Providing Welfare:
The Importance of Public or Private Actors in Welfare State Regimes.

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Introduction

The focus of this paper is contemporary changes in the Social democratic welfare state regime. Most studies of changes in the welfare state regimes have focused on retrenchment in terms of adjustments in the social insurance systems. The main conclusion from this research is that the Social Democratic Welfare state is mostly intact and that the same values as before guides the policy (see e.g Pierson 2000; Lindbom 2001). Even if the original measures of welfare regimes concerned only social transfers, the most defining feature of the Social Democratic Regime is that it provided welfare services on a totally different scale than all other countries outside Scandinavia (Lindbom 2001, Esping-Andersen 1999).

The conclusion that the Social Democratic welfare state have not changed that much can be argued to miss an important point, namely that there has been significant changes in the way social services are provided (Blomqvist 2004). The service sector has become more market-like with private and public actors competing to attract the "consumers". The point of departure of this paper is that the organisation of welfare services is crucial when analysing changes in this welfare state model (cf Clayton and Pontusson 1998).

In the paper I emphasize, in particular, the organisation of welfare services as an important part of the character of a welfare state. This is illustrated by an analysis of contemporary Market-oriented reforms in Sweden, where private companies are allowed to compete for clients on the welfare service market on equal terms with existing and new public service providers. The Centre-Right Government’s main purpose with the reforms is to empower the citizens by giving them the right to freely choose between different welfare service providers according to their own preferences. Sweden has, since Esping-Andersens seminal work, often been pointed out as the most typical Social Democratic welfare state regime (Esping-Anderson 1990). This makes Sweden an especially interesting case if one is to draw conclusions about changes in the Social Democratic welfare regime.

Traditionally, social equality has been defined as the core value of the Social Democratic welfare state, which has underpinned social reforms in order to transgress social cleavages (Esping-Anderson 1990). The market-oriented reforms aiming towards different forms of privatisation that has taken place in the welfare service sectors in the Scandinavian countries since a couple of decades, might challenge this value. It can be argued that welfare state values and market values are hard to combine. Social Democratic welfare states builds on principles of universality and entitlements that is in conflict with

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1 This paper is a part of the research project "Freedom of Choice or Political Control? Swedish Parties' Ideas of Welfare State Organisation", led by the author.
the market principle of relying on effective demand to bring forward service supply (Taylor Gooby 2004).

The conclusions about the changing or non-changing character of the Social Democratic welfare state model is obviously depending on what part of the welfare state is analyzed, but also on what indicators for change that is used. One indicator that has been widely used is to focus on policy decisions about (cutbacks in) benefit programs, used for example by Pierson (1996, 2001) and Lindbom (2001). Another indicator is if the outcome of the political decision leads to actual change in terms of for example an increase in social stratification, which in turn gives the conclusion that the value of social equality have lost in significance (Blomqvist 2004, Blomqvist and Rothstein 2000, Clayton and Pontusson 1998).

If values like social equality are to have any impact on welfare politics, they have to be embodied in political decisions on welfare policy. Since values are carried and expressed by actors (see e.g. Berman 1996) I suggest that in order to draw conclusions on the significance of welfare state values, it is important to focus on the decision makers and analyze their preferences and motives. The welfare state can be viewed as an institutional structure, shaping the preferences and ideas of the decision makers (e.g. Immergut 1998, March and Olsen 1989). This means that the politicians in Social Democratic Welfare state should at least consider social equality when they construct welfare reforms and that decisions concerning privatisation should be mediated or affected by the desire to ensure social equality. The debate and the policy can be expected to contain considerations about social equality and a desire to diminish the effect of social stratification. In this paper, an analysis of the norms and values as expressed in the political parties’ arguments concerning welfare state reforms is suggested as an additional way of drawing conclusions about the character of the welfare states of today. If the Social Democratic welfare state is still the same, institutionalised values such as social equality should be reproduced by the political actors in their decision making. At least we should expect that the political actors should consider the implications for social equality when major reforms of the welfare state is undertaken. If social equality is (still) the core value of the social democratic welfare state, it is reasonable to expect that equality is mentioned or used as an argument in the debate concerning important welfare state reforms. Especially if the reforms from one point of view can be argued to directly put this value into jeopardy, such as privatisation of welfare state services.

