

# Chapter 3

## Long-Term Care in Sweden: Trends, Actors, and Consequences

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### 3.1 Introduction

In the 1970s and 1980s, Sweden had a well-developed system of tax-funded, mainly publicly provided services for older people, and some development of services for people with disabilities aged less than 65 years old. This system has changed significantly during recent decades. There has been some *retrenchment* in eldercare, evident in falling coverage and stronger targeting on people with higher levels of need. This development has led to *informalization* of care for some groups of older people as services, which would have been available as public services for previous generations must now be provided by family members. In disability care, there has been considerable *expansion* of services, perhaps most notably in the introduction of a personal assistance scheme for people with severe disabilities. These divergent trends in services for older people and people with disabilities have coincided with a convergent development across both care fields: the *marketization* of services and the emergence of large, corporate, for-profit providers.

The focus of this chapter is to explain how and why these changes have happened, and to discuss their consequences for service users and for the possible future of social care in Sweden. We explore the roles of different social, political, and economic actors in the change process, and identify which changes were intended and unintended by policy makers. In addition to the dynamic interaction of state-steering and municipal response that are typically important in explaining change in patterns of social service in countries with multilevel government, we identify “invasive displacement” and “layering” as processes transforming the institutions that directly and indirectly organize care service provision.

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### 3.2 Sweden's Care Regime: Institutional Structures and Governance Processes

In comparative perspective, care for both older people and people with disabilities in Sweden is provided within a universalistic care regime, underpinned by a publicly or collectively oriented “care responsibility culture.” The system is organized within a strongly decentralized political structure that has been dominated at the national level by the Social Democratic Party, punctuated by short periods of right-wing government. Within this broad framework, the roles that the family, the public sector, and the private sector each play in providing and funding care have evolved over the years. It is possible that the trajectory along which care provision seems to be evolving is threatening the traditional universalistic care regime, a theme to which we return later. However, this section first sets out the formal institutional structures and governance processes through which the tasks of funding and providing care are distributed and overseen.

One defining feature of the Swedish care regime is that families do not have a legal responsibility to provide for the care needs of their adult members, even though in practice families play a considerable (and, in eldercare, increasing) role. Furthermore, and important to note for readers of this book, “long-term care” is not a concept used in Swedish policy or political debate. Rather, care for frail older people, including nursing homes, and care for people with disabilities are framed as two separate fields of *social care* (rather than health care).

Another feature of Sweden's care regime is the strong tradition of municipal autonomy: municipalities have primary responsibility for organizing publicly funded care services, both home-based and residential. Municipalities also have the substantial taxing powers required to fund much of the total public budget for formal care for older people (85 %) and for people with disabilities (around 70 %). Municipalities are also free to decide on the distribution of different types of care (for example, between homecare and residential care in eldercare services) and between services that meet the needs of different social groups (for example, eldercare, childcare, and disability services).

However, the primary role that municipalities take in funding and providing care services does not mean that the state is unimportant: the national government may currently fund only 10 % of the costs of eldercare (the remaining 5 % is covered by user fees), but it has a considerable impact on municipal care practice, via three steering mechanisms: legislation and regulation; financial incentives; and oversight and guidance. Sometimes, state actions are aimed specifically at reform of one branch of care services (such as the Disability Act of 1993); sometimes they are decisions with a general remit, directed at a wider span of activities, or indeed the whole of municipal activity (such as the Municipal Act of 1991).

Through the mechanisms of legislation and regulation, the Swedish state stipulates which populations municipalities are required to provide care for, how much they can charge for services, and what kind of organizations are allowed to offer services. The needs of both older people and people with a disability are recognized within

the Social Services Act (SSA) introduced in 1982, which regulates home-based care services and residential care including nursing homes. The SSA is a goal-oriented legislation ensuring a general right to claim support “if the needs cannot be met in any other way,” so that the individual can have a “reasonable level of living.” The legislation does not specify “needs” but there is a right to appeal to court if the individual is not satisfied with a decision.

In addition to entitlements established by the SSA, people with severe disabilities have further entitlements under the Disability Act of 1993 (consisting of the Act Concerning Support and Service for Persons with Certain Functional Impairments, LSS, and the Assistance Benefit Act, LASS; the latter has been part of the Social Insurance Code since January 2011). In contrast to the SSA, this legislation confers specific and absolute rights to persons with certain extensive functional impairments<sup>1</sup> (not caused by normal ageing), and sets out the measures that local authorities are obliged to provide to ensure these persons “good living conditions” (a more ambitious goal than in the SSA). Disabled people who qualify for the services under the Disability Act, and who need extensive help with basic needs, may also be entitled to personal assistance, in which case the state covers the municipality’s costs for assistance exceeding 20 hours per week. Thus, an important difference between the SSA on one hand and the Disability Act on the other is that the SSA leaves the municipalities to define or interpret who is entitled to services and what their entitlements are, while the Disability Act prescribes quite specifically who is entitled and what support they should receive, thereby constraining municipal discretion.

The state also steers municipal activity using financial incentives, both via the *scale* of state subsidies, and their *structure*. Over recent decades, financial steering measures that affect care services have changed several times. In 1993, special purpose grants for key service areas were replaced with block grants that could be allocated between different purposes by municipalities themselves. Later, a range of special earmarked funds were introduced alongside block grants, to give municipalities incentives to change their organization or activities in line with the national government’s goals. One example of earmarked project funds that is crucial to our account has been their use as an incentive for municipalities to introduce customer choice models (in effect since 2009); other examples include incentives to introduce support for family carers since 1999, and funds for training on dignity in eldercare since 2011.

Oversight and guidance is the third major category of steering mechanisms, and in Sweden, these activities are largely delegated to the National Board of Health and Welfare, NBHW (Socialstyrelsen). The main trend here is the increasing intensity of soft regulation via such measures as benchmarking, open comparison of data on expenditure and quality in care services, and the development of practice guidelines and assessment tools.

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<sup>1</sup> Three groups are specified in the Disability Act: (1) persons with an intellectual disability, autism, or a condition resembling autism; (2) persons with a significant and permanent intellectual impairment after brain damage in adulthood; and (3) persons with other lasting physical or mental disabilities (not due to normal ageing) if these disabilities cause significant difficulties in daily life requiring extensive support.

