

10. How marketisation is changing the Nordic model of care for older people

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INTRODUCTION

The last thirty years have witnessed significant changes in the ethos and organisation of public services. There has been a profound market shift not only in the liberal welfare states but recently also in the Northern European countries representing the social democratic model. The Nordic countries were well known for their extensive care service delivery for both children and older people. Services were financed by general tax revenues, produced by municipalities, and provided to all the people who needed these services. The Nordic model of care reflected the capability of social democratic states to extend social rights to cover the care needs of adults and to recognise women's right to employment and independence by providing high-quality care services. This model, among other things, contributed to move unpaid female care work from the sphere of the private household economy to the publicly funded care labour market with high professional opportunities.

This is a major reason to look more closely at the avenues and mechanisms through which an increasing proportion of publicly funded care services for older people are recently being removed from the entirely public sphere of state and municipal provision towards a greater involvement of the private household, the formal economy of the market, and the voluntary or third sectors. The Nordic care model thus reflects current welfare re-mixes as discussed in this book (see Martinelli, Chapter 1, in this volume; Leibetseder et al., in this volume). Clear signs of intensified marketisation are emerging most particularly in Finland and Sweden (Karsio and Anttonen, 2013; Meagher and Szebehely, 2013). Here, care services for older people are, among publicly funded services, the most extensively outsourced to private for-profit providers; and, among these services, residential care is proving to be a lucrative opportunity for large international companies.

By marketisation we refer to the growing presence of private for-profit providers and the increasing influence of market ideas, logics and mechanisms within public service delivery (Anttonen and Meagher, 2013). From the point of view of the Nordic model, marketisation is now the major rationality shaping and framing public sector service provision. As with many other concepts in social theory, marketisation is of course a complex and context-bound term taking different meanings in different times, places and academic disciplines. In this chapter, our aim is to map out what marketisation is about in the Nordic countries and in the context of care for older people. We also ask how marketisation fits into the Nordic model of care. Most importantly, does it alter the principle of universalism that in social services refers to *equal access* to services and to the *inclusiveness* of the care service system, meaning that all people, in principle, *use the same services and are treated in the same way in similar care situations?* Universalism also implies that citizens might have a legal right to services and that *service fees – if any – are low and affordable* to users (Anttonen, 2002; Vabø and Szebehely, 2012). The two countries looked at more closely are Finland and Sweden, where marketisation has been a stronger force than in Denmark and Norway.

1. MARKETISATION: A POWERFUL TRANSFORMATIVE IDEA AND IDEOLOGY

Marketisation reflects the overall economisation and commercialisation of social policies and the production of public goods (Brown, 2015; Crouch, 2004; Newman, 2013; Streeck and Thelen, 2005). It was pushed forward by the administrative reform movements pursuing economic efficiency and effectiveness (Hood, 1998), such as New public management (NPM). Reformers in different countries have favoured techniques taken from the private business sector as a solution to a wide range of perceived problems of public sector service provision. For instance, according to early-stage NPM architects, instead of hierarchical and large organisations, preference would be given to lean and small organisational forms. Similarly, an array of market-type instruments, including outsourcing, competitive tendering and performance-related pay, were recommended and widely introduced in the public sectors of many countries (Pollitt and Bouckaert, 2011).

The marketisation of public services has been further advanced by the austerity measures many governments have adopted since the 1990s to cope with the long-lasting crisis in the public financing of social transfers and services. The recent financial crisis has also played a part, leading policy-makers to seek ways of cutting costs, often through greater target-

ing of services, cuts in social welfare programs, as well as the outsourcing of services (Gingrich, 2011; Meagher and Szebehely, 2013).

The market shift is deeply rooted in neo-liberalism. Economic reasoning has changed so that economic organisations are increasingly seen as appropriately organising every domain of life (Brown, 2015). Public sector and public service provision are not left untouched. This is, as Brown argues, very different from the doctrine of unregulated laissez-faire capitalism. It is now widely thought that markets are also the best way to organise public goods such as education and social care, and that this development has to be supported through laws and governmental interventions. Marketisation has turned into such a powerful idea and logic that it has become difficult to oppose it. Markets are a beautiful idea, as Clarke (2010) has noted. This might be one reason why the political Left has supported market reforms in many countries (Erlandsson et al., 2013; Gingrich, 2011). Changes in citizens' values and expectations have also had a role to play, as users' choice is a widely supported idea. The disability movement, for instance, has strongly supported policies that favour freedom of choice and the use of vouchers and personal budgets (Yeandle, 2016; Kremer, 2006).