The more general questions that this paper wants to contribute to address is: Has the recent reforms in Sweden brought the most typical Social Democratic welfare state one more step away from the ideal typical regime? Can this welfare state still be viewed in the same way in a comparative perspective given the recent change in the organisation of the welfare services?
The first more specific research question in this paper is if, and in that case how, social equality is expressed by the political parties in the debate concerning the Swedish Centre-right government’s reform about consumers’ choice in primary health care. This reform gives people right to choose freely between publicly financed private and public care givers (see further below). Does the parties – and in that case which ones – express concern that social equality might be in peril with the implementation of this reform and in that case, is any measures taken to ensure that social equality is prevailed? If the parties no longer consider social equality in welfare state reforms, the core value of the social democratic welfare state may be changed or at least be argued to have lost in significance. The empirical study consists of an analysis of the parties’ arguments for and against the reform. The results shows that most of the arguments against the Government’s reform can be interpreted as equality-related while the arguments in favour of the reform mainly focus on other values. The equality arguments is expressed mainly by the opposition parties and especially by the Left Party. These arguments focus above all on the consequences of the health care providers’ right to establish where they wish, which the opposition parties argues to have negative impact on the right to equal access to good quality health care.

Regardless if the politicians include equality considerations in their decision making, the actual consequences of the reform might bring inequalities. As previous research indicates (see further below), reforms that involve freedom of choice may lead to stratification patterns in service consumption, the problem for social equality being that high status groups might make more active and different choices than groups with lower status, something which in turn may lead to inequalities when it comes to the quality of the health care provided. This is not a self-evident consequence though, since it can be argued that the effects depend on the point of departure. The possibility to choose between welfare providers may in fact lead to increased equality if the situation before the reform have been characterised by inequality in for example access to good quality service. Those who are discontent with their former designated welfare service provider may in a consumers’ choice system choose another that is considered to have a higher quality which might lead to that stratifying patterns depending on for example which area you live in are broken. If consumers’ choice in health care brings stratifying patterns and thus is eroding social equality, is thus an empirical question.

The second specific research question that is addressed in this paper is: Does the possibility to choose health care provider freely seem to have stratifying effects among the consumers? If this is the case, the contemporary welfare state reforms in Sweden undermines social equality irrespective of the decision makers intentions. The question is answered by an analysis of a survey where Swedes have answered questions about the health care reform. The results shows that there are some differences between
social status groups where those with higher education, non-manual workers, and people living in high resource areas tend to make active choices to a higher extent than others. But at the same time, a majority in all groups makes an active choice of health care centre, thus using the possibility to choose from both public and private health care providers.

In the next section of the paper, market-oriented reforms in Social Democratic Welfare states (focusing on Sweden) is discussed. The following section discusses Market-oriented reforms as an ideological issue, and the next how social equality theoretically speaking can be threatened by such reforms. After a brief methodology section, the empirical results and conclusions are presented.

The Social Democratic Welfare State and Market-oriented reforms in the Public sector

The welfare state regime categorisation developed by Esping Andersen were initially used to explain expansion of welfare states but have also been used to explain welfare state restructuring and retrenchment (Pierson 1996, 2001). The social democratic welfare states are characterized by egalitarianism, universal coverage of citizens and a generous social policy aiming to minimise citizens' dependency on the market (Esping-Andersen 1990, 1999). Social democratic welfare regimes have traditionally tried to diminish the role of the market’s tendency to form social stratification patterns.

