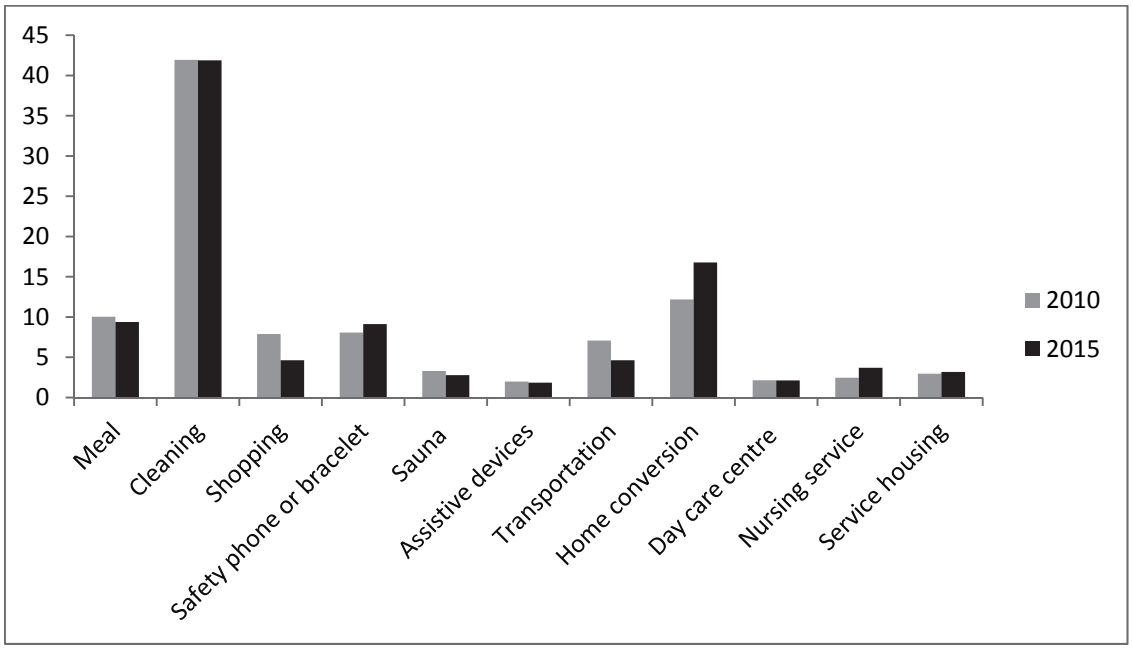

FIGURE 2 Use of different private services in 2010 and 2015 survey data (%).

In a nutshell, users of only private services had better incomes, better educations and better health, and more often lived in owner-occupied housing in urban surroundings, than other groups. Almost half of service users used private care services, indicating that the use of private services is no longer a mar-

ginal phenomenon in Finland. Instead, private services have emerged as a mainstream issue within a short period. The private sector already dominates in some areas of care services, particularly in cleaning, and home repair services for older people.

4.3 Reasons for using private care services

To answer the third set of research questions – 'why do older people choose to use private care services in the context of a Nordic welfare state where there is a tradition of universal public care provision? And is this a free or a forced choice?' – I now summarise almost all the results from Article III: 'Using private social care services in Finland: Free or forced choices for older people?'

The results showed that people used private social care services mainly because of the ease of use of private services (34.8%), the additional need for services (18.6%) and the better quality of private services (14.3%). Reasons stated for not using private services were their expensiveness (42.3%), personal preferences for public services (24.2%) and extensive support received from the public sector (22.2%). The research question was examined further by using the open-ended question 'why do you choose private services, other reason?' One of the reasons for choosing private care services that emerged from the data was the unavailability of public support. People chose private services out of necessity if they required more care to meet their needs. Personal income and a lack of information about public provision also appeared to be significant issues. It seems that publicly funded services are no longer directed towards persons with higher incomes or higher pensions. Service costs, as well as trust in the provider when one is choosing private services, also emerged strongly in the analysis. Furthermore, some respondents reported that they felt more autonomy when choosing private services. Other reasons highlighted through the open-ended question were related to reliability, place of residence, information and bureaucracy.

Out of the total population of service users (Article III, Table 1), 24.6% reported using private services out of free choice, while 17.2% reported forced choice, and 58.2% reported not having used private care services. The results from the multinomial logistic regression (not reported in Table 3 of Article III but mentioned in the text, p. 173) showed that the variables that differentiated the free choice group from the forced choice group were self-reported health and the number of services used. In other words, people who used private services through forced choice were likelier to suffer from poor health and do require additional support than people who used private services out of free choice. Furthermore, respondents who used private services through either free choice or forced choice were highly satisfied overall with the price, quality, reliability and ease of obtaining the service, and their needs were met (Article III, Figure 1). However, compared with the free choice group, the forced choice group showed some dissatisfaction in all these components, particularly price and quality.

In conclusion, the accessibility and availability of private services, additional care needs, and inadequate information on public provision were some of the main reasons reported for choosing private care services. Although the majority of users used private care out of free choice, a substantial number of users also used private services out of forced choice. The main differences in socioeconomic factors between the free choice and forced choice groups were the variables 'self-reported health' and 'number of services used': people in the forced choice group were likelier to choose private care because of their health conditions than were people who used private services out of free choice.

4.4 Summary of results

Table 1 presents a short summary of the responses to all the research questions discussed above. This gives an overview of the main findings of this study.

TABLE 1 Summary of results

Research question	Article	Main results
To what extent do municipalities involve private providers in organising care services for older people, and what municipal factors (care needs of older people, population size, economic situation, political ideology) are associated with the outsourcing of publicly funded care services?	Article I: Outsourcing within the Nordic context: Care services for older people in Finland	The number of municipalities that involve private providers in care provision has increased, particularly in service housing. The shares of outsourced home care and service housing have tripled. The use of service vouchers has also increased. Increasing care needs (demand for care) among the ageing population are the main influencing factor for outsourcing, particularly for service housing.
To what extent do older people use private care services, and how do people who use private care services differ from those who use traditional public care services?	Article II: Users of home-care services in a Nordic welfare state under marketisation: The rich, the poor and the sick	Almost half of service users use private provision. People with higher educations and incomes and good self-reported health are likelier to use solely private services. Use of private care is more usual in support services such as cleaning and shopping than in intensive care services.
Why do older people choose to use private care services in the context of a Nordic welfare state where there is a tradition of universal public care provision? And is this a free or a forced choice?	Article III: Using private social care services in Finland: Free or forced choices for older people?	People use private services because of the services' ease of use, their own additional needs for services, and the services' better quality. Other reasons include the unavailability of public services, a lack of information, and high pension incomes. The majority of users choose private services as a free choice, but a considerable number also use these services out of forced choice.

5 DISCUSSION AND CONCLUSION

Use of private care services: The first research question in this dissertation examines the extent to which municipalities involve private providers in the organisation of care services for older people in two core services: home care and service housing with 24-hour assistance. The results from Article I show an increasing trend towards the outsourcing of public care services. The share of outsourced public home care visits tripled in 15 years. Similar results are also evident in respect of service housing and service vouchers. The number of municipalities involved in outsourcing has also increased, particularly in service housing. These results indicate the effects of the increasing marketisation of the Finnish social care system. State-centred welfare production is drifting towards mixed care production, with a strong presence of for-profit organisations (Anttonen & Häikiö, 2011).

The growth in privately provided service housing needs to be analysed with some caution, because unlike other Nordic countries, in Finland for a long period municipalities relied heavily on non-profit organisations to arrange residential care services, especially service housing. Due to the over-implementation of European Union procurement legislation in Finland, non-profit organisations have had to modify either their entire organisational structure or some part of it (e.g., services for older people) in order to participate in competitions for outsourced municipal service provision. This is mainly due to the competition neutrality formula adopted by municipalities, i.e., non-profit organisations are considered on the same footing as for-profit organisations in the competition arena. The implementation of the Lotteries Act of 2001, as well as national- and regional-level reforms, has also influenced organisational changes in non-profit organisations (Karsio & Anttonen, 2013). For example, the lack of financial support to non-profit organisations has influenced several of them to undertake a market-based survival approach, at least to manage their administrative and operating costs. There are around 1300 private firms (94% of them with fewer than 10 employees) providing care services in Finland, but among these, 10 companies account for almost 30% of the total share, three of which (Attendo, Carema and Aleris) operate internationally (Meagher & Szebehely, 2013, p. 250).

As a part of the 'ageing in place' policy, service housing was introduced as a home-based model, as an alternative to traditional institutional care. As discussed earlier, it is hard to discern the differences between institutional care and service housing with 24-hour assistance. In service housing, users need to pay separately for the services they use, which includes housing rent and care service fees. The implementation of service housing has helped municipalities to save costs by rechannelling service costs directly to users themselves (Hoppania, 2015), and to the social insurance system, which covers some of the medical expenses of people who live outside institutions.

The answer to the second part of the first set of research questions – i.e., what municipal factors are associated with the outsourcing of publicly funded care services? – shows that the care needs of older people and the municipality's population size are the main influencing factors in the outsourcing of service housing. The finding regarding care needs of older people supports the claim that local governments are likelier to purchase care from external providers in order to maintain proper service coverage due to an increase in care needs (Meagher & Cortis, 2009). It is logical to think that if the demand for care increases while financial and workforce resources are becoming more limited, municipalities will utilise different strategies or methods to maintain a sufficient flow of support, usually with the backing of private providers. However, one should keep in mind that the decision to outsource is often complex, and is frequently difficult to capture by merely analysing different indicators or proxy measurements. For example, an increase in demand for care may trigger a political debate over whether or not to outsource, which may also depend on the availability of resources (e.g., workforce), political standpoints, budgetary allocation for health and social care services for older people, other municipal priorities, or the quest for best practice. Nor can lobbying by private providers be ignored. Therefore, the interplay between these variables/situations needs to be studied in detail, using other approaches (e.g., mixed methods) to shed additional light on the reasons for the outsourcing of care in Finnish municipalities. One should not forget that outsourcing practices vary from one Finnish municipality to another, and that generalising might therefore be difficult.

The answer to the first set of research questions clearly shows that the involvement of private providers in the organisation of care services for older people is no longer a marginal phenomenon, as several municipalities are actively involved in outsourcing. As a result of the marketisation of care, a mixed model with a strong presence of for-profit organisations is receiving greater impetus in Finland. Recently, a large-scale social and healthcare reform proposal (SOTE) was discussed in parliament, but it did not succeed in gaining approval. If the reform gains approval in the future, there will be no more municipal care services; instead, 18 regional centres will organise social and healthcare. The promotion of freedom of choice and the private market were at the centre of this reform proposal. In the future, regional centres will depend heavily on private providers for organising care services if the reform along

these lines becomes legislated. Therefore, it is necessary to conduct further research on this topic in the future.

A mixed model of care can bring many challenges. For instance, a survey conducted by JHL (the trade union for the public and welfare sectors) reported that some municipalities are compromising the quality of care in the outsourcing of housing services to private providers; contrariwise, another study reported no quality difference between the public and private sectors (Noro, cited in Karsio & Anttonen, 2013). The recent cases of care negligence in Esperi Care nursing homes and other private companies in Finland raise questions about the quality and reliability of outsourced care provision. Outsourcing can also reverse the power relationship between the municipality and private providers; for example, municipalities may lose the power to revoke contracts, even if the quality of private housing services is found to be poor, unless they manage to find alternative accommodation without service interruption for existing residents (Szebehely & Meagher, 2017).

When it comes to the use of private care services among older people, the findings show that almost half of service users use private provision. This result emphasises that private services are no longer utilised by just a small section of society; they have already become a major source of support for older people in Finland. This change from a marginal to a mainstream role has happened in a very short period compared with other Nordic countries. During the 1990s, the share of for-profit private provision in Finland was close to zero, but it had increased to 18% by 2014; a similar change was also evident in Sweden, although Denmark and Norway (4–6%) were less affected (Szebehely & Meagher, 2017). The reasons for using private care provision show some expected as well as unexpected results. Among the responses, the ease of use of private care services is the leading reason given for their use. This result is not surprising, because several municipalities have strictly targeted their services by focusing on older people with immediate and demanding care needs, while dropping those with less demanding care needs from their target group. Thus it has become a difficult task for older people to obtain support services such as cleaning or shopping from the public sector. In the meantime, private services can be easily purchased from the market using out-of-pocket payments or tax deductions. In this study, the majority of private service users reported using support services such as cleaning, meals, shopping and home conversion services (Article II, Figure 2). Another reason that received a high response rate was 'the need for additional services'. This too is unsurprising, because older people require additional support to complement their present care arrangements in order to maintain an active life, but here the question is why publicly provided services are inadequate or do not reach their target group. This result also suggests that municipalities have already redefined some support services as the responsibility of individuals or families. The quality of private services is ranked third, which suggests that a certain group of service users see private care as being of better quality than public services. However, research related to the quality of care in both public and private services is scarce, and the topic needs further investigation.

Other reasons found from the open-ended qualitative questions provide additional insights for this study. The most unexpected finding is that private services are considered a cheaper option by some users. Usually, user fees are set according to the individual's income, which means that people with higher incomes pay higher user fees for public support. At the same time, similar services (mainly support services) can be obtained from private providers at a fixed price, which is cheaper for this well-off group of older people than the charges they face in the public sector (Kröger & Leinonen, 2012). Lack of information emerged as another important reason. For any service user, information is key to understanding, negotiating or receiving care services. Such information includes, for example, service availability, service costs, and the quantity and quality of the service. Bent (2009) reports that a lack of adequate information brings unwanted consequences; for example, if older people do not receive adequate information regarding their eligibility to receive public support, they may end up living without care services. In our data, several service users raised concerns about the lack of information from the public sector, leading to an essential question about the relationship between municipalities and service users. Do municipalities show less interest in disseminating information to their residents, or do older people lack the interest to obtain the required information? A correct answer to this question is not available, but one has to keep in mind that older people are not always active consumers in the care market (Roberts, 2001). Therefore, further research is needed to explore the effectiveness of the communication channels used between service users and care managers. Additionally, further research is also needed to explore how older people use self-purchased private services in municipalities that have outsourced their entire social care services to private providers. Unfortunately, the survey data used for this study cannot answer this question because both Tampere and Jyväskylä municipalities produce a part of their services in-house besides outsourcing some of their services to private providers.

Forced choice for older people: Not every choice made by older people is a free choice: often users are forced into their choices. For example, delays in existing services, or a need for urgent services, can force consumers to search for alternative resources (Dhar & Simonson, 2003). A part of the third set of research questions examined whether older people chose private services out of free choice, or whether it was forced upon them. Although a majority of respondents reported having used private services out of free choice, for a considerable number of users the choice of private services had been forced on them. Key reasons for such forced choices were the unavailability of and delay in receiving public care services. The issue of forced choice cannot be ignored in the present transformation of care in Finland, because using private support services such as cleaning or shopping requires extra money. For example, a cleaning service costs around €30–€40 per hour, and a meal service costs about €6–€8 per meal, which adds up to €180–€240 per month. However, the tax deduction does not support meal services. This type of care arrangement raises concerns, especially for the people on lower incomes in the forced choice group.