In Europe, the United Kingdom was among the first countries to reform thoroughly its public service model back in the late 1980s. These reforms have 'led the way in making welfare more conditional, more targeted and more oriented to market logics' (Clarke, 2010, p. 384). Other countries have followed the British route, at least to some extent. International organisations such as the OECD and the EU also have paved the way for the 'new politics of social care' with recommendations and regulation structured along market logics (Jenson, 2009). All this has changed the ethos of social service delivery and the governance of these services. The active creation of 'managed markets' has obtained a strong foothold in different public policy fields, such as health and social care, housing and education, leaning on a wide range of mechanisms (Gingrich, 2011; Brennan et al., 2012): purchaser/provider split, competitive tendering, vouchers and personal budgets (Clarke, 2006; Newman and Tonkens, 2011; Vabø, 2006). The benefits of coordination through competition – or 'market discipline' – have been advocated, whether driven by the re-organisation on the supply side or by consumer choice on the demand side (Martinelli, Chapter 1, in this volume; Gingrich, 2011).

New public management and other market-centred doctrines have also emphasised the notion of service *users*, reframing them as 'consumers' or even 'customers', who are entitled to more choice and voice (Clarke, 2006; Glendinning, 2008; Clarke et al., 2007; Rostgaard, 2006). The reframing of the service user as a consumer is linked not only to marketisation, but also to the personalisation and individualisation of the service provision. These

processes invoke tailor-made solutions that are very different from the so-called ‘one-size-fits-all’ conception of services and they also refer to a shift in responsibilities. People themselves and their families are expected to take over greater responsibility over meeting care needs than earlier (CAP Anttonen and Häikiö, 2014; Yeandle, 2016). Along marketisation there are of course other ideas and logics that are contributing to changing the provision of public services, such as ‘network governance’, public–private ‘partnerships’ and ‘mixed economies of welfare’ (Anttonen and Häikiö, 2011; Leibetseder et al., in this volume), but they are not addressed in this chapter.

Marketisation and consumerism are deeply rooted in theories advocating ‘freedom of choice’, ‘rational choice’ and ‘public choice’ in public service delivery (Pollitt and Bouckaert, 2011). These theories have influenced public policies and political decision-making and finally actual service delivery all over the world, although the pace and timing of implementing market-intensive reforms vary (e.g. Bouckaert et al., 2010; Gingrich, 2011). One interesting finding is that public sector change has been deep in countries, such as for instance Finland, Sweden and the UK, where service provision was previously built upon hierarchically and professionally organised systems, rule of the law, and incremental budgeting (Pollitt and Bouckaert, 2011). Marketisation has thus got a fairly strong foothold in countries where the grand idea of universalism was first launched after the second world war (Sipilä and Anttonen, 2012) and, most importantly, extended to cover numerous social services. This brings us to argue that marketisation in the Nordic countries means that governments are marketising their welfare state and its institutions in the first instance ‘from within’. In fact, most of the mechanisms of marketisation adopted are leaving the *funding* of services to the public sector and are marketising only the *production* side of these social goods. This is a clear difference with countries where marketisation has taken place more or less outside the public sector because there was no notable public service provision to start with, or because the public sector is not growing sufficiently to meet rising needs.

2. MARKETISATION *FROM WITHIN*: THE NORDIC WELFARE MARKET MODEL IN THE MAKING

Marketisation takes different forms and is accelerated and implemented through diverse strategies and mechanisms in different countries. Marketisation *from within* is advanced mainly through the *outsourcing* of public services to for-profit providers and through implementing *customer*

choice models. These two strategies represent the two main marketisation avenues in the Nordic countries.