The value of equality have defined the character of the nordic welfare model (Esping Andersen 1990). As a consequence of the embracement of equality as a primary value, the public welfare sector is traditionally extensive and the private sector has been given limited space, in order to give citizens equal access to welfare services. Access to services should, according to this model, be based on need, not wealth. Additionally, the social services should be the same for everyone, and because of that they have been constructed in a unitary way and provided by the public sector. The consequence of equality as a foundation for the organisation of welfare state services has thus been that citizens on equal conditions has been given access to public welfare services such as school, health care and care (Blomqvist and Rothstein 2000).

New Public Management inspired reforms in the public sector has aimed in different ways to introduce private alternatives. The recent Welfare State reforms in Sweden changes the mix of public and private welfare services and is a way of “contracting” or ”contracting out” public services which means that public agencies delegate responsibility to private firms to conduct services in for example elder care although financing and regulation is the responsibility of the public agency (Trygdegård 2001, Winblad and Stolt 2009). Private firms compete to get the responsibility to run a service, and the public agency choses a provider which is both cost effective and promises the best quality (Stolt and Winblad 2009).
The arguments in favour of privatization that have been pointed out in the academic literature is for example cost efficiency and cost reduction, improvement of service quality and increased user satisfaction (Green Pedersen 2002; Kastberg 2010). The arguments against privatization have mainly focused on the decrease in democratic control over welfare state services and the risks that such reforms will increase social segregation and social inequality (Blomqvist and Rothstein 2000; Kastberg 2010; Lundqvist 2001).

The development towards an increase in privately provided welfare services in Sweden can be said to have started with the critical debate about the welfare state during the 1980’s. The criticism was for example that the welfare state bureaucracy was too inflexible to meet the peoples needs (Rothstein 2010). Also, the finances for the local governments was getting problematic. During the 1980’s there was thus some reforms allowing (local) government to purchase services on behalf of the public.

Blomqvist (2004) and Blomqvist and Rothstein (2000) results show that social stratification have increased more or less in Swedish welfare state services as a consequence of privatisation reforms. In the case of health care, they find evidence that indicate that the highly educated have proved more likely to use their right to choose care providers. Additionally, there is no evidence that private care providers offer a better quality. In primary education, the conclusion is that private providers tend to be over-represented in high income areas. Also, children of parents with higher education and higher income are overrepresented in private schools. Stratification in the primary school system, where some schools become elitist in character and others get a bad reputation, is mainly due to the different choice patterns of the parents. The same goes for child care, where patterns of parental choice - where children of the highly educated are overrepresented within the private sector - and patterns of regional establishment of private childcare leads to social segregation. Also in elder care, there are stratifying tendencies because of an increase in private alternatives. Elderly people with low incomes rely increasingly on their families, while elderly with better incomes turn to the private sector for care and help (Blomqvist 2004, Blomqvist and Rothstein 2000. Se also Szebehely 2000).

Blomqvist (2004) argues that these stratification tendencies undermine the solidaristic character of the Swedish welfare system and also that the welfare state is governed by other values compared to the period before the 80’s: The values guiding the Social Democratic welfare state in its heydays was aimed to shield the public sector against market forces, in order to promote the goal of social equality. Values like consumerism, individual rights, economic efficiency and private initiative are stronger today which means that a policy re-orientation has taken place in the Swedish welfare state since the public sector is, from the 90’s, seen as mainly a service producer instead of an instrument of social transformation (and promoter of social equality).
Market-oriented reforms as an ideological issue

In the beginning of the 1990's, the Centre-right government in Sweden started introducing "the choice revolution", with the purpose of giving the citizens the right to choose welfare services. The Social Democratic government that returned in office 1994 continued the development, which indicated that the ideological positions when it comes to privatisation was not as polarised as before. The Social Democratic party have initiated and supported market oriented reforms, but on the other hand still advocates a strong public sector and an ambivalent stance towards private actors in the welfare state (Stolt and Winblad 2009, Green Pedersen 2002).