If people are required to pay out of their own pocket for services even when they are covered by welfare support, eventually we will end up in a situation where income becomes an essential criterion for obtaining care. This type of requirement will widen the gap between social groups and bring inequality into the use of care services. It is time to ask whether unequal groups have already formed in the use of practical care services. Moreover, people on lower incomes may end up in a situation where their care needs are unmet. A recent study conducted in Finland by Kröger et al. (2019) showed that around 18% of older people's practical care needs are unmet, and this unmet care needs group represents lower socio-economic strata such as those who live alone, have lower incomes and are in poor health. Greater attention must be given to unmet care needs, even where the services are for practical needs. Unmet needs can quickly increase the risk of health-related problems, and can also affect the individual's financial condition (Kehusmaa et al., 2012; Sands et al., 2006).

Under the choice model, all people, including the oldest old, are considered to be active consumers. Usually, people need a set of skills to exercise their choice – for example, the skills to find and use information about the service, provider, service costs and quality of the product. When it comes to care services, older people may not be able to perform their skills as effectively as they do elsewhere (e.g., in a supermarket). Moreover, older people face limitations in exercising the 'entry and exit' formula, because care is a basic necessity which enhances one's well-being and cannot be interrupted. The main question here is how well 'freedom of choice' fits within the care context of older people – for example, how well can a person with memory problems exercise free choice? Furthermore, 'choice' is seen as answer to the criticism of lack of diversity among providers (the public monopoly), but another question arises here as to whether a new type of private monopoly is developing in a particular type of welfare service – i.e.., support services – since Finnish municipalities are limiting or no longer providing some support services. Therefore this topic needs further investigation.

The question about how people who use private care services differ from those who use traditional public care has yielded interesting results. The results clearly show that users of private care services represent some basic characteristics of the well-off group. More precisely, people with higher household incomes, better educations, good health and owner-occupied housing are likelier to use private care services. However, the users of public services show the opposite profile: they represent the lowest household incomes and low levels of education, and they live in rented housing and outside urban localities. These results are not surprising, because earlier studies (Geerlings et al., 2005; Szebehely & Trydegård, 2012) conducted in other Nordic countries have reported similar results, and have emphasised a strong positive relationship between people in higher socio-economic strata and the use of private care services. However, this result is new in the Finnish context, because minimal research has been conducted on the issue in Finland. Moreover, the well-off group benefits in a maximal way from tax deductions because of their tax level, i.e., a high-

er tax deduction is possible for higher taxpayers. Even the possibility of topping up the service vouchers scheme attracts the well-off group more than the lower socio-economic group. In the future, class-based usage patterns may affect the balance of equality which to some extent has existed hitherto in the Finnish social care model. For example, if the higher-income class prefers to use private services only, then in future the Finnish social care model may be transformed into a new system where public services support only the less wealthy – a trend which is already somewhat visible in services related to practical needs.

There are several strengths to this study. First of all, the articles included in the dissertation are among the few studies conducted in the Nordic countries that examine the use of private care services among older people. Although some of the results that have emerged from these articles might be familiar in countries with a strong private care market, the results are relatively new to Finland due to the lack of research in this area. The use of both longitudinal and cross-sectional methodological approaches gives greater strength to this dissertation. Additionally, the utilisation of the open-ended question approach (Article III) has provided further insights to examine the third research question more profoundly, and to strengthen the argumentation in this dissertation. Even though the data used in Articles II and III was collected from only two cities (Jyväskylä and Tampere), I assume that rather similar results will emerge if a similar type of study is conducted in other Finnish cities.

5.1 Final remarks

From this dissertation, I would like to highlight some key findings. Social care services for older people in Finland have clearly been affected by the marketisation approach. Private care provision is no longer a marginal phenomenon. There has been a steep and steady growth in the use of private provision for older people at the municipality level (i.e., outsourcing) as well as at the user level. It is somewhat clear from this study that the groundwork for a fuller-scale marketisation of care has been prepared. If the SOTE reform planned by the Sipilä government gains approval in the future, the existing decentralised care system will become more centralised (with 18 regional centres), and private (for-profit) providers will play a prominent role in the organisation of care for older people. Although it is still early to discuss how much such a reform might affect older people in terms of social care, one thing is certain: for-profit providers will expand their space significantly in the coming years. In the future, municipalities will probably need to register as companies if they want to provide care services to their residents. They will also need to compete with other providers, including other municipalities and private (for-profit and non-profit) providers, to win the bidding. It should not be forgotten that big multinational companies have had and always will have adequate resources at their disposal to expand their market. Additionally, the effectiveness of the public monitoring system is a question of interest, because of the recent cases of care negligence in

Esperi Care nursing homes and other private companies in Finland. Another question here is whether the public monitoring system and the self-monitoring of private providers are functioning properly. This question needs further analysis. This study, at least to an extent, may be considered a baseline to capture the marketisation of care after the implementation of the SOTE reform, if the latter should happen in the near future.

Socio-economic differences are evident in the use of formal care provision, i.e., well-off people are likelier to use private provision, while the lower-income group uses public provision. Although this difference is most evident in the use of support services, it cannot be ignored, because it may also build a foundation for the future development of other care (nursing and health) services. As discussed earlier, the tax deduction for domestic help is best suited to a particular section of society who pay higher taxes. However, for those without that privilege, i.e., people who live on a state pension, it is always a question whether their care needs are met. Paying for cleaning or shopping services (which are no longer municipal services in most municipalities) may significantly affect older people, because there is no ceiling on user fees in social care. Older people may end up spending the majority of their monthly income on home care services, or else living without adequate support. Even in the utilisation of service vouchers, older people often exceed their flat-rate service vouchers and need to pay an additional amount to maintain an uninterrupted service. The provision of service vouchers can also be interpreted so that once the service voucher has been provided to older people, the municipality's responsibility ends and the user's responsibility starts. Presently, no policy exists regarding maximum spending on social care, except in traditional institutional care, and sometimes in service housing with 24-hour assistance, where people can retain 15% of their income.

There is no doubt that choice (to an extent) promotes the empowerment of a particular population who can manage the complexity of choice-making. However, for others, choice brings more responsibilities and the pressure of making a choice. Here I considered forced choice through the limiting of public provision and the expansion of scope of private (for-profit) providers as a strategy enforced by local governments to shift some of their care responsibilities onto individuals themselves. Whatever models or strategies the government draws on when arranging care for older people, one crucial question should not be forgotten: whether all older people's care needs are being met inclusively, or whether a particular group of people is being sidelined or excluded from care provision due to their lack of resources (e.g., economic, family, community). Inclusiveness – that is, universalism – is a core value which is firmly upheld by Finnish society and should not be downgraded.

YHTEENVETO (FINNISH SUMMARY)

1990-luvun lama toi mukanaan merkittäviä muutoksia suomalaiseen hyvinvointivaltioon, etenkin hoivapalvelujen markkinoistumisen. Nykyisin arvioidaan, että yksityissektori tuottaa neljäsosan kaikista sosiaali- ja terveyspalveluista. Tämä tutkimus pyrkii osaltaan tuottamaan tietoa suomalaisen hyvinvointivaltion käynnissä olevasta kehityksestä ja täyttämään yksityisiä sosiaalipalveluja koskevaa tietoaukkoa. Tutkimuskysymykset kohdentuvat yhtäältä kuntatasolle ja toisaalta yksilötasolle. (1) Kuntatasolla tässä tutkimuksessa tutkitaan, missä määrin kunnat käyttävät yksityisiä palveluntuottajia vanhojen ihmisten hoivapalvelujen tuottamisessa ja mitkä tekijät selittävät julkisesti rahoitettujen hoivapalvelujen ulkoistamista. (2) Yksilötasolla tutkitaan, missä määrin vanhat ihmiset käyttävät yksityisiä hoivapalveluja ja missä suhteissa yksityisiä palveluja käyttävät eroavat julkisten hoivapalvelujen käyttäjistä. (3) Yksilötasolla tutkitaan lisäksi myös sitä, miksi vanhat ihmiset käyttävät yksityisiä hoivapalveluja pohjoismaisessa hyvinvointivaltiossa, jossa on vahva universaalien julkispalvelujen perinne. Onko kyse vapaasta vai pakotetusta valinnasta?

Aineistoinaan tämä tutkimus käyttää ensinnäkin Sotkanet-indikaattoripankkia ja Tilastokeskuksen kuntatietoja. Nämä tilastoaineistot kattavat Suomen kaikki 311 kuntaa ajanjaksolla 2001–2015 ja niiden avulla pyritään vastaamaan kuntatason tutkimuskysymyksiin. Yksityisten hoivapalvelujen käyttö kunnissa keskittyi kahteen palveluun: kotihoitoon ja tehostettuun palveluasumiseen. Yksilötason tutkimuskysymyksiin vastaamisessa tämä tutkimus puolestaan käyttää ”Arki, apu palvelut” -kyselyn aineistoa, joka on kerätty Jyväskylässä ja Tampereella kyselyn kahdessa toteutusvaiheessa vuosina 2010 ja 2015. Aineisto kerättiin kotona tai palveluasunnossa asuvien yli 74-vuotiaiden joukossa. Aineistoja analysoitiin eri kvantitatiivisilla menetelmillä kuten ristiintaulukoimalla, pylväs- ja viivadiagrammeilla, χ^2-testeillä, multinomiaalisella logistisella regressioanalyysillä ja GEE-menetelmällä (generalised estimating equations model).

Markkinoistuminen on vaikuttanut vanhojen ihmisten hoivapalveluihin Suomessa. Ulkoistettujen julkisesti rahoitettujen kotihoitokäyntien määrä on kolminkertaistunut 15 vuodessa. Vastaava kehitys on nähtävissä palveluasumisessa sekä myös palvelusetelien käytössä. Ulkoistamista harjoittavien kuntien määrä on sekin noussut. Hoivatarpeiden kasvu eli palvelujen kasvava kysyntä on tärkeimpiä kuntien palvelu-ulkoistuksia selittäviä tekijöitä, etenkin palveluasumisen osalta. Kunnan koko osoittautui myös merkittäväksi tekijäksi: suuret kunnat ulkoistavat palvelujaan yksityisille tuottajille pieniä kuntia tavallisemmin. Yksilötasolla kolmannes vastaajista käytti yksityisiä hoivapalveluja ja heillä oli selvästi korkeammat tulot, korkeampi koulutustaso ja parempi terveys kuin vain julkisia palveluja käyttävillä. Vanhat ihmiset käyttivät yksityisiä palveluja etenkin niiden helppouden vuoksi ja koska heidän tarvitsemiaan palveluja ei ollut saatavilla kunnalta. Vaikka suurin osa yksityisiä palveluja käyttäneistä teki niin vapaasta tahdostaan, monet vanhat ihmiset olivat valinneet yksityiset palvelut pakon edessä.

Yleensä ottaen tutkimuksen tulokset osoittavat, että yksityiset hoivapalvelut eivät ole Suomessa enää marginaalinen ilmiö. Yksityiset palvelut ovat lisääntyneet nopeasti ja jatkuvasti niin kuntien palvelu-ulkoistusten johdosta kuin vanhojen ihmisten omien palveluostojen seurauksena. Yksityisistä hoivapalveluista on siten tullut merkittävä avun ja tuen lähde monille suomalaisille ikäihmisille. On selvää, että hoivan markkinoistuminen on vaikuttanut merkittävästi Suomen sosiaalipalvelujärjestelmään.

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ORIGINAL PAPERS

I

OUTSOURCING WITHIN THE NORDIC CONTEXT: CARE SERVICES FOR OLDER PEOPLE IN FINLAND

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Outsourcing within the Nordic context: Care services for older people in Finland

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Outsourcing within the Nordic context:

Care services for older people in Finland

The early 1990s economic setback brought significant reforms favoring the outsourcing of care in Finnish municipalities. In this context, this study examines the growth in the outsourcing of service housing and home-help services in 311 municipalities from 2001 to 2015 and investigates the municipal factors associated with outsourcing using four dimensions: care needs, population size, economic situation, and political ideology of the municipality. The findings reveal a steep increase in the outsourcing of home-help and service housing. Care needs of older people is the most influential factor for outsourcing, particularly for service housing. Overall, the findings show a growing trend in private care provision in Finnish municipalities.

Keywords: Social care, outsourcing, older people, Finland, municipality.

Introduction

As in other Nordic countries, municipalities in Finland have an overall responsibility not only to organize health and social care provision for their residents but also to generate the major share of funding to support these services (Häkkinen, 2005). However, in contrast to the Nordic tradition of public provision, Finland has witnessed an accelerating growth trend in the outsourcing of care to private providers, especially for social service care for older people. Currently, the private sector is estimated to produce almost one-quarter of all health and social care services (Ministry of Social Affairs and Health, n.d). Among the Nordic countries, Finland has been an eager promoter of this care market, although Sweden has also been more affected by marketization than Norway and Denmark (Meagher & Szebehely, 2013).

During the economic recession of the early 1990s, overall municipal expenditures were downsized, especially care provision for older people that was once heavily subsidized by central grants (Kröger, 2011). During this period, a liberalist market ideology was promoted with an emphasis on how to increase the economy, efficiency and effectiveness of the social service delivery system (Anttonen & Häikiö, 2011). Since that time, marketization ideas have become a dominating trend. Marketization refers to a change in the governance and organization of publicly funded care services by introducing market rationalities and practices (Meagher & Szebehely, 2013). Outsourcing is a marketization instrument that is used to implement market-like mechanisms (Karsio & Anttonen, 2013) and is generally referred to as a process by which public agencies allocate their responsibilities for delivering care services to private organizations while retaining control over the financing, commissioning, regulation and monitoring of those services (Stolt & Winblad, 2009; Tynkkynen, 2013). The same definition applies in the Finnish context; however, in this study, outsourcing refers to the practice of municipalities employing for-profit or non-profit private

organizations through different means (e.g., open tendering or service vouchers) to deliver public care services. In Finland, municipalities decide whether to outsource care services, whereas the regional state administrative agencies (AVIs) direct, license and oversee these private providers. The central government (Ministry of Social Affairs and Health) defines the legislation and policy frameworks.

The opening of the care market was indirectly present in the Social Welfare Act 710/1982, which entitled municipalities to organize and produce their own social care services and gave them liberty to purchase services from other municipalities and from external providers using central government grants (Karsio & Anttonen, 2013). However, active promotion of such outsourcing by inducting for-profit organizations into care arrangement strengthened in the late 1990s and then accelerated from 2000 onwards. Other policies, such as the introduction of tax credits for domestic help in 2001 (which enabled a tax deduction for the purchase of private services), the voucher system introduced in 2004 (which included flat rate vouchers used to purchase private services with an option to top up from a user's own pocket), and the Public Procurement Act of 1992/2007 (which promoted fair competition between external providers) further expanded the scope of the care market in Finland (Anttonen & Häikiö, 2011; Kröger & Leinonen, 2012). Although Finnish municipalities have a long tradition of outsourcing the care of older people to non-profit organizations for both service housing and institutional care, the active role of for-profit providers became stronger only in the late 1990s (Karsio & Anttonen, 2013).