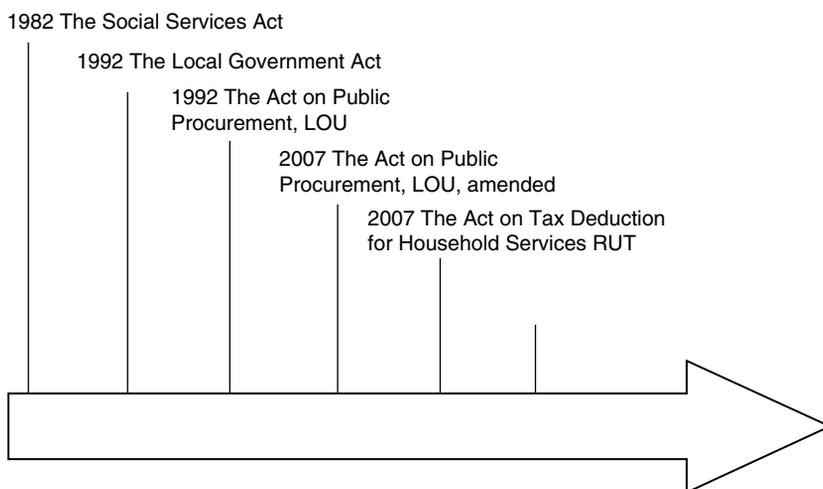
The Legislative Milestones

The beginning of marketisation is fairly similar in the Nordic countries. Up until the early 1990s virtually all care services were provided by the public sector. A series of legislative changes made it easier for the state and municipalities to start outsourcing services to private providers in the course of the 1990s.

In Sweden, the Social Democratic government introduced a new Local Government Act in 1992 (*Kommunallag 1991:900*), which ‘codified norms and rules that had, in practice, already been in use in some municipalities’ (Erlandsson et al., 2013, p. 26). The subsequent Conservative-led government made further amendments to the law, strengthening the role of private for-profit producers. Changes were made also to many other laws so that, in practice, only services that included the direct exercise of public authority were not outsourced. Since in Sweden public authority includes also the assessment of needs in care services for older people, the 1992 law meant that the assessment of needs and the provision of services became separated. Also in 1992, the Act on Public Procurement (*Lag om offentlig upphandling 1992:1528*, hereafter LOU) came into force, regulating the outsourcing of public services to private producers and introducing the obligation of competitive tendering.

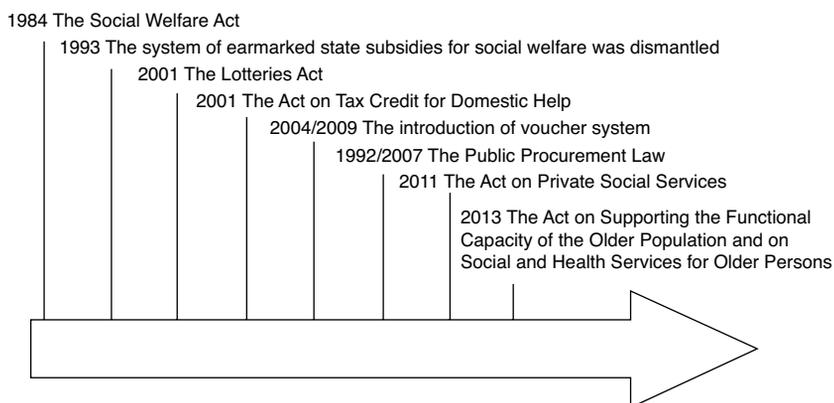
In Finland, the revised Social Welfare Act came into force in 1984 (*Sosiaalihuoltolaki 710/1982*), ruling that local authorities are obliged to organise social services, to provide social assistance, and to pay allowances for their residents. State subsidies can be used for purchasing social services provided not only by the municipal authorities but also by not-for-profit and for-profit providers, as well as for making payments for informal care. The act represents a framework legislation that gives a ‘right’ to services or assistance only if needs cannot be met in any other way. The legislation does not include detailed regulations or subjective rights but guarantees access to needs assessment, which must be done by professional service workers. As in Sweden also in Finland decisions are mainly left to public authorities, most particularly with functions such as decisions over involuntary placements in child protection and mental health care (Huhtanen, 2012).

In Norway, the Procurement Act of 1992 (*Lov om offentlige anskaffelser, hereafter LOA*) gave more autonomy to the local authorities to choose whether to produce public services in-house or outsource them to private producers (CAP Øverbye et al., 2012). The act was amended in 1999,



Source: Authors' compilation, based on Erlandsson et al. (2013).