### 3.3 Trends in Long-Term Care: Changing Coverage, Spending, and Organizational Forms

We began this chapter by noting that there has been significant change in the scope and organization of services to older people and people with disabilities in Sweden in recent decades. This section briefly describes these changes in order to provide evidence of the trends, which this chapter seeks to explain, including falling coverage in eldercare; the emergence and growth of new programs providing care to people with disabilities; and the marketization of different kinds across both forms of care.

In contrast with most other European countries, provision of eldercare services has declined in Sweden, relative to the share of older people in the population. Thirty years ago, 16 % of people 65 and over received public homecare, while approximately half as many were in residential care (Szebehely 2005). By 2000, the proportion receiving homecare had fallen to 8 %, while the proportion in residential care remained more or less stable. Over the last decade, there has been a significant decrease in residential care, which has only partially been compensated by an increase in home-based care. Thus, according to the most recent national statistics, in 2011, 9 % of the older population (65 years and over) received homecare, while 5 % were in residential care, including sheltered housing (NBHW 2012a). Declining coverage can only partially be explained by improved health among older people; hence the probability of receiving publicly funded homecare is now clearly lower than it was 30 years ago (Larsson 2006; Szebehely and Trydegård 2007).

The trend in service provision for people with disabilities aged less than 65 years has been quite different from that in eldercare. Coverage rates cannot be calculated for people with disabilities in a way analogous to older people, so here we rely on absolute numbers of recipients. Available data show that the number of disabled people receiving any form of public social care increased by 29 % between 2000 and 2009 (Szebehely 2011). Yet informal care also remains important for people with disabilities, especially for those who fall outside the scope of the Disability Act. As for older people, the majority of care for those with disabilities is provided by family members, even though Sweden is a country with comparatively well-established formal long-term care services. In fact, since the end of the 1980s, there has been an increase of family care for people with disabilities with fewer care needs as well as among older people with all levels of need. Only among people with extensive disabilities, in particular those covered by the personal assistance scheme, has there been an increase of formal care services and a decrease of those receiving informal care only (Szebehely and Trydegård 2007).

Spending trends mostly reflect this changing profile of service provision in long-term care. Public spending on eldercare increased during the 1980s (from 55 to 64 billion SEK between 1985 and 1990) despite falling coverage, for reasons we explain in the following section. Between 1990 and 2000, spending increased by only 5 %—in relation to the number of people aged 80 years and older in the population, this corresponds to a decrease of 14 % (Government Report 2004). Between 2002 and 2009, spending declined in absolute terms by 4 %, from 93.4 to 89.6 billion

SEK in 2009 prices (NBHW 2011a). By contrast, between 1993 and 1999, public spending on provision for disabled people increased by 68 %, with most of the increase occurring between 1993 and 1995 with the introduction of the disability reforms LSS and LASS, mentioned earlier (Palme et al. 2003). Between 2000 and 2009, public spending on disability services increased a further 66 %, from 37 to 61 billion SEK in 2009 prices.<sup>2</sup> As a result, spending on disability services as a share of public spending on long-term care has increased significantly and was 41 % in 2009 (Szebehely 2011).

Despite these changes to the long-term care profile, public resources flowing to eldercare services remain generous in Sweden, from a comparative perspective. Although comparable data on spending on social services are difficult to come by, available evidence suggests that Sweden remains one of the most generous countries in the OECD when it comes to services for older people. Public spending amounted to around 2.4 % of GDP in Sweden in the mid-2000s, compared to 1.7 % in Denmark, 1.1 % in Italy, and 0.9 % in the United States. Indeed, of the 14 countries for which data are available, only the Netherlands spends a higher proportion (2.5 %; Huber et al. 2009). The same data source put spending on long-term care (including care for both older and disabled people) in Sweden at 3.9 % of GDP, higher than any other of the 24 European and North American nations analyzed (Huber et al. 2009).

If the care needs of Sweden's elderly have changed less than formal care offerings, the question arises: who is helping them now? Evidence suggests that the gap is being bridged by family members, especially daughters (Johansson et al. 2003; Szebehely and Trydegård 2012) and it has been estimated that, between 1994 and 2000, families' share of all community care increased from 60 to 70 % (Sundström et al. 2002). Privately funded, privately provided services purchased on the open market, outside the needs assessment and oversight processes of the formal care system, have also come to play a greater role in the overall arrangements for support for older people. Since 2007, the state has sought to promote such private purchases with a tax rebate; thereby blurring the boundary between the private market and publicly funded care services. While those with lower education are likely to rely on family carers, those with higher education often turn to the market to buy services (Szebehely and Trydegård 2012). Thus, the decline of tax-funded services has had different consequences for older people from different social groups as well as for their families.

Informalization and privatization through the increased use of privately purchased services are not the only developments of note in the Swedish care system. Private service *providers* have also come to play a significant role, *inside* as well as outside the publicly funded, publicly organized care system, as a result of a range of policy changes since the early 1990s. In 1993, only 2 % of publicly funded hours for older people receiving homecare were privately provided (NBHW 2003); by 2010, this

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<sup>2</sup> Childcare is another area where increased government ambitions have reduced the municipal resources available for eldercare: with the implementation of the School Act 1995, municipalities became obliged to offer childcare to all children 1–12 years of age. As a result, between 2000 and 2009, the public resources for childcare increased by 67 % (National Agency for Education 2011).

proportion had increased to 19 %; in 2010, a similar proportion, 19 %, of older people in residential care lived in privately run facilities (NBHW 2011b). Among disabled people less than 65 years receiving services, the rate of private provision is higher: in 2010, 23 % of homecare hours and 28 % of the places in residential care were privately provided (NBHW 2011b), while among those using the personal assistant scheme, just more than half (55 %) received services from a private provider (Swedish Social Insurance Agency 2011). Significantly, the entire increase in private provision has been among *for-profit* providers; the share of cooperatives and other nonprofits has remained stable since the early 1990s. Furthermore, large corporate providers are dominant among for-profit private providers. The two largest players, Carema and Attendo, both owned by international private equity companies, controlled half the eldercare market in 2008 (Meagher and Szebehely 2010).