In Finland, municipalities are not obliged by law or any other policy guidance to outsource their services; therefore, the degree of outsourcing and the methods used for outsourcing followed by different municipalities can be diverse and complex (see, Karsio & Anttonen, 2013). However, limited knowledge is available regarding the actual outsourcing of public care services for older people in Finnish municipalities. In this context, this study

focuses mainly on home-help services and service housing with 24-hour assistance, because these two services are considered important aspects of older people's long-term care, especially from an 'aging in place' perspective. Additionally, these two services are the most outsourced forms of social care for older people. Home-help refers to services related to personal care and the activities of daily life performed in the users' homes. These services may include activities such as bathing, dressing, toileting and sometimes home nursing (e.g., medical tasks, such as dressing wounds and performing medical tests). Service housing refers to housing that includes accommodation and related services (e.g., personal care). Ordinary rental flats and housing without daily or regular home-help services are not included in this particular housing group. The difference between service housing and traditional institutional care is that service housing is always based on a rental relationship or owner-occupancy, where users pay separately for the services they use. The definitions of both services described above are derived from the Finnish Statistic and Indicator Bank (SOTKA-net, n.d). These two services have a clear distinction in their organization, and thus business opportunities differ. Home-help services are often provided by local companies with a small number of employees (often one) (Karsio & Anttonen, 2013), and these services are easier to organize without any substantial investment except manpower. Conversely, service housing is mostly organized by larger firms due to the involvement of property ownership, which comprises a large investment. Larger companies are also involved in home-help services but are generally clustered in larger cities.

Municipal factors and the outsourcing of care

Several studies have examined the factors associated with the outsourcing of public services, but their results vary and demonstrate both similarities and dissimilarities. Generally, the outsourcing of care is considered a local governmental strategy used to regulate economic pressure on the government, expand service coverage, increase consumer

choices and reduce administrative burdens (Green-Pedersen, 2002; Karsio & Anttonen, 2013; Stolt & Winblad, 2009; Rostgaard, 2011). In the literature, Boyne's (1998) work was notable; he examined the outsourcing of services across local governments in the United States using four broad dimensions of municipal factors (financial pressure, market structure, power of public employees and public preferences of local governments). Several studies conducted after Boyne's (1998) work have used these dimensions and others (e.g., administrative professionals, political orientation and policy diffusion) to broaden knowledge of the outsourcing process in local governments (Bel & Fageda 2017; Bhatti, Olsen, & Pedersen, 2009; Green-Pedersen, 2002; Pallesen, 2004; Petersen, Houlberg & Christensen, 2015; Stolt & Winblad, 2009). However, few studies have focused on the outsourcing of care services for older people (Petersen, Houlberg & Christensen, 2015; Stolt & Winblad, 2009), and even in these studies, the care needs of older people are missing as a factor that should be considered as a reason to outsource. Therefore, to understand the outsourcing of care services in Finnish municipalities, this study analyzed the care needs of older people as one dimension of municipal factors together with three other dimensions (population size, economic situation and political ideology).

Care needs of older people. Few studies have used the 'care needs' dimension connected to a hypothesis that a higher number of older people in a population is associated with an increased likelihood of outsourcing (Stolt & Winblad, 2009; Petersen, Houlberg & Christensen, 2015). The theoretical argument behind this hypothesis is based on the notion that a larger older population will more likely increase the demand for long-term care needs (Stolt & Winblad, 2009), which in turn puts pressure on the local government to maintain sufficient care support. As a consequence, a local government may be likely to outsource services to external providers to regulate the increasing care demands (Meagher & Cortis, 2009; Rostgaard, 2011). A single measurement, such as the quantity of the older population,

does not fully represent the care needs of older people. A more precise measurement, such as limitations in activities of daily living (e.g., eating and toileting) of older people, is preferable as a measure of need; however, due to the absence of such measurements in the available data, this study includes five proxy indicators to reflect care needs. Pensioner's care allowance is a tax-free benefit paid to older people who need support in daily functions to supplement extra costs due to illness or disability. It is only provided to a person whose ability to look after him- or herself remains impaired for one year and who needs care on a daily basis. Pensioner's care allowance is used here as a measurement based on an assumption that an increase in the number of people receiving pensioner's care allowances is most likely associated with an increased care demand. Another proxy indicator used here is the proportion of older people living alone. Several studies have reported that older individuals living alone are more likely to require care from formal or informal sources due to the lack of spousal support and growing health issues (Hammar, Rissanen & Perälä 2008). Presently, 47.2% of people aged 75 years and above in Finland live alone (SOTKA-net, n.d). An increasing percentage of people living alone most likely reflects the possibility of increasing care demands. The other two proxy variables included in the analysis to represent the increasing demand for care in municipalities are the number of people receiving regular home-help (people with a valid care plan or receiving home care at least once per week) and people living in residential care (including people living in institutional care or service housing). Therefore, the hypothesis herein is that municipalities with higher care needs for older people are more likely to contract out their social care services.

Population size. The population size of the municipality is recurrently included as an explanatory variable based on the theoretical argument that the availability of external providers is higher in larger municipalities due to their better market opportunities and because competition between providers is likely to reduce the service cost, which in turn

encourages municipalities to outsource more services (Hefetz & Warner, 2011; Petersen, Houlberg, & Christensen, 2015). These arguments are more logical in terms of the outsourcing of care; for example, in home-help services, private providers are more likely to focus their businesses in densely populated municipalities because shorter distances between users create a better market than long distances in sparsely populated municipalities (Stolt & Winblad 2009). Although population size is a debatable measurement (Boyne, 1998; Petersen, Houlberg, & Christensen, 2015), it is still used to assess the market capacity in the absence of other valid variables. The hypothesis herein is that populous municipalities are more likely to outsource care services to private providers than smaller municipalities.

Economic situation. In the literature, the economic condition of the municipality is considered an important explanatory factor. The main argument is that municipalities experiencing fiscal stress are more likely to outsource their services (Bel & Fageda, 2017; Zullo, 2009; Geys & Sørensen, 2016), because outsourcing help municipalities to save costs without increasing the municipal tax, reducing the service coverage or eliminating care provisions. The counterargument is that affluent municipalities are likely to 'experiment' with innovation by accommodating private providers, since they have adequate resources (in terms of finance and administration) to organize the complexity of outsourcing in an efficient manner (Bhatti, Olsen, & Pedersen, 2009; Pallesen, 2004). In a recent study conducted in Norway, Geys & Sørensen (2016) found that decreased municipality revenues positively correlated with outsourcing in the public sector. Other researchers have included different indicators, such as the ratio of local taxes to local income, local tax level, total expenses, annual contribution margin and total debt of the municipality, to capture a picture of the actual fiscal influence on outsourcing (Boyne, 1998; Fredriksson, Hyvärinen, Mattila, & Wass, 2010; Petersen, Houlberg, & Christensen, 2015; Stolt & Winblad, 2009; Warner & Hebdon, 2001). The annual contribution margin indicates the adequacy of the income

situation in the municipalities by measuring the difference between the revenues (e.g., taxes) and the running costs of the municipality (Fredriksson, Hyvärinen, Mattila, & Wass, 2010). However, the findings of these studies show mixed results (i.e., a negative relationship, a positive relationship, or no relationship). Therefore, to reanalyze the situation and to understand the relationship between economic factors and the outsourcing process in Finnish municipalities, this study uses four variables to represent the economic situation. First, the tax revenue (collected from taxes on income, profits and other taxes) reflects the economic sufficiency of the municipality (Geys & Sørensen, 2016). A higher tax revenue indicates a stronger economic condition of the municipality. The second indicator is health and social care expenditures; this indicator echoes the care-related fiscal stress on the municipality. The other two variables are central government grants and the annual contribution margin. Central government grants are seen as a significant factor that causes financial constraints for municipalities (Yliaska 2010, Hoppania 2015). From the late 1990s onward, central grants for municipalities were significantly downsized, which affected the overall revenues of the municipalities. However, these grants still aim to equalize the financial conditions of municipalities by supporting those in a weaker economic condition in particular to guarantee the availability of public services in all parts of the country. Thus, the amount of central grants can be used as an indicator of the economic strength of each municipality. The annual contribution margin indicator measures the difference between revenues and the running costs of the municipality; a negative value indicates that the revenues are insufficient to cover all operational costs.

Political ideology. Previous studies have noted that countries with right-wing governments introduce various market-oriented reforms in the public sector, whereas left-wing parties stand for more public provisions (Green-Pedersen, 2002; Plantinga, de Ridder & Corra, 2011; Sundell & Lapuente, 2012). This scenario was also true in Finland to some

extent during the recession in the 1990s, when the then-right-wing central government implemented many market-type reforms in the public sector. Fredriksson, Hyvärinen, Mattila and Wass (2010) noted that the significance of political ideology on policy changes in Finland was very complex; for example, local politicians who are themselves local government employees show less political affiliation (in terms of right-wing or left-wing ideology) than their colleagues who are not hired by these municipalities. Therefore, the trends and practices of outsourcing can also be shaped by the whole institutional structure and the rationality of governance (Yliaska, 2014). A cross-national study from England, Australia, New Zealand, Norway, and Sweden (Zehavi, 21012) and another study (Stolt & Winblad, 2009) from Sweden supported the existence of a strong relationship between right-wing parties and market reforms. However, a study conducted in Finland revealed no significant relationship between right-wing parties and market liberalization in the public sector (Fredriksson, Hyvärinen, Mattila, & Wass, 2010). Nevertheless, recent political debates on strengthening the role of external providers in care services in Finland has led to the inclusion of right-wing parties as an explanatory variable in our analysis to enable comparisons with findings from previous studies. Therefore, the hypothesis herein is that municipalities led by a right-wing majority government are more likely to outsource their social care services than municipalities led by a right-wing minority government.

Research Question

This study aims to understand the general trends in the growth of the outsourcing of home-help services and service housing with 24-hour assistance services in Finnish municipalities. More precisely, the research questions of the study ask how much growth has occurred in the number of municipalities involved in outsourcing and whether changes have occurred in the quantity and intensity of outsourcing. In additional, this study investigates whether and how municipal factors (care needs of older people, population size, economic

situation and political ideology) are associated with the outsourcing of these two key care services.

Methodology

Sample and Data Sources

The quantitative data for this study were obtained from the Finnish Statistic and Indicator Bank (SOTKA-net) and Statistics Finland (Tilastokeskus). These statistical banks offer key population data for all Finnish municipalities starting in 1990. The study includes all 311 municipalities (as recorded in 2015) in Finland from 2001 to 2015. The political party variable was collected from Statistics Finland, whereas the other variables were retrieved from the Finnish Statistic and Indicator Bank (SOTKA-net). Data from these banks are considered both valid and reliable; indeed, several studies have used these databanks (Anttonen & Haïkïö, 2011; Kröger & Leinonen, 2012). Ethical issues do not apply in this study, because the data are freely available for research purposes from the above databanks.

Measurement

Dependent and independent variables. Home-help services and service housing for 24-hour assistance were measured as dichotomous variables. The home-help variable was coded as "1" if the municipality purchased services from private providers (including both for-profit and non-profit providers) and "0" for municipalities not involved in outsourcing; the same procedure was applied to service housing. For the independent variables, all variables concerning the care needs of older people theme were measured in percentages except for the pensioner's care allowance, which was reported as the number of recipients per 1000 inhabitants. Additionally, all variables in the above theme belonged to the age group 65 years and above except the people living alone variable, which represented the age group of 75 years and above. The population size of the municipality was converted into a natural log

scale to reduce skewness in the data. All economic situation variables were measured in euros per capita; however, to overcome the skewness in the data, these variables were reduced into smaller units (measured in 100s of euros). The total percentages of municipal council members from five political parties (National Coalition Party (KOK), Christian Democrats in Finland (KD), Swedish People's Party in Finland (RKP), Centre Party of Finland (KESK) and the Finns Party (PS)) were counted in the 'right-wing parties' variable.

Data Analysis

This study used a simple graphical analysis (i.e., line diagrams and scatters plots) for its descriptive analyses and a generalized estimating equations (GEE) model to analyze the association between municipal factors and outsourcing using panel data. The GEE was considered a suitable technique to analyze the data due to the dependent variables, which were measured repeatedly (at 2-year intervals) within the same municipalities for a period of 15 years (2001 to 2015). The "GEE model is a population-average estimation which measurement is nested within individuals and its explanatory variables indicating the expected changes in the population for a unit change in one of the predictor variables" (Heck, Thomas, & Tabata, 2013, p. 198). An advantage of GEE models is that they allow different correlation structures to be assumed within units in the model. Measurements of longitudinal data are usually highly correlated when they are close in time and uncorrelated when the measurements are more distant. To confirm this assumption and to select a suitable correlation matrix, within-subject correlation structures for dependent variables were generated prior to the GEE analysis. The result showed a steep decrease in correlation coefficients whenever the time interval between measurements increased, which led to the conclusion that an autoregressive correlation [AR(1)] matrix was an appropriate model (Heck, Thomas, & Tabata, 2013). However, robust estimates for the standard error were included to maintain a constant inference and to rectify any issue resulting from the selection

of an incorrect working correlation structure. The GEE model is not limited to explaining differences between subjects but also examines changes over time within subjects. The data were analyzed using IBM SPSS version 22. The results were presented using beta coefficients with standard errors and 95% confidence intervals. A multiple imputation method was used to overcome the problem of missing data in the service housing variable. However, the outcome from the original data and the imputed data showed very similar results with very slight/ignorable changes in the regression coefficient.

Results

Figure 1 describes the increase in the number of municipalities outsourcing home-help services and service housing with 24-hour assistance between 2001 and 2015. In 2001, 113 municipalities (out of 311) outsourced at least some of their service housing to the private sector; however, in 2015, the count reached 191, indicating a growth of 69% over a 15-year period. The number of municipalities outsourcing home-help services remained nearly stable for the whole period except in 2015, when a fluctuation occurred. In 2015, 89 municipalities were using private home-help support.

[Please insert Figure 1 here]

Figure 2(a) shows the overall provision of home-help visits by both public entities and private providers. In 2015, 89 Finnish municipalities (out of 311) purchased approximately two million home-help visits from the private sector with an average annual growth rate of 14.5%. However, the growth of home-help visits over the last four years was enormous. A similar trend was observed in service housing in Figure 2(b); the number of people living in service housing rose from 6,000 in 2001 to 19,000 in 2015. The number of people receiving service vouchers for home-help also doubled (although the growth was slower), and public service housing also increased. Notably, users of traditional institutional

homes provided by both public and private providers decreased considerably over the last 15-year period (not reported in the results).

[Please insert Figure 2 here]

Figure 3 presents the population-based analyses to visualize the distribution of outsourcing in the different municipalities (68% of Finnish municipalities have less than 10,000 people). The proportion of private home-help visits was determined by dividing the total number of home-help visits outsourced to private providers by the total number of home-help visits provided by the municipality (including both outsourced services and in-house services). Although several municipalities outsourced part of their services, few municipalities outsourced more than 25% of their total home-help visits. Interestingly, several municipalities outsourced all of their home-help services (see Figure 3(a)). However, outsourcing was much more popular for service housing in both highly populated and smaller municipalities.