Figure 10.1 The marketisation timeline in Sweden



Source: Karsio and Anttonen (2013, p.97).

Figure 10.2 The marketisation timeline in Finland

stating that public procurements should be based on competition as far as possible. It resulted in increasing outsourcing in some municipalities, but not to the extent it reached in Sweden and Finland. Furthermore, Norway protected the participation of the non-profit sector in the produc-

tion of social and health services. In 2006, an amendment was introduced in the public procurement legislation, whereby public authorities could outsource services to non-profit organisations without using a competitive bidding procedure. In other words, the Norwegian public sector can award non-profit organisations contracts to produce services without putting them on the same line with for-profit producers, unlike its Swedish and Finnish counterparts (Vabø et al., 2013, p. 176).

Thus, through changes in political preferences and several legislative reforms, more space for market provision within social services has been opened up in all three Nordic countries. It is important to stress, though, that local authorities are not *obliged* to outsource any of their social and health services in Finland, Sweden or Norway. Outsourcing is always a *voluntary* option in public service provision. In Finland, municipalities can outsource services and use vouchers if they prefer, but they can also provide services themselves or in collaboration with other local authorities. Thus, outsourcing in itself does not automatically lead to an increase of market provision. In fact, Finnish municipalities have a long tradition of outsourcing to purchase care services from non-profit providers, which has not been the case in Sweden.

The first wave of marketisation was thus mostly about *outsourcing* former publicly produced services. In Sweden services were outsourced through competitive tenders to for-profit providers from the very beginning, while in Finland the early years of outsourcing favoured non-profit providers. This was due to the special status of Finland's Slot Machine Association (in Finnish RAY), which had (and still has) a monopoly over slot machines in the nation and was, and is, obliged to use its profits for the public good. With financial aid from RAY, about 50 old age homes were built as early as the 1960s; whereas about 14 000 'service' housing flats were constructed between the mid-1980s and the mid-1990s, for older people who needed some help in their daily affairs but not 24-hour attendance (Pasanen, 2010, p. 22). RAY subsidies were thus crucial for the expansion of care services for older people. Moreover, since 'service' housing, funded by RAY, could not be provided by local authorities or for-profit providers, it gave a very strong position to third sector organisations.

The close partnership between municipalities and third sector associations, however, ended in 2001 with the Lotteries Act (*Arpajaislaki 1047/2001*), which marked a clear turn towards a policy of competitive neutrality. This principle was written in the legislation of public procurements and was a key factor behind the rapid growth of for-profit providers and the *incorporation* of welfare associations that took place after 2001. In Finland, non-profit organisations and associations provided welfare service as registered associations (registration was and is required for these

organisations to sign contracts with local authorities to provide services). In recent years, many of these registered non-profit organisations have separated the service provision part of their operations from other activities, and changed the registered organisation into a for-profit provider by establishing a new company, which is, however, owned by the registered organisation or association (Kananaja et al., 2008). There are also other reasons for the incorporation of non-profit providers, for instance changes in national taxation practices (Kettunen, 2010). Similar process concerning competitive neutrality took place in Sweden in 2007, when the LOU was amended and market friendlier rules were introduced.

Further steps toward the creation of a welfare market in social care were taken when legislation establishing *tax credits for domestic help* came into force in 2001 in Finland (*Tuloverolaki 995/2000*) and in 2007 in Sweden (*Lag om skattereduktion för hushållsarbete 2007:346*, hereafter RUT). The main political forces behind tax credit reforms were right-wing parties and employers' associations that had been most outspoken in their demands for *free choice* policies and tax rebates to enable people to *purchase* services with their own money and/or to employ domestic or care workers in private households. In Finland, this measure provided a tax rebate on the purchase of domestic or care services or on employing a private caregiver to assist old persons in their homes (Karsio and Anttonen, 2013). The tax rebate clearly represented a market-friendly policy alternative to publicly funded service provisions and further accelerated the market turn.