### 3.4 Explaining the Changing Profile of Long-Term Care in Sweden

The combination of falling coverage of public eldercare in Sweden with the emergence of new, well-funded measures to support certain groups of people with disabilities means that the profile of long-term care recipients in Sweden has changed substantially in recent decades. Although shaped by the consolidation of market-oriented ideas and “New Public Management” (an ideology that signifies suspicion toward traditional public sector ways of working by the policy-making elite), the changes we explain in this section are somewhat separate from the marketization policies discussed later. Much can be explained in terms of the normal cost-shifting strategies that governments in multilevel systems use. Another significant factor is the emergence and impact of a strong disability rights movement in Sweden during the 1980s. We argue that the Disability Act, which fundamentally changed both the scale and scope of services available to people covered by it, is an example of what Streck and Thelen (2005) call “layering.”

#### 3.4.1 *Rationalizing Eldercare*

After the oil shocks of the 1970s, Sweden entered the 1980s with the world’s largest proportion of older people in its population and a fiscal deficit that was to worsen before it eventually improved. At this time, economists who were critical of the size and dominance of the public sector came to hold a much more central place in public and policy discourse, and pressure on public budgets intensified. However, as we noted in the previous section, resources in eldercare did not fall, but rather increased; in fact, the number of hours worked in homecare services doubled over the 1980s. What changed, in the new economic and policy climate, were the kind of needs recognized by the system, the kinds of services delivered to older people, and the

organization of care work and the care workforce, as previous research has firmly established (Sundström and Malmberg 1996; Szebehely 1995; Thorslund 1991). In homecare, services became more targeted at those with larger care needs, so that a smaller proportion of older people received more intensive care. Furthermore, an increasing proportion of care workers' time came to be taken up with personal care rather than domestic help (Sundström and Malmberg 1996). The policy priority of "deinstitutionalization" also contributed to the changing needs profile of homecare clients.

Not all of the increase in measured hours in the homecare service was spent in caring for this proportionally smaller and absolutely frailer cohort. Supported by the Municipal Workers' Union, work in homecare became more professionalized as workers gained rights, which other professionals had long enjoyed (Liljeström and Özgalda 1980). Between the mid-1970s and the mid-1980s, contract staff (paid by the hour) were largely replaced by (mostly part-time) employees (Thorslund 1991). These employees were also paid for time spent traveling between clients, rather than just the time they spent with them. Furthermore, homecare workers began to attend meetings and receive training and supervision, for which they were also paid. Overall, the "indirect" working hours (paid hours not spent with clients) increased from 3 to 34 % between 1970 and 1987 (Szebehely 1995). Funding arrangements reduced municipalities' incentive to contain the growth of indirect working hours: between 1964 and 1993, the state subsidized 35 % of the wages of homecare workers with an earmarked grant, and from 1984, hours for training could be included. Under the influence of New Public Management ideology, there was a related shift from a more person-centered organizational model, under which each care worker was responsible for a small number of clients, toward a Taylorized "assembly-line" model, under which a number of care workers jointly provided specific tasks to a larger number of clients. An unexpected consequence of this rationalization of care was that a larger proportion of working time was required for tasks other than helping, such as planning and coordinating the work (Szebehely 1995).

During the 1990s, eldercare provision came under further pressure from general developments in municipal finance and from specific developments in health and social care policy. The economic crisis of the early 1990s squeezed resources for eldercare, as municipal tax revenues fell and unemployment, which rose from 1.7 % in 1990 to 8.3 % in 1993, increased demand for social assistance benefits. But more active policy changes also affected municipal finances in general, and eldercare funding and regulation in particular. As part of its deficit reduction strategy, a newly elected right-center national government legislated in 1991 to cut grants to local government and to stop municipalities raising their own taxes to compensate for the loss of state funds (Loughlin et al. 2005). This effective tax-freeze was not lifted until 1993.<sup>3</sup>

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<sup>3</sup> Also, after the actual tax-freeze several government initiatives have imposed restrictions on the municipalities' decision latitude in raising tax rates. For instance, between 1997 and 1999, municipalities that raised their tax forfeited government grants equivalent to half of the increase in revenue (Palme et al. 2003).

Furthermore, in 1993, the same national government changed the structure of state grants to the municipalities, merging earmarked grants for specific activities (such as wages of homecare workers) into a single block grant to each local authority. The “Principle of finance,” also adopted in 1993, obliged the state to ensure that municipalities had the means (without raising taxes) to fulfill any new tasks they might be delegated. As Loughlin et al. put it, “this principle has not always been respected, at least according to the municipalities” (2005, p. 357). These changes became particularly significant for eldercare provision, because the ambitious new Disability Act would be legislated in the following year.

Measures aimed at financial regulation of various kinds certainly put new pressure on municipal eldercare, but so did policies directed squarely at the organization of care services. Passed by a Social Democratic parliament in 1990 and in operation from the end of 1992, the Ädel reform shifted the responsibility for nursing homes from the *health* care sector, administered and funded at the county council level, to the *social* care sector, administered and funded at the municipal level. This reform was the result of a long process of contention within and between the right and left political blocs and of “clear conflict” between the county and municipal levels of government over more than a decade (Lakomaa 2009). Ultimately, it involved the work of two committees over more than a decade. Under the reform, municipalities were required to pay for hospital care for older people considered medically ready for discharge. Given the relative cost of a hospital and a nursing home bed, this created a strong incentive to move older people out of hospital. The primary stated aim of the reform was to increase quality of life for older people by “demedicalizing” their care. However, the reform was implemented just as Sweden fell into deep recession, and focus shifted to its cost-saving potential as fiscal strictures tightened. Certainly, the number of so-called “bed-blockers” decreased sharply (as did the number of hospital beds). However, this change also meant that older people were more likely to be leaving hospital with higher care needs, and these people came to use an increasing share of the municipalities’ already squeezed resources. This was yet another factor pushing groups of older people with smaller (but existing) care needs outside the system.

By the early to mid-1990s, municipal finances were squeezed by the combined effect of the recession (which reduced tax revenues), the Ädel reform (which increased demand for eldercare on the municipalities by decreasing the number of hospital beds), and the disability reforms (which made new demands on municipal funds). In this context, many municipalities relied on user fees to steer demand for services and some used fees to increase their income. Income-related fees became a handy instrument to discourage older people with higher incomes from using public services, while low-income pensioners refrained from using services because they were not guaranteed the right to retain a reserved amount of their income. Considerable differences between the municipalities became evident, and along with lack of fairness in the system and inequality of access meant that these problems came increasingly onto the political agenda in the 1990s—put there not least by pensioners’ organizations (Feltenius 2007). However, it was not until 2002 that a remedy, in the form of the “max-fee” reform, was legislated by a Social Democratic government



with the explicit goal of strengthening universalism (Government Bill 2000/01:149). This policy protects older people on low incomes by specifying a reserved amount for users of homecare as well as of residential care, such that fees charged could not reduce their income below a specified level: 4,967 SEK (€ 565) per month plus rent for a single person in 2012. The reform also protects older people with higher incomes with a maximum fee: 1,760 SEK (around € 200) per month in 2012. Nevertheless, municipalities continue to have an incentive to use fees as rationing devices for homecare services, particularly to steer away more affluent groups of older people with fewer care needs (Szebehely and Trydegård 2012).