[Please insert Figure 3 here]

The associations between the municipal level factors and the outsourcing of public home-help services and service housing for older people are presented in Table 1 for two models: a crude model (unadjusted) and a full model (adjusted for all variables). The time variable in service housing in both models showed a significant positive association, thereby indicating a growing trend toward involving private providers over the time period. All the variables in the crude model except the share of older people, central government grants, annual contribution margin and right-wing parties showed a significant association with the use of private service housing. However, after adjustment for all of the variables, only the care need factors (except the share of older people and people receiving regular home-care) and the population size ($\beta = 2.40, p < .001$) revealed a significant association.

[Please insert Table 1 here]

In the crude home-help services model, the independent variables showed a mixed pattern of positive and negative associations. After adjusting for all of the variables, year variable, recipients of a pensioner's care allowance ($\beta = 0.02, p < .01$), population size ($\beta = 0.73, p < .001$) and health and social care expenditures ($\beta = 0.06, p < .05$) showed positive associations. As expected, right-wing parties (in home-help and service housing) did not display any significant result ($p > .05$). Therefore, the hypothesis regarding the connection between right-wing parties and outsourcing was not supported by this study.

Discussion

This study sought to understand the ongoing trends in the outsourcing of public home-help and service housing with 24-hour assistance services in Finnish municipalities. The results show an expected growth trend in private care services for older people. For the past decade, privately provided services have increased continuously in Finland, mainly for service housing (see Figure 1). Each year, an average of 7 additional municipalities were engaged in outsourcing their service housing. Although only a limited number of municipalities actively outsourced their home-help services, the share of services purchased from this sector increased considerably. The number of people using service vouchers for home-help also doubled over the past decade. As mentioned in the introduction, service housing and home-help services are organized differently; therefore, their patterns of growth differ. However, this study cannot provide a clear answer regarding which service has an upper hand in the care market or how the business opportunities in these services have influenced growth because the data from the study provide limited information on this topic. Therefore, this study can only confirm that both services are increasingly produced by private organizations. The overall trends show a clear pattern of an increasing market approach for care of the elderly in Finland. Like Anttonen and Haïkïö (2011), this study also concluded

that Finland is rapidly moving toward mixed welfare production and away from the historical tradition of state-centered welfare production.

The number of municipalities involving private providers and the number of people using private service housing (see Figure 2(b)) have increased significantly over the last 15 years. A glance at the history of service housing helps elucidate this trend. Private service housing traditionally was delivered in Finland mainly by non-profit organizations. However, the implementation of procurement legislation (Public Procurement Act 1505/1992, followed by the Act on Public Contracts 348/2007 based on the EU directive) urged municipalities to promote fair competition in their outsourcing procedures. Even non-profit organizations have to transform themselves into profit-making organizations to participate in the tendering practices (based on competition neutrality) of the municipalities (Karsio & Anttonen, 2013). This factor is not the only reason for the conversion of non-profit organizations, because the implementation of Lotteries Act 2001 (pushing Finland's Slot Machine Association—a non-profit gambling company—to discontinue its financial support of service housing provisions to non-profit organizations) and changes in national and local reforms have also been involved (Karsio & Anttonen, 2013). The policy goal behind the implementation of service housing is to minimize traditional public institutional care by promoting a home-based care model (Anttonen & Karsio, 2016); additionally, a strong market-oriented ideology underlies this transition (Karsio & Anttonen, 2013). Officially, people living in service housing are considered to be living in their own homes, and these residents pay separately for all services they use. This type of care arrangement helps municipalities save care expenses by shifting costs to the users themselves (Hoppania, 2015) and to the publicly funded social insurance system (e.g., to cover the cost of medicines). Finnish municipalities have often found service housing to be a cheaper option than traditional institutional care, because its users pay significantly higher fees (Hoppania, 2015). This fact may explain why the numbers of people

living in traditional institutional homes provided by both public and private providers have decreased considerably over the last 15 years (not reported in the results). Almost all social care services in Finland are subject to a moderate fee, which is relatively higher than the fees in other Nordic countries (Karsio & Anttonen, 2013). However, no comparable data are available to analyze the impact of user fees, since each municipality has its own user fee policy. Furthermore, no separate data are available to differentiate non-profit from for-profit organizations in this respect, and therefore, the findings should be interpreted with caution.

In terms of the research question on the municipal factors and their associations with the outsourcing of home-help and service housing, the results show similar patterns between these two services. The care need factors examined herein, such as recipients of pensioner's care allowances, people living alone and people living in residential care, were positively associated with the outsourcing of service housing. This finding is in line with the claim that increasing care needs are more likely to create pressure on local governments to purchase care from external providers in order to maintain proper service coverage (Meagher & Cortis, 2009). Increasing demand for care in a municipality can become a flourishing market for private providers. This situation results in a stronger mixed care model than the traditional state-centered care model, in which public agencies are solely responsible for producing and providing services. Unsurprisingly, a positive association exists between populous municipalities and the outsourcing of care. Larger municipalities most likely find outsourced services much cheaper due to competition between providers (Hefetz & Warner, 2011; Petersen, Houlberg & Christensen, 2015). Moreover, and this point is especially relent with respect to service housing, they do not need to invest in building their own infrastructures.

This study is not completely in line with other studies that have recognized the economic pressure on the municipality as a strong indicator of greater outsourcing (Bel & Fageda, 2017; Bhatti, Olsen, & Pedersen, 2009). Only the health and social expenditure

variable showed a positive relationship with the outsourcing of home-help services. Therefore, the overall "fiscal stress" assumption cannot be verified from this outcome, because other economic variables, especially the annual contribution margin, show non-significant results. Furthermore, the above outcome can be given weight only if the cost-saving approach to reduce care-related fiscal stress is the core intention of the local government (Boyne, 1998; Green-Pedersen, 2002; Hefetz & Warner, 2011). The local government's decision to outsource is often argued to not be based purely on fiscal stress or any one factor but instead is grounded on a broader capacity of the institutional structure (i.e., the financial capacity, administrative ability and rationality of governance), rising care demands and the influence of neighboring municipalities (Bhatti, Olsen, & Pedersen, 2009; Stolt & Winblad, 2009; Yliaska, 2014). Some researchers have even claimed that outsourcing is the 'politics of good times' (Bhatti, Olsen, & Pedersen, 2009; Bel & Fageda, 2017). Therefore, this study assumes that the positive outcome of the health and social expenditure variable may be because of increasing care demand in the municipality or the rationality of governance (Stolt & Winblad, 2009; Yliaska, 2014). Overall, the findings of this study are rather mixed. The need factors are closely associated with the outsourcing of service housing, whereas the outsourcing of home-help services shows a combination effect of population size, pensioner's care allowance and health and social care expenditures. In line with previous studies (Fredriksson, Hyvärinen, Mattila, & Wass, 2010), this study did not find any significant association between right-wing parties and the outsourcing of care for older people.

Another interesting outcome was that several of the Finnish municipalities (see Figure 3) outsourced all of their service housing and home-help services. There is no clear explanation why this shift has occurred. Tynkkynen (2013) reported that this move was a countermeasure against the aggregation of municipalities and was also due to unsuccessful

cooperation between neighboring municipalities in organizing care services. The findings from this study support the care needs of older people as a main factor for outsourcing; the popularity of market-oriented ideology in municipal governance and/or the influence of neighboring municipalities (Stolt & Winblad, 2009) may be other reasons. However, this assumption cannot be studied using a quantitative method and instead requires a qualitative approach.

The outsourcing of care services to the (for-profit) private sector is a more recent phenomenon in Finland than in many other post-industrial countries, but a rapidly growing trend can be observed at present. Currently, the traditional Finnish social care model (state-centered care production) as a whole is slowly transforming and moving into a new phase (a mixed model with a strong presence of for-profit production) due to the influence of marketization. A mixed care model may bring challenges to the care system. For example, a report from the Finnish trade union for the public and welfare sectors (JHL, n.d) confirmed that some municipalities were compromising quality measures by outsourcing their services to the lowest bidder. Therefore, the effects of this model need to be studied thoroughly in the future. The growth in private service housing and the absorption of small-scale enterprises by large national and international companies raises some concerns about the direction in which the service housing market is progressing (Karsio & Anttonen, 2013). No empirical data or evidence are available concerning the implications of outsourcing in home care services in terms of costs and quality; this topic has been untouched and needs to be studied further. The overall trend shows that municipalities are keen to downscale care costs and transfer financial responsibilities to the service users themselves (Hoppania, 2015). Presently, a large-scale structural reform of social and health care (the so-called SOTE reform) has been initiated in Finland, but this reform will not be implemented until 2020. Through this reform, municipal responsibility for organizing care support will be transferred to a larger regional authority.

This reform relies heavily on the "freedom of choice" concept and the promotion of greater participation by the private sector. Thus, the public care sector will likely rely heavily on private providers to produce care services in the near future while the public sector handles the roles of administrator, financier and regulator. Therefore, further research on this topic is needed to explicate the ongoing trend and its implications for the care of older people.

Limitations

Like all scientific research, this study had its weaknesses. The construction of the dependent variable could have influenced the results, because the municipalities were coded as using outsourcing even when only a few users (e.g., less than 10 users) received outsourced services. The outcome of the care needs variables should be observed with some caution, because these variables do not represent a precise measurement of care needs but instead serve as proxy indicators. Additionally, due to the decentralized service organization structure, different local authorities may use different need assessment thresholds while arranging services for older people, which may not be fully captured through these care need variables. These data do not contain separate information on non-profit and for-profit organizations, because the two organization types are merged in the statistical bank. This study also did not analyze the transaction/unit costs of private production due to the unavailability of accurate data. Despite these limitations, this study has several strengths. This study contributes to knowledge on the changing character of the Nordic welfare model. The results show a developing trend in the outsourcing of care in a Nordic welfare state and examine the relationship between municipal level factors and the outsourcing of care through a longitudinal approach, which is an uncommon focus in previous research.

Conclusion

In summary, the outsourcing of home-help and service housing for older people is increasing steadily in Finland. Although the outsourcing of home-help services is more

common in highly populated municipalities, it is also spreading to more sparsely populated municipalities. However, the outsourcing of service housing is scattered across municipalities without any clear discernible pattern. The care needs of older people are the main influencing factor for outsourcing, particularly for service housing. The present economic austerity, coupled with the increasing demand for care for older people, raises intriguing and necessary questions about whether the current outsourcing of public services will remain the same, increase further or even expand rapidly in the future.

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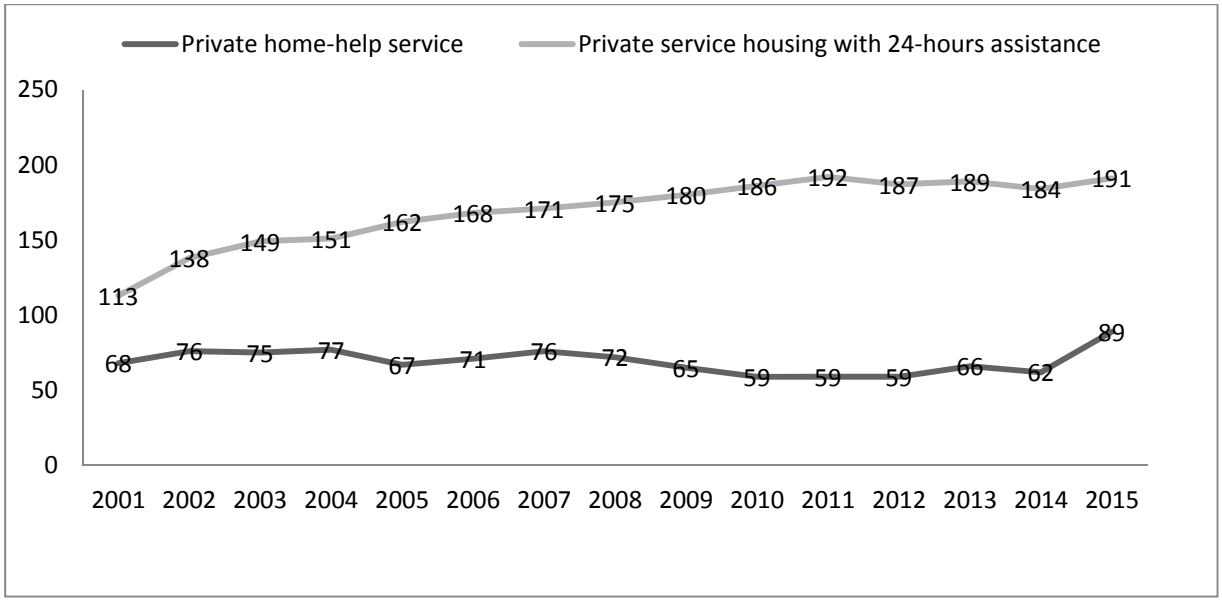

Figure 1. Number of municipalities outsourcing home-help services and service housing with 24-hour assistance (2001-2015)

Figure 2(a). Total number of home-help visits (in millions)

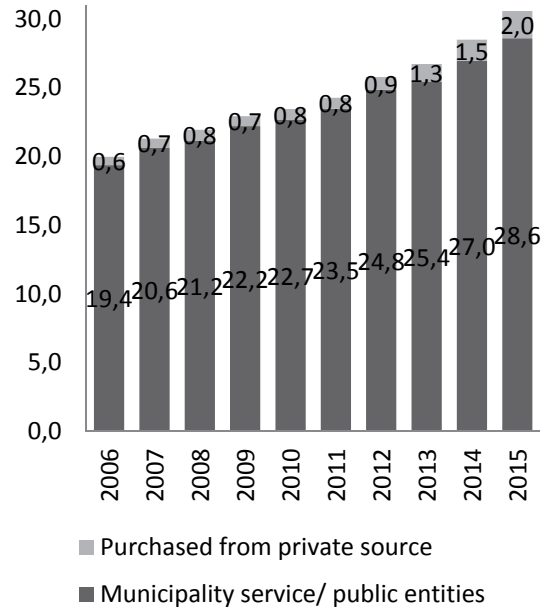

Figure 2(b). Total number of people receiving service (in 1000s)

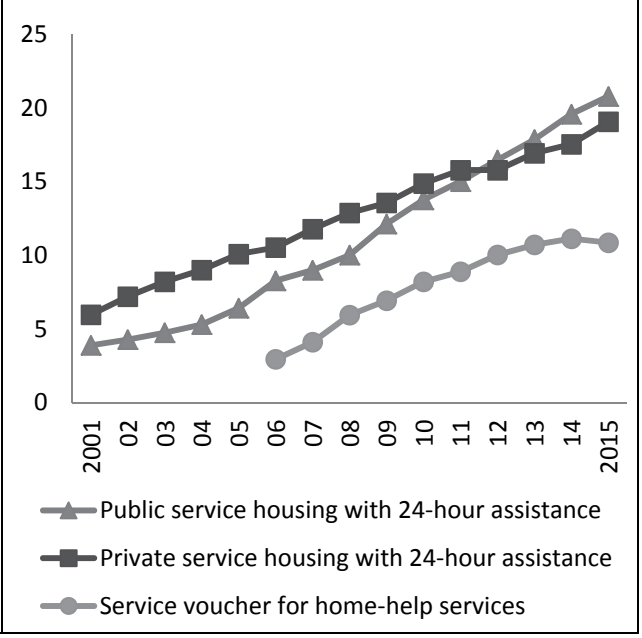

Figure 2. Total number of home-help visits and total number of people receiving service housing with 24-hour assistance and service voucher in Finland (2001-2015).