Customers' Choice

After the above-described first wave of marketisation, Nordic countries increasingly embraced *free choice models* as a way to organise both social and health care. The customer choice model in the Nordic countries refers to a system where users of services can choose an authorised provider following needs assessment made by the public authorities (Erlandsson et al., 2013). In Sweden, the Act on System of Choice in the Public Sector (*Lag om valfrihetssystem 2008:962*, hereafter LOV) came into force in 2009 and marked a very clear shift from the outsourcing model to a customer choice model. 'The Act regulates what conditions apply when a procuring authority allows individuals to choose the provider of service from a list of approved providers in a system of choice' (Erlandsson et al., 2013, p. 30).

The customer choice model was adopted in Denmark in a slightly different form than in Sweden (CAP Jensen and Fersch, 2013). According to Bertelsen and Rostgaard (2013), Denmark, unlike other Nordic countries, has no specific legislation promoting or restricting outsourcing of social and care services. However, although the marketisation process in

Denmark had been more cautious than in the eastern Nordic countries, free choice legislation was implemented in the case of home care and residential care for older people. In 2002 legislation concerning free choice was enacted for home care services with the Law on Free Choice of Provider of Practical Assistance and Personal Care (*Lov nr. 399 af 6. juni 2002 Frit valg af leverandør af personlig og praktisk hjælp*) and in 2007 it was extended to residential care and nursing homes with the Act of Social Services & Law on Independent Nursing Homes (*Lov om friplejeboliger 2007*). Despite the fact that Danish municipalities are forced to offer free choice to customers and there has been some increase in private producers providing care for older people (CAP Jensen and Fersch, 2013), on the whole this has not resulted in a wide use of private producers (Bertelsen and Rostgaard, 2013).

In Finland, individual choice has been promoted through a voucher system first piloted in the 1990s (Heikkilä et al., 1997; Vaarama et al., 1999). Vouchers were then integrated into social legislation in 2004 (CAP Leinonen et al., 2012). In 2009, a specific law, the Act on Health and Social Service Vouchers (*Laki sosiaali- ja terveydenhuollon palvelusetelistä 569/2009*) was passed. This act made it possible for the municipalities to organise all social and health services through a voucher model, excluding emergency and involuntary services (such as involuntary placements in child protection and mental health care). It was justified with arguments that it would enhance customer choice and improve the effectiveness of services through competition. The main difference between outsourcing and the service voucher system is that in the former case it is the local authority that arranges the competition among different providers, whereas in the latter case it is the service user who makes the decision among different service providers. Although, on the whole, the voucher system in Finland has remained fairly marginal, a new reform under preparation is likely to change the entire system of health and social service provision in Finland by introducing a full choice model, first in primary health care in 2017–19 and later in almost all health and social services, if the government proposal is approved in parliament. This reform will also move the responsibility of arranging services from more than 300 municipalities to 18 counties (<https://www.alueuudistus.fi>).

In a country where municipal services constituted the core of the welfare state (CAP Kröger and Leinonen, 2012), the Finnish social and health care reform represents a comprehensive change and has spurred a strong discussion. Among the main advocates of the reform are big national and international for-profit companies operating in social and health care, since the free choice model, the centralised system and the 18 new counties (embedding a promise of larger market areas) paint a lucrative and

successful future. The critics of the reform see black clouds above it. In contrast to the huge saving potential hoped for by the government, a rise in the costs of the system seems to be inevitable unless the service quality or level is lowered, or the client fees are raised. In addition, private producers might well start choosing their customers due to cream-skimming, in contrast to the original idea of free choice. Moreover, free choice is questionable in the context of care for older people, because of the limited ability of frail older people to make informed choices in the emerging care market.

3. WHAT HAS CHANGED IN THE NORDIC MODEL? AND WHAT ARE THE IMPLICATIONS?

Increase in For-profit Service Production and the Role of the Non-profits

A major result of marketisation is changes in the *providers* of care services. The share of the private for-profit sector within all publicly funded services has risen steadily in the last 20 years, especially in Sweden and Finland (Erlandsson et al., 2013; Karsio and Anttonen, 2013; CAP Kröger et al., 2013; CAP Knutagård, 2012). It appears that Norway and Denmark have been more resistant to market forces in the field of care for older people (CAP Vabo and Øverbye, 2012; Meagher and Szebehely, 2013), but in Sweden and Finland the presence of private providers is now significant.