### ***3.4.2 Disability Support: Redressing the Balance?***

One of the most important legislative changes for both older people and disabled people in Sweden was the introduction of the Disability Act in 1993. The need for reform to enable full participation of disabled people in social, cultural, and economic life had been recognized in the mid-1960s (National Insurance Board 2002). However, during the 1970s and 1980s, a range of actors inside and outside the social service system argued that the standard of welfare for disabled people, particularly those with severe disabilities, had not kept pace with developments for the general population. Different groups of actors represented different groups of disabled people, specifically those with learning disabilities on one hand and those with severe physical disabilities on the other.

The National Association for Persons with Intellectual Disabilities (FUB), primarily a parents' organization, played a critical role in promoting the prioritization of support for people with learning disabilities (NBHW 2009). By FUB's own account of its history, the principle of "normalization," according to which the "patterns and conditions of everyday life" for people with learning disabilities should be "as close as possible to the norms and patterns of the mainstream of society" (Nirje 1969), has been central to this organization's ideology. Nevertheless, FUB fought for the specific recognition of people with learning disabilities in the Disability Act, against opposition (including inside the disability movement) that considered the singling out of specific groups as potentially discriminatory (FUB 2007). Inside the social service system, Karl Grunewald was an important advocate for reform of services for people with learning disabilities. Grunewald held a range of key positions in the National Board of Health and Welfare, including as Director of Mental Retardation Care Services (as they were then called) in the 1970s. Similar to FUB, he advocated strongly for giving people with learning disabilities the opportunity to live "normal lives," and deinstitutionalization was a particular focus of his activism (Grunewald 1974). FUB's advocacy, in combination with Grunewald's, succeeded in having people with learning disabilities specifically recognized in the Disability Act.

Another extremely influential organization, with strong connections inside the political system, was the Independent Living Movement (ILM), which advocated primarily for adults with extensive physical disabilities. Founding member Adolf

Ratzka, a Germany-born Swede, severely disabled by polio as a young man, spent several years in the United States during the 1960s, where he came into contact with the Independent Living Movement and experienced self-directed personal assistance services at first hand. Ratzka brought the ideas of the ILM to Sweden, where he organized the first Nordic conference on Independent Living and established a pilot self-organized personal assistance scheme in Stockholm, both in 1983 (Ratzka 1986). In a manifesto published in 1984, Ratzka stated that the ILM was linked to other struggles for equal rights, and was influenced by the ideology of “consumerism,” which, when “applied to disability, postulates that we disabled people are experts on our own lives [and] that we have the right and responsibility of assuming control over our own lives” (1984, p. 3). Significantly, Ratzka’s manifesto goes on to state that “Independent Living subscribes to de-professionalization,” and his account of the history of the ILM in Sweden directly criticizes the Municipal Workers’ Union’s efforts to professionalize services for people with disabilities (Ratzka 1986).

In 1986, then leader of the Liberal Party in Sweden, Bengt Westerberg, met Ratzka for the first time. Addressing a conference celebrating 25 years of the ILM in Sweden in 2008, Westerberg reported being “very inspired by that meeting” (Westerberg 2008). Over the next few years, he was to be an important advocate for a personal assistance scheme for people with disabilities. In 1988, he put a motion to the parliament proposing a personal assistance scheme, but he was overtaken by events. Bengt Lindqvist, Minister for Health and Social Affairs in the Social Democratic government at that time, had recently established a commission to examine provision for people with disabilities, with a view to making recommendations about how support for this group could be improved (Dir 1988).<sup>4</sup> Because disability policy was already under review, Westerberg’s motion failed.

Lindqvist’s original directions to the commission stressed that it should identify possibilities for increased efficiency, despite the stated ambition of improving support for people with disabilities; under the stringent fiscal disciplines imposed during the 1980s, all new proposals had to be financed within existing public monies. However, in 1990, he gave new instructions to the commission, allowing it to propose reforms that could cost more than existing programs for people with disabilities. The revised instructions were the result of three motions by members of parliament from the Center, Communist Left, and Liberal parties, the last signed by Bengt Westerberg, all arguing for the work of the commission to be unrestricted. The commission delivered its report in the early 1990s, by which time a right-center government was in power—with Bengt Westerberg as Minister of Health and Social Affairs. In 1993, when the country was still in a serious economic crisis, this government passed the Disability Act. A personal assistance scheme was a central element of the new provisions for certain people with disabilities.

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<sup>4</sup> In Sweden, a parliamentary commission usually is appointed to investigate an issue before a Government Bill is put to the Parliament. The commission presents one or more Government Reports, which are discussed widely during a consultation process designed to provide feedback to the Government. Bills are drafted after the consultation process has concluded (Ministry of Justice 2007).

### 3.4.3 *Competition Over Resources? Layering in Long-Term Care*

One logical possibility for the government to respond to the emergence of a strong disability rights movement in Sweden would have been to reform the Social Services Act to specify a right to support for all people with significant disabilities, whether congenital or acquired, of any age. Yet, this was not the approach the government took. Instead of revising a policy that takes in *all* citizens who might benefit from more extensive support, the government chose to make separate provision for specific groups of younger disabled people only, in what can be understood as a new “layer” in the social care system.

Streeck and Thelen (2005) define “layering” as a form of institutional change that occurs when policy creates new organizational structures and practices (or “layers”) on top of existing institutions, which are more difficult to change. They argue that, because the process of “layering” does not directly undermine existing institutions, it is less likely to “provoke countermobilization by defenders of the status quo,” even though the new forms may undermine support for the traditional system by offering alternatives to particular constituencies. Thus, Streeck and Thelen (2005) argue, to the extent that new institutions “operate on a different logic and grow more quickly than the traditional system, over time they may fundamentally alter the overall trajectory of development as the old institutions stagnate or lose their grip and the new ones assume an ever more prominent role in governing individual behavior.”