Figure 3(a). Percentage of outsourced home-help visits

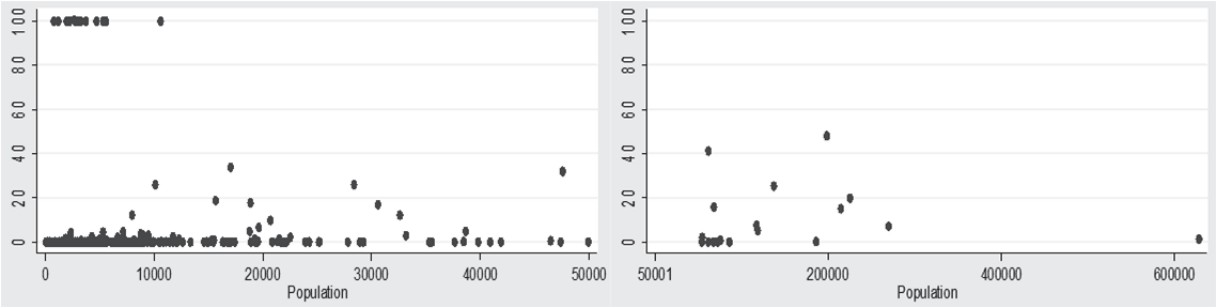

Figure 3(b). Percentage of people living in outsourced service housing with 24-hour assistance

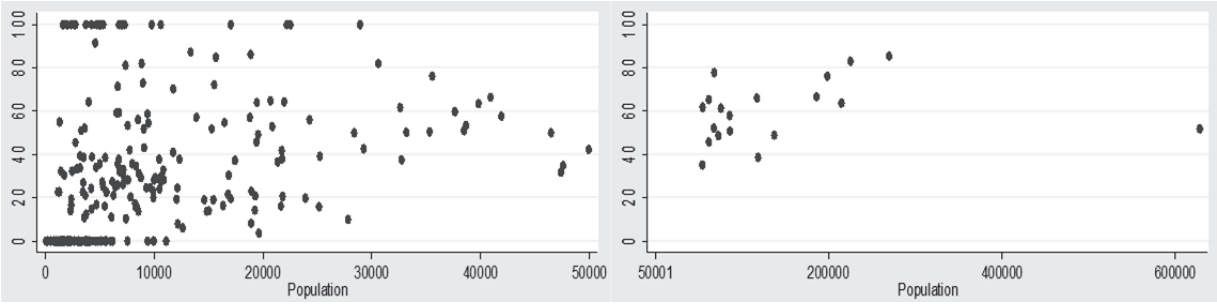

Figure 3. Proportion of outsourced home-help visits and service housing with 24-hour assistance in municipalities with different population size (in 2015)

Table 1. Municipal factors associated with outsourcing of service housing with 24-hours assistance and home-help services (Longitudinal data using generalized estimating equations for binary outcome, 2001–2015 (2-year intervals), N=2488.

Variables	Range	Outsourced service housing with 24-hours assistance †		Outsourced home-help services†	
		Crude Model	Full Model	Crude Model	Full Model
		β (SE)	*β (SE)*	*β (SE)*	*β (SE)*
Year dummies (Ref: 2001)					
2015	-	1.15(0.14)***	2.04(0.54)***	0.38(0.17)*	-0.30(0.49)
2013	-	1.00(0.13)***	1.85(0.49)***	-0.04(0.17)	-0.96(0.45)*
2011	-	1.21(0.14)***	1.91(0.46)***	-0.18(0.18)	-0.97(0.38)*
2009	-	0.92(0.12)***	1.66(0.33)***	-0.06(0.17)	-0.65(0.32)*
2007	-	0.82(0.13)***	1.29(0.29)***	0.14(0.15)	-0.25(0.21)
2005	-	0.55(0.11)***	0.81(0.26)**	-0.02(0.12)	-0.27(0.16)
2003	-	0.37(0.10)**	0.77(0.23)**	0.13(0.10)	-0.01(0.12)
Population size (ln)	4.6-13.4	1.68(0.12)***	2.40(0.22)***	0.67(0.84)***	0.73(0.12)***
Care needs of older people (%)					
People aged 65 years and above	6.7-41.6	-0.01(0.01)	0.05(0.03)	-0.03(0.01)	-0.03(0.03)
People receiving regular home-care aged 65 years and above	0.3-25.7	-0.03(0.01)*	-0.02(0.03)	-0.06(0.02)**	-0.04(0.03)
People living in residential care aged 65 years and above	0-14.8	0.11(0.04)*	0.24(0.05)***	-0.04(0.02)	-0.03(0.04)
People living alone aged 75 years and above	27.5-62.9	0.04(0.01)**	0.05(0.02)*	0.02(0.01)*	-0.02(0.02)
Pensioner's care allowance recipients ‡	0-108	0.01(0.00)**	0.05(0.01)***	-0.00(0.00)	0.02(0.01)*
Economic situation (€/capita) in 100s					
Tax revenue	13.6-63.2	0.08(0.01)***	0.03(0.03)	0.04(0.01)***	-0.02(0.03)
Health and social care expenditure	1.8-57.7	0.03(0.01)***	-0.04(0.02)	0.01(0.01)	0.06(0.02)**
Central grants	0-53.7	-0.01(0.01)	-0.05(0.03)	-0.02(0.01)*	-0.02(0.02)
Annual contribution margin	-13.1-31.2	0.00(0.12)	-0.03(0.04)	0.21(0.13)	0.03(0.03)
Political ideology					
Percentage of right-wing parties	0-100	0.00(0.00)	0.01(0.01)	0.00(0.00)	0.00(0.00)

Note: *p< .05. ** p<.01. *** p< .001; β = regression coefficient; *SE* = standard error; † Reference category = municipality not using outsourcing. Crude Model = unadjusted model; Full Model = adjusted for all variables; ‡= number of pensioner's care allowance recipients in 1000 inhabitants

II

USERS OF HOME-CARE SERVICES IN A NORDIC WELFARE STATE UNDER MARKETISATION: THE RICH, THE POOR AND THE SICK

by

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Users of Care Services in a Nordic Welfare State under Marketisation:

The Rich, the Poor and the Sick

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Conflict of interest

There are no conflicts of interest to report.

Users of Home Care Services in a Nordic Welfare State under Marketisation: The Rich, the Poor and the Sick

Abstract

Stricter access to public services, outsourcing of municipal services and increasing allocation of public funding for the purchase of private services have resulted in a marketisation wave in Finland. In this context of a Nordic welfare state undergoing marketisation, this paper aims to examine the use of Finnish care services among older people and find out who are using these new kinds of private services. How wide is their use and do the users of private care services differ from those who are using public services? How usual is it to mix both public and private care services? The questionnaire survey dataset used here was gathered in 2010 among the population aged 75 and over in the cities of Jyväskylä and Tampere (N=1436). The methods of analysis used include cross-tabulation, Chi-square tests and multinomial logistic regression. The findings showed that among those respondents who used care services (n=681), 50% used only public services, 24% utilised solely private services, and the remaining 26% used both kinds of services. Users of solely private services had significantly higher income and education as well as better health than those using public services only. The users of public services had the lowest education and income levels and usually lived in rented housing. The third group, those mixing both public and private services, reported poorer health than others. The results increase concerns about a development towards a two-tier service system, jeopardizing universalistic Nordic principles, and also suggest that older people with the highest needs do not receive adequate services without complementing their public provisions with private services.

Keywords: Older people, care services, private services, public services, service use, Finland.

What is known about this topic

- Finland is a Nordic welfare state where citizens are by the constitution entitled to have equal access to care services.
- However, recently Finland has undergone marketisation reforms and seen the emergence of for-profit providers in care for older people.
- Access to public care has become more difficult and the use of private services has grown rapidly.

What this paper adds

- Half of all older users of care services in Finland use nowadays private services, a quarter mixing them with public provisions.
- Those using only public services have lowest income while those using solely private services have highest income and best health.
- Those mixing private with public services have poorest health, which raises questions about effectiveness and quality of public services.

Introduction

Like practically every other nation, Finland is facing the challenge of an older population that is growing fast. It has been projected that the population aged 65 and over will rise from 18 per cent in 2010 to 26 per cent by 2030, and to 28 per cent by 2060 (Official Statistics of Finland 2012). At the same time, it is estimated that the 75+ age group will be 14 per cent in 2030 (Räty et al. 2003), growing quickly from eight per cent in 2009 (National Institute for Health and Welfare 2010). With ageing, needs for care increase and these needs have to be met either by informal support (family/friends/relatives) or formal support (public/private/third sector). In Finland, public social care services (integrated home help and home nursing, support services and residential care services) are mostly funded with municipal tax revenues, supported by grants from central government as well as fees paid by the service users. These services have traditionally been offered by municipalities to all older people, complemented with some non-profit provisions. However, since the early 1990s, Finland has witnessed significant changes in its care services.

First of all, the overall coverage in home care services has been dramatically reduced by 40 percent from the level at the beginning of the 1990s (Anttonen & Häikiö 2011, Kröger & Leinonen, 2012). A coverage drop is also evident in several kinds of institutional care provisions: residential homes and long-term care at health care centres as well as in sheltered housing (National Institute for Health and Welfare 2013). At the same time, service home provision with 24-hour assistance has increased its coverage but this increase has not filled the gap left by reducing coverage of other care services. Second, there has been substantial and fast growth in the use of private care services. Until the mid-1990s, for-profit provisions were practically unknown in Finland but since then commercial organizations have rapidly expanded their private home care services and sheltered housing service provisions (Yeandle et al. 2012, Karsio & Anttonen 2013, Van Aerschot 2014). The introduction of policies such

as outsourcing of public services in the municipality, tax credits for domestic help (deducting taxes by max 2000 euro per person per annum as a result from purchasing household service from the private sector) and tax-funded service voucher (an income-related or a flat rate voucher to purchase private services) have steered older people towards private services, particularly in home care support (see, Karsio & Anttonen 2013, Van Aerschot 2014).

Earlier public care services, having modest income-related user fees, were almost the only kind of provision but they were received by a large proportion of older people. Recently, municipalities have narrowed down their care provisions to organize services only for people with highest needs (Kröger & Leinonen 2012). As a result, users with less frequent and less intensive needs are required to purchase private services, either fully out-of-pocket or by utilizing the tax credit or service vouchers. The use of service vouchers is still rather rare but tax credits are used widely. A large part of users nevertheless pay their private services fully out-of-pocket (see, Anttonen & Häikiö 2011). Until 2000, there was no clear statistical report on the extent of care for older people that were produced privately. In 2002, it was estimated that the private sector produced a share of 16 % in health and social care services (Salonen & Haverinen 2004). The number of private social service units (one way of measuring private service) increased from 3,018 in 2002 to 4,350 in 2010 (Karsio & Anttonen 2013). Presently, this sector is estimated to produce almost a quarter of both health and social care services (Ministry of Social Affairs and Health 2013). The above evidence gives a clear indication that the long-term care of the Finnish welfare state has experienced a major wave of marketization and privatization.

In Finland, research on care for older people has so far focused mostly on public services, which is explained by the universalistic tax-funded public sector model that was earlier prevalent in the country. Less attention has been paid to private care services, though they represent an emerging and fast-growing phenomenon. The development towards self-

financed private services and a mixed public-private model has not yet fully influenced the focus of research. There is still very little knowledge on who are using these new private care services and why. Also internationally, earlier studies on the use of formal services have often not distinguished private from public services. These studies have observed that age, gender, economic situation, education level, health status, functional disability and living pattern can have a significant impact on the use of services (Evashwick et al. 1984, Wolinsky & Johnson 1991, Kemper 1992, Roos & Mustard 1997, Houde 1998, Kadushin 2004, Redondo-Sendino et al. 2006, Blomgren et al. 2008, McAuley et al. 2009, Vadla et al. 2011, Kehusmaa et al. 2012, Sandberg et al. 2012).

However, those few studies that have focused on private care services suggest that it is especially the economic situation, education level and health status that are determining factors for using private services (Stoddart et al. 2002, Geerlings et al. 2005, Pappa & Niakas 2006, Szebehely et al. 2012). Beside this, knowledge about service availability, limited access to public service, quality of care and need for extra services might influence people to choose private services (Propper 2000, Rissanen & Sinkkonen 2005, Tountas 2005). However, only very few studies have been conducted to discover the characteristics of private service use in any Nordic country. Moreover, there is a knowledge gap concerning those users who mix public and private services. Therefore, in this article we aim to analyse how older people are acting in this emerging world of privatization: who is using for-profit care services, who is mixing them with public services and how do these two groups differ from those who more traditionally use solely public care services? We also ask: what are the factors most closely associated with the above-mentioned three different categories of service use among older people? By answering these questions, we hope to identify current trends in care systems in Finland and thus to add to the existing knowledge on the ongoing development of Nordic welfare states.

Methods

This study analyses data from the "Care, help and everyday life" (in Finnish: "Arki, apu ja palvelut") project, a joint survey research project between the Universities of Jyväskylä and Tampere in Finland. The study was designed to collect information about the population aged 75 and over living at home (including senior housing) in two cities (Tampere and Jyväskylä). These cities were chosen because they closely resemble each other in many ways, their aged population, home care consumption, and private service units (see, National Institute for Health and Welfare 2013); and also to draw a comparison between the two cities. A sample of 1000 people per city was considered to be a reasonable one as often a sample of that size is large enough to have sufficient power to detect small effects. An initial draft of survey questionnaire was prepared using Swedish and Finnish national survey questionnaires as examples (e.g. HYPA-Welfare and Service, 2006). The questionnaire was pretested with 12 people in Tampere. Based on the feedback received from the pretest the questionnaire was modified and finalised. In the beginning of May 2010, the survey questionnaires and consent letters were sent to 1000 participants in each city using addresses collected from the population registry (Central Finland magistrate and Tampere magistrate). The population registry collected these addresses through a randomised computer-generated method (which was independent of the authors). Three weeks later, reminders were posted to those who had not returned the questionnaire. The overall response rate was 71.5 percent (n=1436), which included a response rate of 69.5 per cent from Jyväskylä and 74.1 per cent from Tampere. The whole process of data collection was carried out between May and August 2010. Two-thirds of the respondents were women and one-third were men, which equals the actual gender distribution of people over 75 years in the two cities. Most of the questionnaires were completed by the respondent themselves (74%); the rest with the help of friends or relatives (21%) or with other assistance (5%).