In Sweden, the share of privately produced care services for older people, measured as the proportion of employees working in the private sector, was 3 per cent at the beginning of the 1990s (Erlandsson et al., 2013, pp. 23, 47). After over 20 years, the corresponding figures were 24 per cent in home care (measured in hours) and roughly 20 per cent in residential care (measured in beds) (Socialstyrelsen, 2016). Moreover, the presence of private for-profit companies in the Swedish care service sector for older people has increased from almost nothing to one fifth of all services.

Finland has experienced a similar change. Here, the share of social service personnel working in public social services fell from 88 to 66.5 per cent between 1990 and 2013 (Ailasmaa, 2015; Karsio and Anttonen, 2013). In care services for older people the proportion of personnel working in private for-profit companies rose from 6.7 to 21 per cent between 2000 and 2013, while that of the public sector fell from 74 to 64 per cent (Ailasmaa, 2015). The increase of for-profit private producers has been intense especially in 'service' housing and other 24-hour residential care. In 2000, the share of for-profit providers within publicly funded services in residential care was 16.4 and in 2013 it had reached 35.6 per cent (Ailasmaa, 2015). On the whole, these figures strongly support the thesis that there is a strong

movement towards intensified marketisation and there really are profound changes in the ways services are produced in Finland.

Another important consequence of marketisation in Finland is that non-profit service providers have to resemble their for-profit counterparts to be successful in competitive bids. They have to compete in terms of service prices to win the bid because the system of direct award is not common in Finland. Thus, there is no longer room for developing innovative but costly services typically piloted and run by non-profits (Lith, 2013). The same is true with the special arrangement within the non-profit service provision that was earlier justified on communitarian principles. These principles have been replaced by the logic of market competition, meaning that traditional non-profit service provision and competitive neutrality do not necessarily fit together.

Competitive neutrality, placing both non-profits and for-profits on the same level in the bidding for public contracts, is applied differently within the Nordic countries. Norway has chosen to exercise positive discrimination in favour of the non-profits by means of legislation (Bertelsen et al., 2013). In contrast, in Finland the national procurement legislation is very strict on the competitive neutrality between the for-profit and the non-profit providers (Karsio and Anttonen, 2013). It is also worth remembering that the values of public goods and the non-profit service ideology might be endangered if welfare associations are forced to give up the communitarian and piloting rationality that their earlier performance was based on. Non-profit welfare associations have been very active in creating personalised services for older people with disabilities or drinking problems. The for-profit sector has so far paid much less or nearly no attention to these groups and their needs.

The Changing Role of the State

Nordic countries have been exceptional in their reliance on the state, public provision of in-kind service and universalism being their leading trademark (Sipilä and Anttonen, 2012; Kallio, 2010; Vaarama et al., 2014). Citizens and decision-makers in the Nordic countries viewed the state and the public sector as the best guarantor of citizens' social rights and of the common good. Accordingly, the welfare state was supposed to correct the failures of the market rather than work for the market (Esping-Andersen, 1985). When welfare is delivered through the market, then the question arises: how are social rights and the common good to be secured?

With reference to the main functions identified by Martinelli (Chapter 1, in this volume), we argue that in the new model the state continues to perform the *regulation*, *financing* and *planning* functions: through its

legislative power it sets the legal frame and defines the rules for service provision; it collects resources (mainly through taxation) and finances the provision of social and other services; it also coordinates the regional and local service provision through old and new functions, such as procurement and tender legislation. But it plays a diminishing role in the actual *production* of services. We can thus expect a growing partnership between the public sector and private service providers, including for-profit companies, non-profit organisations and household provision of care and services. It can also be argued that the state and the public sector are not actually withdrawing from service provision, but are turning into enabler, financer and purchaser of services. Consequently, the role of the state is changing, but so also is the role of citizens and service workers or managers.

Market actors are much more central partners than earlier. This development might lead to a 'differentiated polity', which would encompass diverse features and processes, such as fragmentation, networks, hollowing-out and new governance modes (Rhodes, 1988). A differentiated polity is about mixed markets, hierarchies, and networks (or governance structures) in contemporary states. If universalisation referred to institutional generalisation, uniformity and predictability in processes and outcomes, differentiation refers to the processes of functional and institutional specialisation, fragmentation of policies and politics, increase in complexity and loss of central steering capacity. As Newman (2013) notes, 'divesting' is one of the processes occurring in complex environments, which involves a stripping away of government functions.