The Disability Act enabled policy makers to meet the needs of a particular social group (people less than 65 with specific significant disabilities). Because services under the Act are aimed explicitly at people less than 65,<sup>5</sup> in the context of a growing population of older people, this approach also enabled the government to contain demand for costly services among another group with arguably similar needs (people with significant disabilities acquired after the age of 65). The new structures and practices established by the Act have different underlying logics from those under the SSA (the goals of the Disability Act are more ambitious than the SSA and the Disability Act confers rights to services, while the SSA confers the right only to assessment and appeal), and two systems have evolved divergently (the scale of provision under the Disability Act has grown, while provision under the SSA has shrunk). Moreover, there is evidence that increased expenditure on disability services is directly related to retrenchment in eldercare, through the mechanism of unbalanced growth identified by Streeck and Thelen (2005). Using data from 288 Swedish municipalities for the period 1998–2007, Birkelöf (2009) found that the rapid growth in spending on services to disabled people under the Disability Act (LSS) crowded out spending on services for older people and people with disabilities provided under the Social

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<sup>5</sup> People who begin to access services before they turned 65 are allowed to keep the (typically much higher) level of provision under the Disability Act, rather than be moved into the eldercare system. However, if they have personal assistance, they are not permitted any increase in the service offering, even if their needs change.

Services Act.<sup>6</sup> Controlling for the age structure of the population, the size of the tax base and the municipalities' levels of long-term debt, Birkelöf's model showed that for every increase of 100 SEK in LSS spending, spending on SSA services to older and disabled people declined by 42 SEK.

In summary, within the long-term care system, layering in disability services has led to spending growth and reduced reliance on family among those eligible, while rationalization has led to declining spending and coverage in eldercare, resulting in off-loading of care to the family and the market sector<sup>7</sup> (see also Szebehely and Trydegård 2012). While policy makers have intended the changes to disability services, they did not explicitly intend the informalization of eldercare or (before 2007) its purchase on the private market, outside the social service system.

### 3.5 Explaining Marketization of Swedish Long-Term Care

The rapid emergence and consolidation of a private sector is a particularly noteworthy phenomenon in the Swedish case, because the development of public services in Sweden has been so substantial in comparative perspective, and because these (public) services have been so central to the idea of Sweden as a universal or social democratic welfare state (see for example, Sipilä 1997). This section explains the introduction of competition and the growth of private providers within the tax-funded eldercare system as a process of *invasive displacement* of traditional public sector organization, with *layering* of market measures on top of existing public sector organizations, later amplifying marketization.

#### 3.5.1 *Displacing the Public Sector: Early Market Reforms*

Streeck and Thelen (2005) explain displacement as a process of institutional change that occurs when “new models emerge and diffuse which call into question existing, previously taken for granted organizational forms and practices.” New models do not emerge by themselves—in the case of invasive displacement, Streeck and Thelen argue, change involves “active cultivation by enterprising actors,” who import and cultivate “‘foreign’ institutions and practices.” Using Streeck and Thelen’s concept, we seek to explain which forms and practices have been called into question in Sweden. We ask which “traditional arrangements” have been “discredited” and which “new institutions” and “behavioral logics” have been created, and by whom.

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<sup>6</sup> The study also found that LSS spending also crowded out spending on education, but did not crowd out spending on other municipal social responsibilities, including childcare, social assistance, and culture and leisure activities (Birkelöf 2009).

<sup>7</sup> Younger disabled people with smaller care needs who are not eligible under the Disability Act rely, similar to older people, on services under the SSA, or on informal or market care, and they have been similarly affected.

The traditional arrangements of the postwar Swedish welfare state, before their partial displacement by competition and choice policies, are summarized by Blomqvist (2004) as publicly funded, publicly provided services aimed at offering high-quality services to all citizens. That the services were *public* was critical to social democratic reformers: “only by providing services *itself* could the state guarantee access to high quality social services for all citizens,” thereby achieving both equality and freedom from the market. Universality of high-quality services had a political goal, too, aiming to preserve “broad political support for the welfare system” by ensuring that offerings were attractive to *all* citizens—including the middle class (Blomqvist 2004, pp. 143–144). The behavioral logics of institutionalized public provision were based on high trust in the professionalism of public sector workers, and democratic steering and oversight of services at the local level. In practice, in homecare this meant that care workers had scope to negotiate with care recipients, which tasks would be performed and how (Eliasson-Lappalainen and Motevasel 1997; Szebehely 1995).

In elite discourse, public provision and the active citizen have been displaced as central to the goals of the Swedish welfare state since the 1980s, and a range of policies, proposed as “solutions” to the new “problems” that public provision posed for the Swedish economy and society, have since been enacted (Antman 1994; Blomqvist 2004; Green-Pedersen 2002; Montin and Elander 1995). Many of the reforms that have profoundly affected eldercare services targeted municipal activity in general, catching eldercare services up in their wake. Significantly, governments of both right and left have enacted market-oriented policies, although the intensity and intent of policy change under right and left governments has differed somewhat.

The process of legislating for market reform began in the mid-1980s under a Social Democratic government, which established initiatives to promote competition in the public sector, with the goals of increasing efficiency and quality. Both external (exogenous) and internal (endogenous) forces contributed to this shift in policy. Externally, what Streeck and Thelen (2005) call enterprising actors—in this case, the conservative party and the main employers organization, the Swedish Employers’ Confederation (SAF; today the Confederation of Swedish Enterprise) and neoclassically oriented academic economists—had begun to cultivate and import policy ideas foreign to the traditional arrangements. Inspired by British Prime Minister Margaret Thatcher, the 1980 SAF congress expressed the strongest neoliberal attack on the welfare state since the Second World War, arguing for market mechanisms and privatization of public services (Antman 1994; Svallfors 1989). A new, low-trust behavioral logic underpinned the proposed new institutional forms, which included contracting relationships between public purchaser and private providers. The behavioral logic of competition, rather than trust and professionalism, would drive efficiency and quality gains, ideally leading to a shrinking of the public sector.