Figure 1 around here

The dependent variable was assessed by the question "Where do you receive or obtain the services you use?". This question listed the following services: meals-on-wheels, shopping, cleaning, safety phone or bracelet, sauna or bathing, assistive devices (technical aids e.g. hearing devices), transportation, home conversion, day care centre, nursing service, short-term institutional care and service housing. Answers for each service were coded as a nominal variable as follows: (1) I use municipal service, (2) I have received a voucher that I use to get a private service that is supported by the municipality, (3) I use a service provided by a private company or a voluntary association, (4) I do not know who provides the service that I use. For this study, the dependent variable was constructed using all the service variables listed above. This was done because all these services are considered as parts of Finnish social care provisions and also due to the rather small sample representation in most of the individual variables. The answers for all services were computed and recoded into a new variable of three categories: (1) using only public services, (2) using only private services, (3) using both public and private services. The group who used only public services included those respondents who reported using at least one municipal service but no private service. Accordingly, those respondents who reported using at least one private service but no municipal service were categorized into the group who used only private services. Finally, those who reported using at least one kind of municipal as well as at least one kind of private service were grouped into those who used both kinds of services. The respondents who reported either "I have received a voucher that I use to get a private service that is supported by the municipality" (n=49) or "I do not know who provides the service that I use" (n=57) were excluded from the grouping because of the specific inclusion criteria (i.e. only public,

only private and both services) defined for this study. Furthermore, the respondents in these two groups might not be exclusionary because these respondents might have also answered in the newly constructed dependent variable. After conducting a cross tabulation separately between the dependent variable and these two groups, only 15 respondents were found to be completely excluded; they all belonged to the "I do not know" category.

The aim of this study was to describe the use of different care services; therefore, by design, the analysis only includes the service users and excludes the missing data (hypothesized as non-service users) (n=740) and those who replied "I do not know who provides the service" (n=15) using a listwise deletion approach (Field 2009). Even after all exclusions, we gained almost an equal representation from the two municipalities (Table 1). The average age of the included participants was 83.5 years (range 76-101) and the great majority of them were female (Table 1). Ethical approval was not required because of the minimal participant risk in this project. However, this project followed all ethical guidelines governed by the National Advisory Board of Research Ethics (Ethical review in Human Sciences, 2009). For example, every respondent signed a consent form and was advised that they could leave the study at any time.

The independent variables included age, gender, city, education, monthly household income, living arrangement, area of residence, housing tenure, received informal care and self-reported health status. Age was categorized into two groups (75-84, 85 and above) because earlier studies have showed that the 85+ group consumes home care twice as much as those 75-84 (Anttonen & Häikiö 2011). Living arrangement was coded dichotomously as 'living alone' or 'living with someone'. Informal care received daily, weekly and monthly was coded into 'yes' category and less frequently and no informal help into 'no' category. Area of residence (city/ town, sub-urban/sparsely populated area), self-reported health (very good/good, fair, poor/very poor) were both coded, with three categories. Education was

measured by four levels (no vocational education, vocational course, vocational degree and university degree). The household income variable was measured in 10 categories. To standardize income for household size, the middle value of the each income category was transformed into individual's income and these values were then divided with the respondents' household size using modified OECD equivalence scale. This scale gave the value of 1 to the first adult in the household, the value of 0.5 to other adults, and the value 0.3 to children aged under 13. Equalized income was coded into quartiles with the cut-of points of 850, 1125 and 1500 euros.

The data was analysed using cross tabulations with χ^2 test (Table 1) and a multinomial logistic regression model (Table 2) at a significance level of $p < 0.05$. This multinomial modelling does not assume linearity, normality and homoscedasticity but needs to satisfy the assumption of multicollinearity (Hosmer & Lemeshow 2000). Therefore, redundant independent variables were checked manually and later, a collinearity diagnostic test was conducted using a tolerance values < 0.1 and VIF value > 10 as an indicator to assess the collinearity problem (Field 2009). The result shows no sign of multicollinearity between two or more independent variables. The results of the model are presented as odds ratios (OR) with their 95% confidence intervals. Respondents with missing data were excluded from the regression analysis. All analyses were performed with the statistical software IBM SPSS version 19.

Results

Comparison between three groups

Of the 1436 respondents who returned the questionnaire (see Table 1), 681 respondents reported using some sort of social care service. Among the service users, 50 percent (n=338)

used only public services while 24 percent (n=164) used only private services. The remaining 26 percent (n=179) used both public and private services. Users of solely private and solely public services were concentrated in the 75-84 age groups, while mixing public and private provisions was more usual among the 85+ population. Among those who used only private services, almost one quarter (22%) of the respondents had a university degree while this was much rarer in the two other groups ($p < 0.001$)

Table 1 around here

Solely private services were most often used by older people with the highest household incomes and higher education; however a reverse situation was observed in the only public service group. The respondents who mixed both public and private services probably lived alone (71%), in owner occupied-housing (65%) and reported their health as poor or rather poor (52%). No statistically significant association ($p > 0.05$) was observed in the cities, informal care and gender variables in terms of service use. Furthermore, to make explicit the demographic difference between the municipalities, a descriptive statistical analysis was conducted using a chi-square test (not listed), with all variables recorded in table 1. The result showed a non-significant statistical difference between the municipalities except for one variable, 'living arrangement' ($p = 0.050$).

Figure 2 around here

Figure 2 illustrates the variation in the use of public and private services among respondents when different kinds of services are observed. Support services, particularly cleaning, home conversion services and shopping services, stand out as those where private service use

already dominates while most other services are still overwhelmingly provided by municipalities. It is nevertheless noteworthy that private providers have entered practically every area of care services and in several there is already a substantial minority who use private service provisions.

Factors related to three different categories of service use

Table 2 around here

The effect of socio economic and health variables on the use of only private and both public and private social care services, using 'only public services' as the reference category is shown in multinomial regression analysis (Table 2). From the univariate analysis, it can be seen that people of lower age i.e. 75-84 years old, living in a city centre, in owner-occupied housing, with good health, with higher education and higher household income have higher odds of using only private services. For the group using both public and private services, the findings were relatively similar to those of the group using only private services concerning the education level and household income; however, in other respects this group differed from the first-mentioned one. After adjusting for all variables except city (see Table 2), most of the associations remained almost the same as in the univariate analysis in all groups, with some variation only in the odds ratio. The adjusted results show that respondents in the lowest education group (OR=0.24, *p=0.003*) as well as in the lowest household income group (OR=0.37, *p*=0.011), both had significantly lower odds of using only private care services than of using only public services. Concerning income and education variables, the odds ratio follows linearity in the use of solely private vs. solely public care services: the higher the education and income, the more usual it was to use solely private services. Those who were

living in a city centre or urban area (OR=1.68, *p*=0.037) and were residing in owner-occupied housing were more likely to use only private services. Participants who gave a self-report of good or fair health had higher odds (OR=2.01 *p*=0.058; OR=1.88, *p=0.035*) of using only private services. To sum up, it is clear that private services are most often used by older people with better incomes, better education, who are comparatively healthy, and who live in privately occupied housing in urban surroundings.

On the other hand, those with poor or very poor health had the highest odds of mixing public services with private provisions. In several other respects the mix group and the solely private service use group were close to each other, especially concerning education, but self-reported health status distinguished these two groups clearly from each other. Apart from the self-reported health and education variables, other variables in the mix group do not show any statistically significant results.

Discussion

This paper has analysed the use of care services among older people and examined to what extent private services are currently used by the older population in Finland, based on questionnaire survey data covering people aged 75+ in two Finnish cities. Marketisation tendencies have changed the Finnish welfare state context for the production of care services. Nordic public sector centeredness and universalism have been giving way to a policy that limits the access to public care services and encourages the production and consumption of private care provisions. As a consequence, the use of private care services has grown rapidly. However, until now, there has been very limited knowledge available on these new private services and their users (Anttonen & Häikiö 2011, Kröger & Leinonen 2012).

The findings show that half of all 75+ service users already use private care services, another 50% using solely public services. It is thus clear that private services are no longer a marginal phenomenon in Finland, used by only a small group of older people. Instead, in a very short period of time they have changed from a total non-issue to a major mainstream issue. The group that uses private services is further composed of two subgroups that are of almost similar size, one where older people use both public and private services and another where public provisions are not present. Looking in more detail at the kinds of services used, it was found that within support services such as cleaning, shopping and home conversion services, private providers have already reached a dominant position, while in other care services the majority still use municipally provided public services (see Figure 2).

The focus of this paper has been on comparing the composition of three groups of users of care services for older people: those who use only private services, those who use only public services, and those who use both. Concerning the first group, the findings show clearly that this group represents the well-off among the older population, that is, those who have the highest household income and education and who also have the best health and live in owner-occupied housing, often in city centres. In brief, within this sample, they could be named "the rich".

Membership of the second group is also best explained by income and education variables, as well as by housing tenure and living area. Those older people who use only public services have regularly low income, low education level and live in rented housing out of city centre. All in all, they are almost an opposite group to the first one - only in regard to health are they not the least advantaged group – and are particularly characterized by a distinctive lack of material resources. Thus, this group can be categorized in this study as "the poor".

The third group, those mixing the public and the private, proves to be different in character to the two other groups. As regards its members' income and education level this group has a close resemblance to the "rich" group but in other respects distinctive differences emerge between the two groups. Unlike in the group using solely private services, housing tenure and residence area do not explain membership in the mix group. Nevertheless, it is self-related health that most clearly separates the two groups: while those who use only private services have low odds of having poor health, it is those who use both public and private services who have the worst health conditions within the sample. Thus, this latter user category could be named as "the sick".

The difference in service use patterns between the first two groups, "the rich" and "the poor", is not a surprise. It has been observed in previous studies (e.g., Stoddart et al. 2002, Geerlings et al. 2005, Szebehely et al. 2012), that there is usually an association between socioeconomic, demographic and health factors and the use of care services. The results of this study follow earlier observations: people from a low educational background use less private services and rely more on public services and, at the same time, the highly educated group uses more private and less public services.

This is not surprising as it feels logical that people with higher education and income would have better access to private services. However, in a Nordic context, these findings raise serious concern. The results suggest that there is a trend towards increasing inequality in the use of care services among older people. In Finland, where earlier almost no private provisions existed, this is a new situation and there seems to be a widening gap between socioeconomic groups in regard to patterns of their care service usage. Booming private care sectors not only benefit more well-off sectors of society but also make the service provision more urban-centred. In addition, the increasing number of out-of-pocket payments combined with cuts in the public services might also cause people from low economic strata to seek

additional support from their families and friends and might also force some people to leave their care needs unmet. Previous research in the Finnish health care setting has reported increasing income-related inequality in accessing care support (Van Doorslaer et al 2006, cited in Wahlbeck et al 2008). A development towards a two-tier service system where people with low income use public services while well-off people instead use private provisions threatens the basis of Nordic universalism (see also Kvist & Greve 2011), according to which all social groups should have equal right to access services which are adequate, uniform and mainly funded with general taxes (Anttonen 2002). A growing divergence in service use between low-income and high-income groups raises questions about whether the shift towards marketisation and privatisation in Finland is starting to jeopardise the opportunities of people from all socioeconomic strata to have such an equal and universal access to care services. Further research is required to identify and confirm whether this risk is real and whether inequality in access to care services has actually grown in Finnish society.

According to the results, "the rich" are not only more wealthy but also more healthy than others. This finding raises additional questions about the policy of current years that has directed public funding, in the form of tax rebates and vouchers, to support the use of private care services. If the users of private services have a better health condition than other service users, then public money that is spent on them is not well allocated, not because they are rather wealthy – as in the Nordic welfare model well-off people are also included in the tax-funded service system – but because, due to their good health, they are not in real need of care services. The profile of private service provisions, seen in Figure 2, seems to support this conclusion as it is particularly low-intensity services, such as cleaning, and not high-intensity personal care services that are most usually received from private providers.

It is not only the gap between “the rich” and “the poor” that raises further questions in the findings. The existence of “the sick” category, that is, the finding that the public-private mix usage model is best explained by poor health, may also be a cause for concern. When there is a high need for services, it seems to be extremely hard to depend completely on a single service provider sector. Older people seem to need a public-private mix of services in order to cope with substantial health problems and care needs. Does this imply problems in the effectiveness and quality of public care services? Do older people with the highest needs complement their public services with private provisions because public care is not extensive or good enough to cover their needs?

We do not yet know enough to answer these questions. Previous studies have mainly examined the use of public services (Portrait et al. 2000, Kadushin 2004, Litwin 2004, Broese et al. 2006, Kim et al. 2006, Blomgren et al. 2008, McAuley et al. 2009, Kehusmaa et al. 2012, Sandberg et al. 2012), and little is known even about the users of private care services in a Nordic welfare context. There is a remarkable knowledge gap concerning those older people who mix private and public provisions. As this is a new phenomenon in Finland and other Nordic countries, information is lacking concerning the situations of this group - which nevertheless represents a quarter of all care service users, based on this data - and their motivations to use private services. The only thing we know at present is that their service use is best explained by health-related factors. The changes that marketisation has brought in the service system have clearly caused an urgent need for new research on the conditions of the new user groups.

This study did not find significant differences in older people’s service use between the two cities (Tampere and Jyväskylä), though a previous study has observed variations in service provisions and use between different municipalities in Finland (e.g., Kehusmaa et al, 2012). The findings of this paper cannot be expected to reveal the national situation because the

sample population represents only two cities in Finland. These samples are sufficient to generalise the result at the local, and not at the national level. It could be expected that the result might be rather similar in other Finnish cities but there is a need for further research that uses a broader national sample and compares variations between Finnish municipalities in a comprehensive way. International comparisons between Finland and other Nordic and non-Nordic nations would also shed more light on what is unique to Finland and which findings have broader relevance across different countries. Even though the data used in this study was derived from 2010, the outcome result is still relevant in the Finnish context as the trend of privatization and marketization has continued in the 2010s. This data is meant to be a part of a longitudinal project.

The results obtained here need to be treated with some caution because missing value represented over half of the total population. Hypothetically, missing values could be considered to represent non-service users; however, in reality, it was impossible to identify whether these respondents did not use any formal care service or were just unwilling to answer questions about their service usage. Demographic comparison shows some dissimilarity between excluded and observed respondents; but among the dissimilarities we found self-reported health variable to be more relevant. As most of the excluded respondents reported good (46%) or fair (43%) health, we can assume them to have only minor care needs. Furthermore, the design of this study does not include people living in institutional care; this exclusion might have some influence on the results because people in institutional care are sicker and require more care than people living at home. It is also possible that some service users did not identify correctly the provider of their services. Especially in cases where municipalities had outsourced their services or provided vouchers, users might have thought they were using a public service when they were actually utilizing a private, outsourced service. Furthermore, 12 % of the respondents were reported to have significant

memory problems, which might have had some influence on how these respondents answered the questions. It is also necessary to remember that the private services reported here were primarily support services such as cleaning and shopping, not intensive personal care services (see, Figure 2). Thus, when comparing the user groups it is also important to consider their group differences in terms of service need and usage. Furthermore, the way services are clustered (i.e. grouping of public and private services) in this study also needs to be taken under consideration because this might influence the results.