The phrase 'hollowing-out of the state' is used to summarise some of the changes taking place in the Nordic countries, such as the decreasing scope of public intervention. It also refers to the loss of functions upwards to the European Union and outward to new service actors. Yet the role of the state in Finland and Sweden has been, and is even today, fairly strong in regulating these new managed markets and, most importantly, in the funding of services. Funding principles have not changed very much: even in the late 2010s the state, regional and municipal governments still finance care and other services for older people on the basis of general taxation. Moreover, there are no notable changes in legislation when it comes to the right to the assessment of care service needs. These parts of the Nordic care model have remained more or less untouched and the huge increase in the for-profit provision of care services has not yet changed all pillars of the model.

On the other hand, the changes that have already taken place might lead into a further radical reorganisation of the public sector and a much more extensive use of for-profit services. The marketisation shift in Nordic countries has already proved to be a lucrative opportunity for large interna-

tional care companies. This is by no means a small aspect in the discussion about the impact of marketisation on the Nordic care model and welfare state. The concentration of the care markets in a few large, private, for-profit companies in Finland and Sweden has been highlighted in several studies (Karsio and Anttonen, 2013; Erlandsson et al., 2013) and has many implications. First, international companies become powerful political actors, capable of influencing the development and planning of care systems (Brennan et al., 2012). Their lobbying power is on a very different level compared to small and often local companies or associations providing services, i.e. those lean and small units praised by the early stage NPM architects. Secondly, international companies are quite efficient in tax avoidance. OECD (2015) and national non-governmental organisations have assessed the amount of tax revenues lost due to aggressive tax planning by multinational companies. Finnwatch estimated that in Finland alone the state loses between 430 and 1400 million in tax revenues annually (Ylönen and Purje, 2013; Finér and Telkki, 2016). The share of this annual loss due to care companies is not known but is significant. Thirdly, as private companies provide more and more publicly funded services, a larger share of people work now in the private sector.

Finally, we need to pay attention to the new identity of ‘customers’ involved in the market shift, meaning that the user of services as a buyer now has the right to complain. Fountain (2001, p. 63) noted that in earlier times ‘legislators may never have intended to promise service excellence when passing legislation to mandate certain services’. The same applied to public servants: they had the obligation to provide services equitably. Service universalism is at least partly about meeting needs of large numbers of people in a decent but not luxury way. Freedom of choice might instead lead into a situation where the ‘customer’ has the right to set the standard and pay extra for better or more luxury services compared to an average situation. This might in the longer run change the Nordic care model. There are also other differences emerging between the system of public service provision and the system of customer choice models: customers possess no particular loyalty to their for-profit service providers. They are motivated by risk avoidance and price. The more services are outsourced and commercialised, the less there is motivation to maintain ‘the public interest’ or the ‘community feeling’. This again might change the relation between the citizen and the state and citizens’ willingness to pay taxes. Another development might be, as the father of the voucher system Milton Friedman (1955) stated in a later article: ‘Vouchers are not an end in themselves, they are a means to make transition from a government to a market’ (Friedman, 1997, p. 343). Thus, Nordic countries might just be at the beginning of the marketisation development.

4. CONCLUDING REMARKS

Our main finding is that marketisation is a process that is intensively and comprehensively re-organising and re-shaping the public provision of care for older people and other social services in the Nordic countries (Meagher and Szebehely, 2013). Thus, if marketisation first involved liberal welfare states, such as the UK (Newman, 2001), it has now reached the Nordic countries, where the state earlier assumed a wide responsibility for both financing and producing care services for its residents.

It is important to stress that the emerging welfare market model, which includes publicly governed and subsidised social and health care markets, is not just an evolution. It has to be created, and once the welfare market model is created it has to be maintained and reproduced. Both its establishment and maintenance require considerable use of public interventions, public money and public regulation. We have highlighted the main avenues and mechanisms behind creating and maintaining managed care markets in the Nordic countries. We also provided a more concrete definition of marketisation, which refers to the growing presence and influence of market ideas, logics and mechanisms in public and publicly funded service provision, which we also define as marketisation 'from within'. In the Nordic countries, there has been very little increase in free market care service provision, irrespective of the introduction of tax rebate schemes.