Over the coming years, SAF consolidated its invasion strategy, significantly increasing resources devoted to propaganda activities while completing its defection from the previous tripartite (state, labor, and capital) consensus on the economy and the welfare state (Blyth 2001; Ryner 2002). SAF’s propaganda efforts included sponsoring market-oriented think tanks such as SNS and Timbro. Through publications

and seminars, which drew in academic economists, other opinion-makers, and senior figures from state agencies, especially the Ministry of Finance (MoF) and the Bank of Sweden, these think tanks became “vital agents in promoting change” (Blyth 2001; see also Ryner 2002). Actively promoted by Timbro, criticism of the public sector got a strong foothold in the media (Blyth 2001). The welfare state was described as wasteful, overly bureaucratic, and, above all, depriving the Swedish people of their right to choose freely which services they preferred (Montin and Elander 1995).

These efforts fostered a milieu in which economists, policy makers, and opinion leaders cohered into an epistemic community, centered around the ideas of neoclassical economics and New Public Management. This epistemic community provided intellectual authority to the private interests of Swedish big business, effectively constituting an “invading force,” seeking to discredit the traditional institutions of the Swedish welfare state.

This epistemic community had members inside the Social Democratic government as well as outside in SAF, SNS, Timbro, and the universities. Indeed, Streeck and Thelen (2005) argue that “exogenous change is advanced by *endogenous forces pushing in the same direction but needing to be activated by outside support*” (2005, p. 32, emphasis added). In this case, economists within the (Social Democratic) government acted as an endogenous force, activated by exchanges with academic economists, within international organizations (such as the OECD) and forums organized by SNS and Timbro (Ryner 2002). The key role of economists within the Social Democratic Party became evident in 1980—the year of the SAF congress—when the Social Democrats established an internal “crisis commission” to analyze the party’s loss of a second election in 1979. The crisis group was strongly dominated by economists, and its work arguably marks a starting point of the marketization of Swedish social policy. The Social Democrats were returned to power in 1982, and Kjell-Olof Feldt, a neoclassically trained economist and prominent advocate of public sector reform, was appointed Finance Minister (1982–1990; Ryner 2002). Among his other actions, Feldt “trebled the number of academically trained economists among top advisors within the Ministry of Finance” (Korpi 1996, p. 1729). Over the next few years, economists in and around the Ministry of Finance published several reports arguing for reorganization of the public sector—in a market direction (Antman 1994). Indeed, during the second half of the 1980s, virtually all publications from the Ministry of Finance came to advocate the introduction of various types of so-called “quasi-markets” in the social services sector (Blomqvist 2004).<sup>8</sup>

One example of the impact of Ministry of Finance economists on welfare policies is the Competition Commission, appointed in 1989 by the Ministry of Civil Affairs under a Social Democratic government. The commission focused initially on the private sector, but in 1991 received further instructions from the Minister to investigate how increased efficiency through competition would stimulate the development of

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<sup>8</sup> Particularly important was the 1987 Long-Term Survey, which suggested both limits on taxation and the introduction of market mechanisms such as a division between purchaser and providers and that private companies should be able to compete with public providers. The argument was that “the consumers’ free choice will show under which organizational forms an activity is best provided according to the consumer’s wishes” (Government Report 1987, p. 178).

the public sector. The market-oriented voice of MoF economists entered the commission via the Minister's instructions, which referred to the recent budget proposal that argued for increased competition and "market-type solutions by dividing between purchaser and providers" (Government Bill 1990/91:100, Appendix 2, pp. 33–34). This idea was acted on even before the report of the Competition Commission was published, in the new Municipal Act passed by the Social Democratic majority in 1991. The act allowed municipalities to introduce a division between purchasers and providers, and to outsource the provision of services to private companies.<sup>9</sup>

The report of the Competition Commission (Government Report 1991) was published in November 1991, just after the Social Democrats had lost the election, and the new conservative-led government had proclaimed a "Freedom of choice revolution." In 1992, the government presented a proposal (Government Bill 1992/93:43) based on the Commission's report, proposing further clarifications regarding the municipalities' right to outsource services. This proposal and its reception by the Social Democrats reveal something about the politics of privatization. The Social Democrats did not oppose either competition or for-profit companies in welfare service provision. Rather, they argued that the clarifications were not necessary for marketization, since the Municipal Act—passed by the Social Democrats—already allowed municipalities to contract out welfare services. They only expressed a fear that the suggested amendments might lead to private monopoly rather than competition. As Montin and Elander (1995, p. 38) argue, "A pragmatic and apolitical view of privatization was dominant in the government just before the election of 1991. When the non-socialist majority took their seats in government after the election, the former government had already partly paved the way for further privatization."

Comparison with Denmark sheds further light on the politics of market reform in Sweden. In Denmark, the impact of NPM or market reforms has been much more muted than in Sweden, even though Denmark has had longer periods of non-social democratic government. Green-Pedersen (2002) attributes this to the position the Swedish Social Democratic party has taken on marketization. As Green-Pedersen puts it: "Right-wing parties can be expected to be proponents of NPM reforms" (2002, p. 274), making support among Social Democrats critical to the enacting market reform—and in need of explanation. In the 1980s, under the influence of the epistemic community discussed above, the Swedish Social Democrats (by contrast with the Danes) had begun to view the public sector as part of the problem, not the solution (Antman 1994). Once Social Democratic parties positively embrace NPM reforms, Green-Pedersen concludes, "they will find it hard to change to a negative response" (2002, pp. 274–275). Having started down the marketization road, Swedish Social Democrats found themselves without strong arguments to combat the "freedom of choice revolution" proclaimed by the right-center government in 1991. The market-type reforms implemented by the nonsocialist government between 1991 and 1994 followed a path that the Social Democrats had laid down (Green-Pedersen 2002), and "the Social Democrats resumption of office at the election of 1994 . . . did

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<sup>9</sup> The same Minister was responsible for both issues, the Minister of Civil Affairs, Bengt K.Å. Johansson, former Assistant Minister of Finance.

not spell a return to the previous system to any appreciable extent” (Palme et al. 2003, p. 82). Thus, between 1994 and 2006, when the right-center coalition next regained power, there was a slow but steady introduction of market principles and private provision into tax-funded welfare services. A purchaser–provider model had been introduced by 10 % of municipalities in 1993, the year after the possibility had been opened up; by 2003, more than 80 % had introduced the new institutional model (Gustafsson and Szebehely 2009), and the proportion of for-profit private providers had begun its growth trajectory.