The main conclusion of this study is that there is an evident need for more in-depth knowledge about different user groups of public and private care services for older people. The divergence between "the rich" and "the poor", that is, the distinctive difference in service use patterns between well-off and disadvantaged socio-economic groups, raises concern and challenges the Nordic principle of universalism. Similarly, the conditions of "the sick", who combine private provisions with public services in order to cope with severe health problems and care needs, raise doubts about the effectiveness and quality of public care services. However, in order to have confirmation of the validity of these doubts and concerns, more research is needed.

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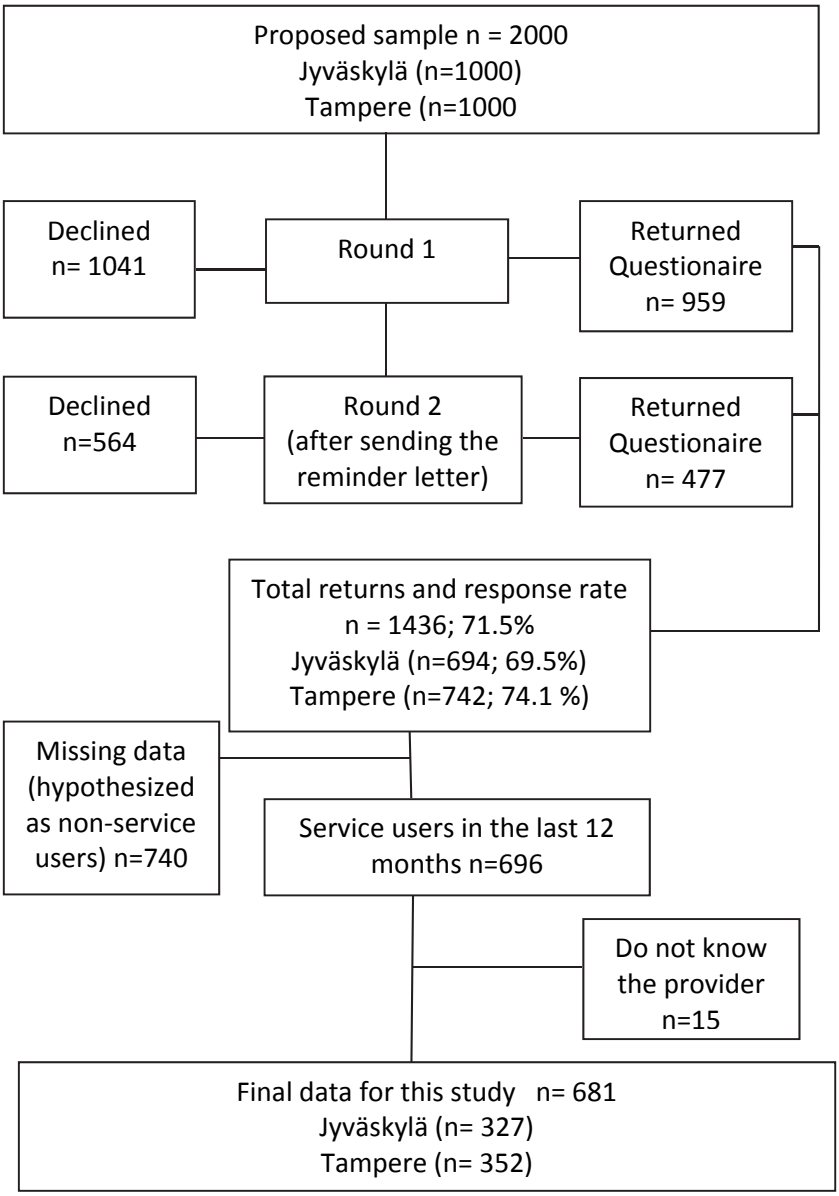

Fig. 1 Flow diagram for recruitment and participation of respondents.

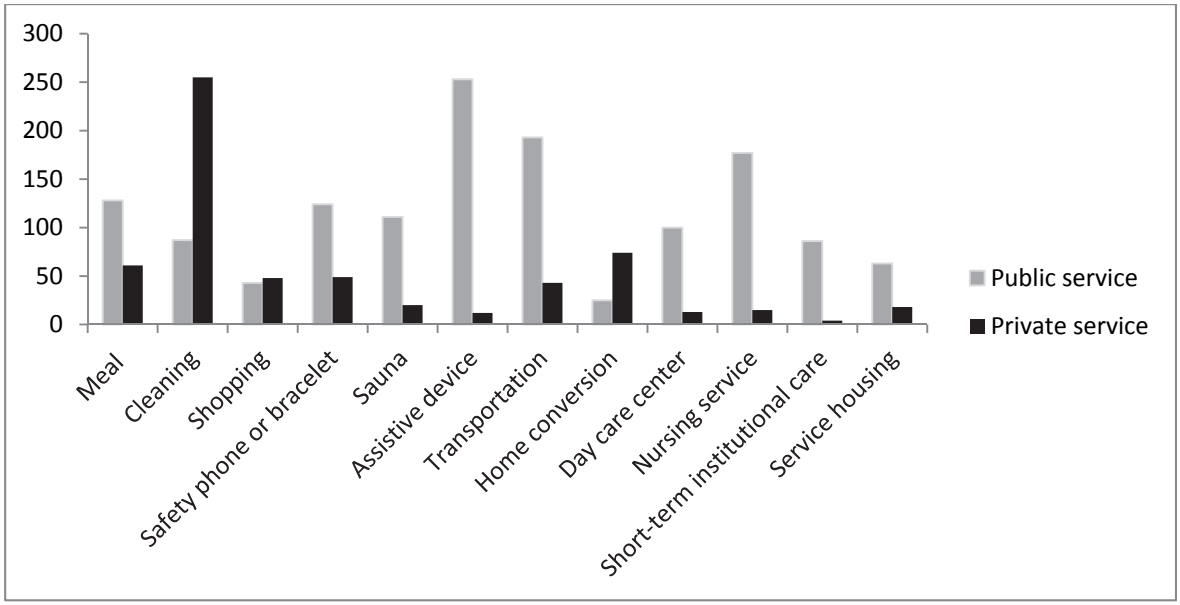

Fig. 2 Use of services according to the service provider

Table 1 Descriptive statistics of service users (n, %)

Variables	Total (*n*=681)	Only public services (*n*=338; 50%)	Only private services (*n*=164; 24%)	Both public and private services (*n*=179; 26%)	*P*-value
City					0.844
Tampere	352 (52)	171 (51)	88 (54)	93 (52)	
Jyväskylä	327 (48)	165 (49)	76 (46)	86 (48)	
Age					<0.001
75-84	399 (61)	195 (60)	125 (77)	79 (45)	
85 or over	259 (39)	127 (40)	37 (23)	95 (55)	
Gender					0.101
Female	467 (69)	223 (67)	109 (67)	135 (75)	
Male	209 (31)	111 (33)	54 (33)	44 (25)	
Living arrangement					0.014
Living alone	422(62)	201 (60)	94 (57)	127 (71)	
Living with someone	259 (38)	137 (40)	70 (43)	52 (29)	
Area of residence					<0.001
City center	320 (47)	134 (40)	97 (59)	89 (50)	
Sub-urban or sparsely populated	355 (53)	198 (60)	67 (41)	90 (50)	
Housing tenure					<0.001
Rented housing	185 (29)	103 (34)	21 (13)	61 (35)	
Owner-occupied housing	447 (71)	198 (66)	136 (87)	113 (65)	
Received informal care					
Yes	538(79)	269(80)	120(73)	149(83)	0.068
No	143(21)	69(20)	44(27)	30(17)	
Self-reported health					<0.001
Good/very good	127 (19)	56 (17)	49 (30)	22 (13)	
Fair	301 (46)	157 (49)	83 (52)	61 (35)	
Poor/ very poor	226 (35)	108 (34)	29 (18)	89 (52)	
Education					<0.001
No vocational education	261 (41)	150 (48)	34 (22)	77 (46)	
Vocational course	152 (24)	86 (27)	29 (18)	37 (22)	
Vocational degree	154 (24)	62 (20)	59 (38)	33 (20)	
University degree	71 (11)	15 (5)	35 (22)	21 (12)	
Equalized household income					<0.001
Quartile (4/lowest)	182 (30)	112 (39)	31 (20)	39 (24)	
Quartile (3)	149 (25)	69 (25)	27 (17)	53 (32)	
Quartile (2)	137(23)	68 (24)	32 (21)	37 (23)	
Quartile (1/highest)	134(22)	35 (12)	65 (42)	34 (21)	

Note: Numbers of categories within a variable might not add up to total because of missing values (including 'I cannot say'). Missing data in the following variables: City, 2; Age, 23; Gender, 5; Living arrangement, 14; Area of residence, 6; Housing tenure, 49 (others =32); Self-reported health, 27 (I cannot say=8); Education, 43; Equalized household income, 79 (I cannot say=32).

Table 2 Multinomial logistic regression on the variables associated with the use of care services

Independent Variables	Univariable						Multivariable (*n*=508)					
	Only private services			Both public and private services			Only private services			Both public and private services		
	Unadjusted odds ratio	95% C.I.	*p*-value	Unadjusted odds ratio	95% C.I.	*p*-value	Adjusted odds ratio	95% C.I.	*p*-value	Adjusted odds ratio	95% C.I.	*p*-value
City												
Tampere	1.11	0.76-1.62	0.561	1.04	0.72-1.50	0.818	-			-		
Jyväskylä	1			1								
Age												
75-84	2.20	1.43-3.38	<0.001	0.54	0.37-0.78	0.001	1.70	0.99-2.93	0.054	0.53	0.33-0.84	0.007
85 or over	1			1			1			1		
Gender												
Female	1.00	0.67-1.49	0.981	1.52	1.01-2.30	0.043	1.80	1.02-3.16	0.040	1.56	0.91-2.67	0.104
Male	1			1			1			1		
Living arrangement												
Living alone	0.91	0.62-1.33	0.646	1.66	1.12-2.45	0.010	0.97	0.54-1.71	0.919	1.44	0.82-2.54	0.198
Living with someone	1			1			1			1		
Area of residence												
City center	2.13	1.46-3.13	<0.001	1.46	1.01-2.10	0.042	1.68	1.03-2.74	0.037	1.16	0.74-1.82	0.511
Sub-urban or sparsely populated area	1			1			1			1		

Housing tenure												
Rented housing	0.29	0.17-0.49	<0.001	1.03	0.70-1.53	0.853	0.35	0.18-0.67	0.001	1.13	0.70-1.83	0.604
Owner-occupied housing	1			1			1			1		
Received informal care												
Yes	0.70	0.45-1.08	0.107	1.27	0.79-2.04	0.316	1.02	0.55-1.88	0.948	1.88	0.63-2-23	0.593
No	1			1			1			1		
Self-reported health												
Good/very good	3.25	1.85-5.71	<0.001	0.47	0.27-0.84	0.010	2.01	0.97-4.13	0.058	0.41	0.20-0.83	0.013
Fair	1.96	1.20-3.20	0.007	0.47	0.31-0.70	<0.001	1.88	1.04-3.40	0.035	0.45	0.27-0.73	0.001
Poor/very poor	1			1			1			1		
Education												
No vocational education	0.09	0.04-0.19	<0.001	0.36	0.17-0.75	0.006	0.24	0.09-0.62	0.003	0.29	0.11-0.74	0.010
Vocational course	0.14	0.06-0.30	<0.001	0.30	0.14-0.66	0.003	0.31	0.12-0.82	0.018	0.21	0.08-0.58	0.002
Vocational degree	0.40	0.20-0.82	0.012	0.38	0.17-0.83	0.016	0.71	0.29-1.69	0.443	0.28	0.10-0.72	0.009
University degree	1			1			1			1		
Equalized house hold income												
Quartile (4/lowest)	0.14	0.08-0.26	<0.001	0.35	0.19-0.65	0.001	0.37	0.17-0.79	0.011	0.50	0.23-1.08	0.079
Quartile (3)	0.21	0.11-0.38	<0.001	0.79	0.43-1.43	0.437	0.49	0.17-0.88	0.024	0.95	0.44-2.02	0.896
Quartile (2)	0.25	0.14-0.45	<0.001	0.43	0.30-1.04	0.066	0.48	0.24-0.96	0.040	0.77	0.37-1.60	0.496
Quartile (1/highest)	1			1			1			1		

Note: For adjusted nominal regression model χ^2= 162.285($p < 0.001$); 2 Log Likelihood = 792.582; Nagelkerke R^2 = 0.310 (list wise deletion of missing data). 'Only public services' was used as reference category in the analysis. Last category in the independent variables was considered as reference group.

III

USING PRIVATE SOCIAL CARE SERVICES IN FINLAND: FREE OR FORCED CHOICES FOR OLDER PEOPLE?

by

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Running head: Using private social care service in Finland.

USING PRIVATE SOCIAL CARE SERVICES IN FINLAND: A FREE OR A FORCED CHOICE FOR OLDER PEOPLE?

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USING PRIVATE SOCIAL CARE SERVICES IN FINLAND: A FREE OR A FORCED CHOICE FOR OLDER PEOPLE?

Abstract:

Use of private social care services among older people is increasing considerably in Finland. This study aims to understand why older people choose private care in a comprehensive tax-subsided social care system, and also examines whether people choose private service as a free choice or a forced choice as well as factors that contribute towards these choice. Data for this study (N=1436) was collected in 2010 from people aged 75 and above, living independently at home in two Finnish cities: Tampere and Jyväskylä. Data were analyzed with quantitative techniques, mainly chi-squared test and multinomial regression analysis and qualitative content analysis (open-ended responses from the survey questionnaire). Findings reveal that people chose private services mostly because of the effortlessness in its use and requirements for additional services. Majority of the respondents performed a free choice to use private services. People who lived in a city center with a higher level of income and who needed more services are more likely to be constrained towards using private support. Major concern is about the service accessibility of the weaker section, therefore more research is required to understand the effects of the growing private care market on older people in Finland.

Key words: older people, private service, free choice, forced choice, Finland.

INTRODUCTION

Older people are the main consumers of health and social care services in Finland, same as they are in most European countries. With population aging, need for care increases; however, older people may often not depend on a single source of support (family/public/private) but on a combination of several (Kröger & Leinonen, 2012). In Nordic countries, families feel 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 up by local authorities. The municipality arranges tax-subsidized care for their residents either through providing the services themselves, through collaborating with neighboring municipalities or through purchasing services from the private sector. Local authorities also offer older people some choice through tax deduction for domestic help and tax-funded service vouchers to buy private care from the market.

