# Summary

Elder care is an important public service, demanding significant economic resources. Today, the costs of elder care amount to one fifth of municipal revenues. A marked trend is that more elderly people receive help in their own home, whereas fewer and fewer live in nursing homes. Elder care is also a service that is increasingly traded on a market; private providers now account for about 20 percent of all provision. Since 2009, the share of privately produced elder care has increased faster than previously. The increase has been steeper for home care and coincides with the introduction of user choice systems in a large number of municipalities, while the increase for nursing homes has consisted mainly of producers contracted through public procurement.

Just as for many other welfare services – as well as many services in general – the quality of elder care is difficult to observe and measure. The provider has better information concerning quality and this problem of asymmetric information is aggravated by third-party financing, i.e. by the fact that the user normally pays only a small fraction of the cost. In particular for home help, the user choice system is appropriate, especially if time spent at the user is registered electronically. The user's subjective assessment of quality is a good measure of true quality and it is not too cumbersome to switch to another provider. However, the low cost of entry in a user choice system increases the risk that opportunistic firms enter the market. Therefore, somewhat higher barriers to entry than today would probably be beneficial. For nursing homes the beneficial impact of user choice is hampered by the users' high cost of moving to another home and by the fact that medical aspects are more important – and more difficult for the users to assess. On the other hand, higher barriers to entry reduce the threat of entry by opportunistic firms. These differences also

make government supervision more important for nursing homes than for home care.

Compared with many other publicly financed services both home care and nursing homes appear to be well suited for privatization. An important argument to this effect is that the exercise of government authority (the decision that a person is entitled to help) is separable from the production of the services and so can remain with the municipality. According to the few available empirical studies, the quality of services does not appear to change in any appreciable way when external providers replace municipal in-house production. If anything, the Swedish experience suggests that the presence of private providers contributes somewhat towards better quality and efficiency.

The costs of elder care vary significantly between municipalities. The production units of many municipalities report deficits, which is likely due to the fact that the municipal in-house units find it hard to compete with private providers, especially since the introduction of time measurement. The introduction of a user choice system implies that the entitlement decision directly determines the cost of elder care. The new role of the case officers (or "needs assessment officers") as gate keepers will be a challenge for the profession.

Even if the users' stated perceptions and their choices are good quality indicators, there is a need for additional control of objective quality measures; by the municipalities as well as by the national government. Considering the emphasis on process and inputs when providers are authorized and selected, it is reasonable to shift focus towards results, including user satisfaction, when conducting supervisory control. We believe that surprise inspections should be used more often. Today, there exist many measures of the quality of elder care. Linking each of these measures to one well-defined purpose, e.g. supporting user choice, would increase their usefulness.

The key challenge for purchasers and other responsible authorities is to design contracts, rules and routines in a way that creates incentives for high quality. The fixed prices used in government procurement and in user choice systems prevent providers from charging a premium for high-quality services. However, high quality attracts users within a user choice system, although this mechanism will only be effective if there is excess capacity within the system. The formal procurement rules also

make the link between current quality and future sales volume at best tenuous. However, that link can be strengthened by standardizing post-performance references and by the municipalities implementing a policy with less mechanistic use of contract-extending options.

Barriers to entry are important in shaping the elder care market. For home care the barriers are small. However, large firms may hesitate to enter new markets with user choice if they cannot benefit from economies of density (since their potential customers live far apart) and if they face strong competition from small firms. For nursing homes the barriers to entry are higher. A firm that wants to enter the market must take on significant economic risk. Additional barriers exist due to requirements upheld by the municipalities and the national government.

Barriers to entry will weaken competition, which is a disadvantage as such. However, the barriers may also result in a more favorable selection of suppliers. High barriers to entry will impose a stronger deterrent for substandard firms, whose *modus operandi* is to make a quick buck. Properly designed entry requirements – e.g., good routines and qualified staff – will also reduce the cost of "doing the right thing". The existence of good profit opportunities (so-called quasi rents) in a market with barriers to entry will also give the firms incentives to perform well, so as to be able to remain in the market and continue earning those profits. Hence profits will also function as a safe-guard for quality – in addition to the more obvious social benefit of making investments feasible.

For user choice to be effective and quality improving, there must exist some excess capacity in the market. This is not always the case for elder care; many municipalities have a waiting list for nursing homes. Even if it is efficient from a static point of view to utilize all capacity, doing so will be problematic from a dynamic perspective as the providers do not have incentives to exert effort to reach full capacity. A similar problem will arise if users that abstain from making a choice of provider are, by default, slotted into nursing homes with low capacity utilization; a practice that is not uncommon. From the perspective of creating incentives for high quality, a better method is to slot those elderly into nursing homes with *high* capacity utilization or to homes that rank high in terms of user satisfaction and other quality evaluations.

Procurement rules make it difficult to transfer a particular tendered nursing home into a nursing home within a user choice system – except after a major restoration. However, a municipality can offer its elderly citizens an extended user choice system that encompasses homes within the voucher system proper, tendered homes as well as the municipality's own nursing homes. In our opinion, there is much to gain from such coordination. This is so, even if it will in practice be difficult to achieve full competitive neutrality between the three categories of providers, e.g., because of the renting cost for the facility.

For home care, economies of density suggest that a "pie-slice model" may be a good idea. The municipality can first procure home care within a few districts or zones and then, in a second stage, open up for competition between the different providers and across the zones. This method will offset the incumbency advantage of the municipality's own production unit. However, we have seen seemingly well-functioning systems in municipalities such as Nacka and Danderyd that introduced user choice in home care early on. A related model (proposed by the Swedish Inquiry on Public Procurement) would allow a municipality to procure home care from a limited number of providers (e.g., five), and then giving users the choice between those. This model combines economies of scale with an enhanced possibility of foreclosing dubious providers.

A key challenge when procuring publicly financed services is that market mechanisms combined with inappropriate rules may erode professional norms. Economic incentives as well as tight supervision can reduce the staff's willingness to "do the right thing". Primitive bonus systems, single-minded attention to processes and easily measurable targets rather than real results – in combination with procurement rules that make it difficult to reward high-quality provision – can result in a vicious circle, to the detriment of quality.

A well-designed system, however, which combines user choice, pre-delivery control and authorization, supervision and rewards in suitable way, may instead create a virtuous circle of quality competition. We believe that user choice should be a key building block of such a system. The users' active choices should provide the incentive to deliver high quality. When a good reputation becomes a good investment, the market can in fact strengthen professional norms.

High quality can be upheld by for-profit as well as by non-profit providers – but by means of different incentives and mechanisms. Even though empirical studies – mainly from the United States – indicate that non-profit nursing homes deliver slightly higher quality than for-profit homes, it is difficult to generalize to the Swedish situation and arrive at policy conclusions regarding the type of preferred provider. We therefore call for letting all three types of organizations – public, private for-profit, and private non-profit – compete against each other to give the most suitable organizations and units the chance to show how to achieve the best elder care possible.