The fact that marketization in Swedish long-term care began as competitive tendering for large nursing homes and geographical areas of homecare, rather than with a customer choice model, is important in explaining the oligopolistic structure of private sector provision, with its two dominant providers. During the recession of the early 1990s, competition over price (rather than quality) dominated (Edebalk and Svensson 2005). This gave an advantage to larger for-profit companies, with their greater capacity to manage the bidding procedure, over small companies or not-for-profit organizations. Larger organizations could also underbid, if necessary, to enter the market (Government Report 2007). Once a larger company is established, further growth by acquisition is relatively easy.

### ***3.5.2 Consolidating the Market Model: New Layers, New Behavioral Logics, New System Dynamics?***

The pace of marketization increased with the change of government in autumn 2006, when new behavioral logics and new system dynamics were introduced through a process of layering. The new right-center government did not proclaim a “Freedom-of-choice revolution,” but its intentions in this direction became clear in spring 2007, when the Assistant Minister of Health and Social Affairs appointed a Freedom-of-choice commission. The commission’s task was to suggest new legislation to make it easier for municipalities to introduce consumer choice models in care for older and disabled people. The process was quick: the commission’s report (Government Report 2008) was published in February 2008; half a year later the Government Bill 2008/09:29 was presented to the parliament, and the new legislation *Act on Free Choice Systems*, came into effect on January 1, 2009. As argued by the commission, and echoed by the Minister, the goal of the legislation was to “move power from politicians to citizens, to increase the choice and influence of users and to promote a diversity of providers” (Government Report 2008).

The new law encourages municipalities to introduce customer choice models, with a quasi-voucher system. Legislative change was combined with financial incentives to municipalities to introduce the customer choice model. We characterize the introduction of this act as “layering,” because the stated intention is not to *replace* the old system with the new; rather, the new was to “function as a voluntary tool” to develop the market model. “In-house” (public) provision by municipalities remains one of the “alternatives open to a public authority” under the act, alongside purchaser–provider



arrangements introduced in 1992 (Government Report 2008) and the new customer choice “layer.” Although the new system has not yet replaced the old, a primary goal of the act is to promote the “differential growth,” which Streeck and Thelen argue is central to the system-changing dynamics established by institutional layering. Two aspects of the new legislation are designed to have this effect. One is that barriers to entry for private providers into customer choice systems should not be too high, to encourage entry of a diverse range of private providers; as the commission argues: “the higher the requirements set, the fewer the companies that will be interested in an agreement with the authority” (Government Report 2008, p. 29). The second is that, within the customer choice model, only private providers are allowed to offer additional services, with which customers “top up” the needs-assessed publicly funded offering. An explicit goal of this preferential treatment for private providers is to encourage the growth of “small enterprises” and to allow them to “increase their operation and reach a higher profitability” (Government Bill 2008/09:29, p. 123). The commission considered but ruled out allowing public care providers to offer “extra services”: “An option for a municipality to provide extra services can have negative consequences for small enterprises, including women’s enterprise, something that the Act on free choice systems is intended to encourage instead” (Government Report 2008, p. 34).

The behavioral logic of the new legislation is quite different from that of the earlier market reform, which introduced a purchaser–provider split. The logic of the earlier reform operated entirely on the supply side—to mobilize the discipline of competition within the public sector and/or between private providers. The new law seeks to bring the *demand* side into the competitive process, by enabling consumers, as well as local authority purchasers, to control which organizations offer services. The commission, as well as the Minister, expressed high expectations that the quality of services will be enhanced by the introduction of this new, demand-side, market mechanism: “It is the individual’s opportunity to choose and choose again that is the very core of the system and that is intended to help to maintain and further develop the quality of the services included” (Government Report 2008, p. 32).<sup>10</sup>

Evidence suggests that the Minister’s faith in customer choice as the core quality driver may be misplaced, not least because most service users are reluctant to change providers. A recent study found that only 4 % of the older homecare users in municipalities with choice models actually changed their provider during 2009 and one in five changes were because the provider closed down (Svensson and Edebalk 2010). Another frequent reason for changing homecare provider is that the older person’s ordinary homecare worker had moved to another employer (Fried 2007).

In practice, the ambition to empower older people by giving them the right to choose may have had the obverse effect—at least for those with fewer resources. The eldercare “ombudsman” in Stockholm (where customer choice and private provision are highly developed) notes that older people who complain to the city officials are advised to choose another provider. But what the older people want is for their

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<sup>10</sup> In contrast to the “real” market, the price is set in advance; thus the providers are expected to compete only with quality.

complaints to be properly attended to, without needing to change provider; they feel that the local authority is not taking responsibility for guaranteeing all individuals high-quality care (Stockholms stad 2010). Furthermore, while a customer choice model fits reasonably well with the aspirations and demands of the Independent Living Movement, especially for personal assistance schemes, there is no evidence that older people and their organizations have advocated for this service model (Edebalk and Svensson 2005). Research finds that although some older people appreciate being able to choose a provider, many find that choice stressful, and most find the ability to affect the actual tasks carried out to be more important (Hjalmarson 2003; Hjalmarson and Norman 2004).

The increased focus on consumerism and choice may, therefore, have different consequences for different social groups. Compared with young, physically disabled persons, frail older people are, in general, less prepared to act as customers. Therefore, there is an obvious risk for increasing inequalities when Swedish municipalities introduce choice models and tend to leave part of the quality control to these frail older “customers” by relying on them to make active choices and to complain (Svensson and Edebalk 2010; Swedish Competition Authority 2009; Winbladh et al. 2009). Individuals with more resources, such as higher education, will probably have an advantage in navigating the new landscape of care markets (NBHW 2011c).

The introduction of a customer choice model in publicly funded services combines with another measure introduced 18 months earlier as another “layering” reform that promotes the development of private sector provision in eldercare. In July 2007, the right-center government introduced a *tax deduction on household services and personal care*. Under this reform, taxpayers are entitled to deduct 50 % of the price of household services up to 100,000 SEK (close to € 11,000) per person per year if the service company has a business tax certificate. The services may be carried out in the purchaser’s own home or, significantly, in a parent’s home. The government expressed several goals when introducing the tax deduction, including gender equality (reducing the burden of domestic work and care for parents that falls primarily on women), bringing the gray economy “on to the books,” and promoting small business (Government Bill 2006/07:94, p. 94).