Private social care services in Finland

Traditionally, the municipalities offer social care services to their residents with some complementary support from non-profit organizations. At present, alongside the municipality, a large number of for-profit and a few not-for-profit organizations are actively involved in providing a wide range of care support for older people. Transition from publicly provided 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, over time, the

favoring of a mixed economy of care and a strong prioritization of privatization on the political agenda have driven a rapid expansion of the for-profit sectors. Thus, within two decades, privately provided care increased in quantity, whereas public coverage for older people decreased considerably (Anttonen & Häikiö, 2011). A report showed that the private sector offered in 2002 an estimated share of 16% of health care and social care (Salonen & Haverinen, 2003). A recent study (Karsio & Anttonen, 2013) observed an increase in the number of private social care units from 3,018 units in 2002 to 4,350 units in 2010. Even though the introduction of 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 around one third of the 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 (Karsio & Anttonen, 2013; Rissanen & Sinkkonen, 2005; Rissanen et al., 2010).

Choice in the 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. whether public or private or any other resource available 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 its provider (Anell, 1997; Fotaki et al., 2005; Robertson, 2009; Scott, 2000b). However, rational thinking does not always underlie people's choice of providers because rational thinking requires adequate information about the service availability, mental ability to compare services and self-control

in making the choice (Exworthy & Peckham, 2010; Kooreman & Prast, 2010). Sometime, people find themselves often in a situation where they feel not quite capable of making a right choice (Albada & Triemstra, 2009; Victoor et al., 2012b). People's choice can also be influenced by other factors, such as affordability, availability, and accessibility of care (Exworthy & Peckham, 2010; Nordgren & Ahgren, 2011; Pechansky and Thomas, 1981). In their work Levesque et al. (2013) founded that people's information about the service, trust and expectations about the service, personal and social values, and social support also influence their access to care services. Furthermore, individuals' socio-economic and health status also play an important role in determining the service provider (Burge et al., 2004; Exworthy & Peckham, 2010; Lako & Rosenau, 2009; Lent & Arend, 2004; Levesque et al., 2013; Mathew Puthenparambil et al., 2015; Mukamel et al., 2004; Stoddart et al., 2002; Szebehely et al., 2012; Van Aerschot, 2014). Hence, people's choice is not often driven by a single factor but by a combination of many factors; mainly characteristics of the individual (e.g., income, information) and of the service (e.g., price, availability, accessibility).

Free choice, forced choice and negative choice

In this study, the term 'choice' is conceptualized into three categories: free choice, forced choice and negative choice. The term 'free choice' is often discussed in health and social care policy. Free choice is generally considered as an approach that asserts users' autonomy as well as encourages users' active participation in the care process (Dixon et al., 2010; Greener, 2003; Victoor et al., 2012a). Many scholars consider this approach as a way to increase the provider's responsibility to increase consumer value and to promote care quality (Christensen & Hewitt-Taylor, 2007; Greener, 2007). Based on a general free choice definition, here, for the purpose of this study, 'free choice' is conceptualized as operating in a situation where an

end-user of service has the flexibility to select a private care service from among different options that concern quality, availability and personal preference. The term 'forced 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, 'forced choice' is conceptualized 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 due to receiving support from the public sectors, skepticism towards the private sector or personal preferences

Based on the conceptualized definitions, variables are grouped into three categories (free choice, forced choice and negative choice) 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 choices are made, that is, whether the choice is based on free choice or on forced choice and (3) to identify factors that contribute towards these choices.

METHODOLOGY

Sample and Source of Data

This study was a part of "Care, help and everyday life" (in Finnish: "Arki, apu ja palvelut") research project conducted in 2010 in collaboration between the research teams from the

University of Jyväskylä and the University of Tampere in Finland. The aim of this project was to collect information about everyday life situations of older people which comprises managing everyday life activities, providing and receiving support for others (e.g., spouse, children and grandchildren) and use of social care service (public and private services). Data was collected from people aged over 74 years, living independently at home or in sheltered housing (therefore excluding people residing in institutional care) in the two cities of Jyväskylä and Tampere. These middle sized cities were selected on the grounds that they both share very similar features concerning the number of aged population, the figures for service use and the number of private service units (National Institute for Health and Welfare, 2013); and also to draw comparison between the two cities. Researchers prepared a self-administrative survey questionnaire using Swedish and Finnish national survey questionnaires as examples (e.g., HYPA survey; see Moisio, 2007). Later, this questionnaire was pretested with 12 people in Tampere city, and was modified and finalised based on the feedback received from the pre-test. The questionnaire covered questions related to socio-economic and demographic background, self-reported physical and mental health, managing everyday life, providing and receiving support for others, and use of social care service. A sample of a thousand participants from each city was considered as adequate to represent the total population (Guthrie, 2010). Researchers collected the participant addresses from population registries of the cities of Tampere and Jyväskylä. These addresses were randomized by the population registry through a computer-generated method (which was beyond the control of the authors). An informed consent covering letter 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, a total of 959 questionnaires were received, but after sending reminders to the non-respondents, 477 questionnaires were added. Thus, the project 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 thirds of the respondents were women and the remaining one-third were men with a mean age of 81.93 (*SD*= 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 for the purchase of private service.

Researchers did not apply for an ethical committee approval because of the minimal risk to participants emanating 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 n.d.). However, this project followed ethical guidelines governed by the Finnish Advisory Board of Research Ethics. For example, participants were well informed about the research project in the covering letter and were also briefed that all information collected will be kept strictly confidential and anonymous.

Inclusion and exclusion

This study included only those respondents who reported to have used public or private care service (n=679; 47.2%) and excluded other respondents (people do not need services and missing values; n=757). This exclusion was required because of the proposed research objectives in this study, which focused mainly on the users of care support. Disadvantage of this exclusion approach was that it would affect the total size of the sample; similarly, sample size of this study was also reduced to half. However, the acquired size after exclusion remained sufficient to conduct quantitative analysis (Guthrie, 2010). Furthermore, to

determine the difference between the excluded and observed respondents, a comparative analysis was conducted using independent-sample *t*-test and chi-squared test. As expected, health related variables such as number of IADL limitation and self-reported health showed statistically significant results (p=<0.001). In other words, respondents in the excluded category had very minimal health related problems and could manage their everyday life activities without any external support. As the present study focused mainly on the service users, the exclusion of other respondents from the data analysis was reasonable.

Dependent Variables

Based on the conceptualization of choice described in the introductory section, the dependent variable was constructed as a nominal variable with three categories (1) free choice (2) forced choice (3) negative choice. The dependent variable was assessed through the question, "Why do you use private service?" The following answers were computed within the "free choice" group: (a) private services are of better quality; (b) it takes no effort to use private services; (c) personal preference towards private services. In the "forced choice" group, the following answers were included: (a) services are not offered by the municipality; (b) services from the municipality are not offered fast enough; (c) need for additional services which the municipality does not provide. In the "negative choice" category those respondents who gave an answer to the following question "why do you not use private service?" were included, thus expressing that they had chosen not to use private care services.

Independent variables

The independent variables include: age, number of children, number of limitations in IADLs (Instrumental Activities of Daily Living: shopping, cleaning, house maintenance, transportation, managing medication, etc.) and number of social care service uses (as continuous variables). Area of residence (city center 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 three categorical variants (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 the OECD equivalence scale, the income variable was measured into equivalized household income by dividing the monthly income with equivalence factors (a value of 1 for the first adult in the household, a value of 0.5 for any other adults, and value 0.3 for each child aged under 13). Equivalized 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 a multiple response frequency test (Table 1), one-way ANOVA and cross tabulations with the 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 needed to be satisfied (Hosmer &

Lemeshow, 2000). However, there is no predefined technique for testing multicollinearity when using a 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). This technique was followed to identify any collinearity between independent variables; the outcome showed a negative result. In the multinomial analysis, "free choice" and "forced choice" were considered as dependent categories and "negative choice" as the reference category. For the multinomial regression analysis (adjusted model), only those variables which showed a statistically significant results in the chi-squared test were included. 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 were deleted using a listwise approach.

Additionally, qualitative content analysis was performed to explore other reasons contributing 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 forced choice, with three sub-categories in each. References to price, trust and autonomy were grouped under free choice while, on the other hand, themes of availability, information and income were annexed with forced choice. Themes that could not be coded under the above categories (e.g., reference to bureaucracy) were placed under a different sub-category, 'other issues', under each main category. Of the total 95 open-ended responses, only 43 were included, while the other responses were excluded due to irrelevant answers (e.g., "I don't need private services"; "I do not use"). Out of the selected responses, 23 were grouped within free choice under different themes and others within forced choice. An author translated the open-ended responses from Finnish to English with the help of a research colleague and also crosschecked with the co-author 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 respondents 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 for public service (24.2%) and extensive support received from the public sector (22.2 %).

[Please insert table 1 around here]

Of the total population (n=679), 24.6 % are reported to have used private service as a free choice and 17.2 % as a forced choice (Table 2). Most of the respondents were females (65.9 %). On 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 forced choice group had a higher mean age (*M*= 83.92, *SD*= 5.22), a higher number of difficulties in IADL activities (*M*= 4.25, *SD*= 2.83) and a higher number of service used (*M*= 3.48, *SD*= 2.99) than the other two groups.

[Please insert table 2 around here]

In both the free choice and the forced 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 Figure 1, it can be observed that respondents in the free choice and forced choice categories were overall highly satisfied with the price, quality and other components of private care. However, compared to the free choice group, the forced choice group showed a higher level of disagreement in all five components, particularly in the price and the quality.

[Please insert figure 1 around here]

The multinomial regression model (Table 3) was performed to investigate the relationship of socioeconomic and other variables with the dependent variable 'choice' (free choice and forced choice as dependent categories and negative choice as reference category). The results show many statistical similarities between the free choice and the forced choice groups. In both, people living in the city center and with higher income level had higher odds in favor of choosing private care services compared to members of the negative choice group. The variables that differentiated the free choice group from the forced 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, forced choice group used private care if they required more care services (OR=1.27; p=<0.001), 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 forced 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=>0.05). In other words, people in the forced choice group are more likely to choose private care if they require more care support than the free choice group.

[Please insert 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 forced 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 provision appeared to be a significant issue for the forced 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 in practice no longer entitled to public funded provision “Pension and that is why I will not receive support i.e. too high income; Due to my income I do not get the service from the city”. In the free choice category, respondents gave ample importance to service cost as well as to trust towards the provider when choosing service provider, “…the service was not very expensive; the service person is always the same - in municipal [service] they will always be different”.

[Please insert table 4 around here]

Few participants thought that the private sector provided more autonomy than the public provider during and after product selection, “I think the services are right for me, when I order them myself I pay for them myself and receive a 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 private sheltered housing” and information “I have not been up to finding out about all the service”. 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 services. 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 service 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 the 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, it could be assumed 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 closed-ended answers, qualitative results (see Table 4) provide additional insight enabling one 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 set on the basis of the individual's income level (Karsio & Anttonen, 2013). Consequently, higher income earners need to pay higher fees for public services, but the same recipient may be able to 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 emphasizes 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, it could be argued 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 important but at the same time, lack of information could create unnecessary consequences for the user (Bent, 2009). Here, users report 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 is it the users who lack interest in seeking information from the local authorities. It will be hard to give a correct answer but, as a rule, older people are not always active consumers in the care market (Roberts, 2001). 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 needed to choose a health care support (Nordgren & Ahgren, 2011). Some of the reasons emerging from our quantitative and qualitative analysis are familiar in countries with a strong private market, but for Finland, where these results are new because of very limited studies in this area. Thus, almost similar results can be expected if an identical study is conducted in other Finnish municipalities or even in other Nordic countries.

The second research question was to explore whether older people choose private service on the basis of a free choice or forced choice. Although majority of the respondents made a

free choice, a considerable number has chosen private service by forced choice (see, Table 1). Common reasons described by the forced 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 forced choice groups, i.e. users need to pay out-of-pocket for the supplementary support. The forced 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 forced 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 it will probably be a matter of time for the gap between social groups to widen, bringing about income-based health inequality in the society. The above-described development cannot be proved from this study alone, but requires further attention because several existing studies do show an increase in income-based health inequality (Van Aerschot 2014; Van Doorslaer et al., 2006; as cited in Wahlbeck et al., 2008)

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 the effortlessness 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 prevailing within local authority. Hirschman (1970) and Le Grand (2006) in their notable work describe that when people experience dissatisfaction (e.g., delay, poor quality) with the product of an organization, they may either 'exit' by not buying the product or by 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 to all social

groups (as cited in Karsio & Anttonen, 2013). Furthermore, both the free choice and forced choice groups seem highly satisfied with the price, quality and other components of the private provision (Figure 1), though the forced 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. A clear explanation cannot be provided for this outcome but can suggest that the dissatisfied forced choice group members may come from the less advantaged group. Therefore, more research is needed to understand and further explore this finding.

The third research question was to identify the attributes which explain membership in the free choice and the forced choice group, and to explore how these two groups differ from each other. The multinomial regression analysis (Table 3) shows that people who live in the city center and have higher income are strongly associated with membership in both free and forced 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; Exworthy & Peckham, 2010; Lako & Rosenau, 2009; Mukamel et al., 2004). Another outcome from the regression analysis (forced choice vs negative choice and forced choice vs free choice) indicates that, with increasing service needs, people are more likely to be forced to use the market-based care. Therefore, exact reason cannot be pointed out but can suggest that this could be a part of new public management's 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 a serious question arises. If the municipalities are restricting their care provision (which is increasingly happening) and at the same time the alternative option seems too expensive for many, then this raises the question of 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 user drop-out, something 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 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, force 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 warrant generalization of the study outcome. Our survey data was collected from the general population, of whom the majority was non-users of services; therefore, further studies are required, to be conducted with a higher representation of 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 it as public service or vice-versa. Therefore the findings of this study must be

interpreted with some caution. Despite these limitations, there are several strengths to this study. First, this study is among the few conducted in the Nordic countries that have 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 answers serve as an extra asset to 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. Reasons for choosing private care provision include accessibility and availability of private services, additional needs of older people and insufficient information from local authorities. The result of this study not only disclose 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, at present, several local authorities are showing more enthusiasm in promoting privately organized care provision. 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 of better quality	67	14.3
Personal preference of private service	46	9.8
Forced choice		
Need for additional services which are not available through the municipality	87	18.6
Services from the municipality are not fast enough	57	12.2
Services from the municipality not offered	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 to 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)	Forced 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 (2^{nd})	28.5	23.6	27.7	20.8	
Quartile (1^{st}/highest)	16.4	31.4	21.3	8.8	

*p< 0.05; ** p<0.01; *** 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.

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

Variables	Free choice		Forced 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: 1st/ highest quartile)				
Quartile (4th/ lowest)	-1.84(0.33)	0.15***	-1.61(0.40)	0.20***
Quartile (3rd)	-1.27(0.35)	0.28***	-0.63(0.39)	0.53
Quartile (2nd)	-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. Model was adjusted for all variables.

Table 4.

Qualitative findings from the open-ended question: Other reason for choosing private care services (n=43)

Free choice (*n*=23)	Forced choice (*n*=20)
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] they 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 right for me; when I order them myself I pay for them myself and receive a 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 compared to private services because one cannot receive domestic help tax credit from them…
You get to choose.	Pension and that is why I will not receive support i.e. too high income.

	Due to my 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 a private sheltered housing	Other issues: Lot of bureaucracy.

Figure 1.
Level of agreement towards private care services