When we speak about Nordic countries it is important to underline that care is still regarded as a social right: it is not considered a private responsibility of individuals and families but a public good among other tax-financed services. All people, irrespective of their economic and social status, have a right to claim for care and other services, and public authorities are obliged to assess their needs and ensure they are met. Actual access to these services is based on a professional, individual assessment of the person who claims services. This is the case even today and marketisation has not changed this principle. Nevertheless, marketisation is introducing many other changes that, in the end, might also undermine this well-established principle.

As we have shown, marketisation is triggered by both bottom-up and top-down pressures. We have referred to these mechanisms as marketisation from within and from without. The Nordic countries are a grand example of marketisation taking place mostly from within. Marketisation has advanced mainly through local choices and decisions made by municipalities. The national legislations enable municipalities to marketise their service and governance systems, but do not force them to do so, with the exception of Denmark, where – surprisingly – marketisation has not proceeded as rapidly as in Finland and Sweden. It is difficult to evaluate

the power of marketisation pressures from without. The EU, OECD and other powerful international actors have clearly favoured market mechanisms in their policy guidelines and directives (Jenson, 2009), but, as the examples from Finnish and Swedish legislation show, these countries have implemented more market-friendly laws than EU directives call for. Why then Finland and Sweden have been more anxious to marketise from within than Norway and Denmark, is an important question and should be studied further. Although marketisation from within seems to be a stronger mechanism than marketisation from without, we are not underestimating the power of travelling ideas and discourses mobilised by the EU and other international advocates of marketisation. We have, however, shown that the actual marketisation processes are context-dependent and reforms take place in processes driven by both bottom-up and top-down forces (see also Martinelli, Chapter 1, in this volume).

Marketisation from within has advanced mainly through two avenues, outsourcing of services and free choice models. Although the Nordic principle of care as a social right remains more or less untouched, the increasing involvement of for-profit companies in service provision and the expanding free choice model are changing the welfare state ethos. The principles of universalism, inclusiveness and equality are threatened by the logics of profit making and free choice. First, the more the access to public care services is dependent on individual choices and resources, whether money or the ability to make rational informed choices, the further the principles of inclusiveness and equality are undermined. Secondly, as private for-profit companies strive for profit in the area of social and health services, the integrity of the welfare state system is compromised. Advocates of marketisation argue that profit making and its implications can be regulated by state, but as research shows, this is not always the case, and regulation has many unintended consequences (e.g. Gingrich, 2011; Armstrong, 2013; Banerjee, 2013). Even though market forces can be controlled – at least for the time being – by the public authority, the more radical advocates of marketisation have no intention to stop here (Friedman, 1997).

Finally, marketisation is changing the identity – status and rights – of service users. In the context of the welfare state, an individual is understood as a citizen with social rights. In marketised welfare states individuals are seen as rational consumers and decision-makers who, by making active choices, shape the welfare markets and systems and make them more effective. According to the market ethos, the social right to welfare and care is not a priority, but a right to make free choices as a consumer in the market. Thus, it is possible that rights will be weakened. We must then ask ourselves for how long the citizen-consumer will support and legitimise the welfare state. Since consumers do not need to turn to bureaucrats but

only to market actors to fulfil their needs, the loyalty toward state and municipal (or regional) public agencies might vaporise. Due to outsourcing and the increasing share of for-profits in the provision of care services, this change of the user identity from citizen to consumer might already be a reality. We should also stress that, while the shift from citizen to consumer is already a focus of research (Clarke, 2006; Clarke et al., 2007), we know very little of what happens to the identity of care workers.

To conclude, marketisation in the context of care and its implications do challenge the core principles of Nordic welfare states. Our evidence from the COST Action IS1102 *SO.S. COHESION – Social services, welfare states and places* and from other critical research does support the argument that the ethos of the welfare state is changing – and rapidly so – as a consequence of the growing role of markets within public service provision. Marketisation from within and from without, the increasing share of private for-profit producers, the changing roles and identities of service users and employees are all factors that might question the very roots of the Nordic welfare state and universalism. On the other hand, despite the directions of change discussed in this chapter and the increasing pace of marketisation, some basic features of the Nordic model are standing their ground. Universalism is still a fundamental idea and principle, at least if we refer to inclusiveness and the extensiveness of public funding of care services.

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