This deduction is available for all age groups and is not part of the eldercare services. Yet it clearly interacts with the eldercare system. In the vast majority of municipalities, older people with relatively small care needs and medium-high incomes would find it cheaper to use the deduction to purchase services on the private market, rather than use municipal care services. (These citizens receive a state subsidy for assistance via the tax system rather than a municipal subsidy via the social service system.) For those who choose a private provider for their needs-assessed homecare service, the deduction halves the cost of “extra services.” In practice, the combination of customer choice models and the deduction creates an incentive for well-to-do older people to choose private providers for their tax-funded and needs-assessed homecare services, which they can complement by buying extra services from the same staff, paying half the actual cost, thanks to the tax deduction. For the same social group of older people but with fewer care needs, the tax rebate serves as an incentive to entirely refrain from the tax-funded homecare and buy private services instead.

Evidence shows growing use of privately purchased household services in Sweden, now further encouraged by the introduction of the tax deduction. However, compared to tax-funded homecare services, the deduction is still used by fewer older persons (by 6.3 % of people 65 and older in 2010—up from 1.7 % in 2008—compared to 9 % using the needs-assessed homecare services from public or private providers).<sup>11</sup> The income profile also differs: the deduction is used mainly by older people with high incomes while the homecare services are (so far) used by all social groups (NBHW 2012b). In 2010, 14 % of older people with high annual incomes (more than 500,000 SEK) used the deduction, compared to 5 % of those with low incomes (less than 120,000 SEK). Furthermore, although average annual deductions were rather small (at an average of 2,800 SEK, which would purchase around 20 hours of help per year), older people with higher incomes deducted twice as much as those with lower incomes. This measure is also becoming increasingly costly: the figures for 2010 report expenditure of 1.3 billion SEK, up from 440 million SEK in 2008 (Statistics Sweden 2012).

A key feature of the “layering” of customer choice and the tax deduction is that older people with good incomes and larger care needs can use the deduction to top up with extra services from the same staff that provide their municipally funded care—if they choose a private provider. As Streeck and Thelen (2005) point out, citing Rothstein on the Swedish case, the risk is the loss of the middle class as a constituency for, and user of, public services. Although publicly provided, publicly financed services have neither been abolished, nor declared residual, the layering of customer choice and the household rebate promotes dualization within the eldercare system, such that they risk becoming residual services for the poor.

### 3.6 A Turning Point for the Swedish Model of Long-Term Care?

From one perspective, the Swedish model of long-term care, with generous, publicly funded, publicly provided services looks more or less intact; spending remains high, and less than a fifth of publicly funded eldercare services are in private hands. Yet, behind the national average of 19 % private provision of publicly funded eldercare services, there is wide variation between the municipalities. In more than half (54 %), there is no private residential care at all and in two-thirds (65 %) of the municipalities, all homecare services are publicly provided. In contrast, more than half of the homecare services and more than half of the residential care beds are privately provided in close to 5 % of the municipalities (NBHW 2011b).

Our account of the marketization of Swedish eldercare has emphasized the top-down push from the national government. The wide variation in the level of private

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<sup>11</sup> As the deduction is offered to all purchasers of domestic and care services, without needs assessment, it is not possible to determine whether these purchases are a direct substitute for publicly subsidized services offered via the formal care system.

provision of tax-funded services in municipalities raises questions about why this top-down push has been only partially successful, and about the likely future trajectory of marketization of long-term care, in Sweden. We cannot predict the future, of course. However, we can point to some of the processes that have been set in train by, and the interests that have emerged under, marketization policies.

Part of the explanation for local variation is the political color of governments in the context of strong municipal autonomy. Although Social Democratic national governments have been market-oriented, right-wing governments at both national and municipal levels have been more so. For example, in Stockholm, which has a conservative political majority, 60 % of the publicly funded homecare was privately provided in 2010 (NBHW 2011b), up from 37 % in 2006 (NBHW 2007). In Sweden's second biggest city, Gothenburg, which has a Social Democratic majority, all homecare was still in public hands in 2010 (NBHW 2011b). The cases of Stockholm and Gothenburg show that Social Democratic and right-wing politics do diverge, and that the combination of a right-wing coalition both at central and local level can make a difference. More comprehensive modeling has found that municipalities that are more middle class<sup>12</sup> and which have right-wing majorities tend to have more private eldercare (Stolt and Winblad 2009).

But this is not the end of the story. Cutting across this political pattern is evidence of a kind of geographical "contagion" of privatization. Stolt and Winblad (2009) found that privately managed eldercare was pioneered in metropolitan areas where right-wing majorities dominate, but that "surprisingly, neighboring municipalities tended to follow these pioneers *irrespective of their political colour or economic situation*" (Stolt and Winblad 2009, p. 903, emphasis added). This process of diffusion has meant that, even in municipalities with stable Social Democratic majorities, there has been privatization of eldercare. Sometimes, the municipality's economic situation is a precipitating factor, as the "seducing power in the neo-liberal process of privatization" (Stolt and Winblad 2009, p. 910) conquers the ideological hostility of Social Democratic municipalities in straitened financial circumstances. But the idea of "what worked for others must also work for us" (Stolt and Winblad 2009, p. 911) was in itself also important, and once introduced, privatization is rarely reversed. Furthermore, there is a real possibility that municipalities' capacity to choose to resist marketization may be legislated away in the future. In 2010, unhappy with the slow pace of change, the national government introduced further incentives for municipalities to introduce customer choice models during 2011–2014 (Government Bill 2010/11:1, p. 163). The Bill included the warning that "compulsory legislation would be considered" if all municipalities had not responded by 2014. Finally, the emergence of large corporate providers in long-term care creates a powerful interest in further privatization (Meagher and Szebehely 2010).

Over 30 years, a range of somewhat disparate reforms have rationalized eldercare, expanded provision for people with severe disabilities, and opened up long-term care services to the market. Together, through a complex set of interactions, these policy

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<sup>12</sup> As measured by a higher proportion of residents with university education and a higher tax base, both of which correlate to higher average household incomes.

changes have consolidated into a real threat to the universality of long-term care in Sweden. There are already signs of class differences in response to retrenchment of publicly funded eldercare services, as poorer people turn to family and richer to the market. There is not yet evidence of class differences *within* the publicly funded system. However, ongoing marketization may give incentives for more resourceful groups to leave the public system. If a class gap opens up *within* the publicly funded system, a vicious cycle of middle class flight and falling quality could become established. Over time, creeping selectivity could leave the poor with poor-quality services—precisely the outcome that universal services enable societies to avoid.

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