In the Swedish case, several researchers concludes that the debate on privatisation of welfare state service have been characterised by ideological conflicts, although there has also been some arguments of a more pragmatic or strategic kind (see e.g Lundqvist 2001; Feigenbaum m fl 1999). Trygdegård (2001) concludes from an analysis of the local municipalities that there was a correlation between the share of votes for the largest right-wing party and the numbers of employees in the private elderly care sector. A more recent study of the swedish elder care corroborates these results, showing that right-wing representation in the local municipalities is still associated with a higher share of privately employed workers (Stolt and Winblad 2009). Bendz and Johansson (2008) concludes that there is a correlation between political majority and the share of privately provided welfare services in the local municipalities.

In the New Public Management research area, there are some indicators that party politics have some significance for the exention to which NPM-reforms have been introduced when it comes to privatising public services. At the same time, few studies within this research tradition have considered parties as actors, which indicates that there is a need for New Public Management research to bring the parties in (Green Pedersen 2001). Privatisation can thus be seen as not only a necessary adjustment to economic or other structural circumstances, but also as a party strategy to appeal to certain groups in society for example (Feigenbaum et al 1999). This is an explanation put forward by Baggesen Klitgaard (2007), who explain why Social Democrats in for example Sweden and Denmark choose deliberately to introduce and support NPM-reforms even though it could be expected from power resource theory that these parties should avoid reforms that risk to increase social stratification. The reason is that market oriented reforms implies a risk of undermining the conditions upon which different societal groups are prepared to cooperate for social protection. And so also the mechanism that links social democrats to power is put to risk. If citizens no longer support only publicly provided service with no freedom of choice, (even) Social Democrats can be expected to act.
Consumers’ choice in Swedish health care was implemented by the Centre/right government in 2010. If the assumptions of regime theory is valid, even the right wing parties should express considerations about social equality, although less than the left wing parties. The ideological cleavage concerning privatisation implies that we should expect that Social Democrats and left-oriented parties is more concerned about social equality than right wing parties and that they should be more negative towards reforms that allow the market forces to risk leading to an increase of social stratification.

The (potential) threat to Social Equality

In what ways is social equality as defined in Scandinavian welfare state policy threatened by marketisation reforms? Freedom of choice and competition isn’t necessarily a problem for citizens’ equal access to welfare services. A problem will arise if there are differences when it comes to the capacity to make choices, for example between those with high and low education. Then the allocation of resources is at risk of becoming more unequal. It has been pointed out that the problem with freedom of choice is the gap between demand and need. That a person in an objective meaning has a need for a certain type of education or health care, does not mean that he or she has the ability to express this by exercising the right to freedom of choice. This, in turn, means that the principle of equality in the sense that needs should guide the allocation of resources is weakened (Blomqvist and Rothstein 2000).

The phenomenon of creaming, that producers of welfare try to address only people with good resources, is a well known problem for equality. Equal treatment as a principle is put aside if citizens or groups of citizens is not given access to services on the same conditions as everyone else, by the producer. The risk of creaming can be modified by the rules surrounding the services. In the Scandinavian Welfare model, an important goal is that every citizen shall have equal right to welfare services of equally good quality. It is contested whether competition between welfare service providers increase the quality of the services or not. The proponents argue that competition forces the providers to keep a good quality to attract clients, while the opponents argue that service providers will try to cut costs as much as possible to make profits (Blomqvist and Rothstein 2000, Kastberg 2010).

According to the Swedish National board of Health and Welfare, equality in health care as defined for example in Swedish health care laws, means that the individual citizen’s access to health care shall not be affected by geographical, demographical, social, linguistic, religious or cultural circumstances. When evaluating consumers choice in health care, the authority’s focus is therefore on establishing if everyone, irrespective of education, ethnicity and socio-economic group gets equally good health care.
Additionally, the value of equivalence refers to that the citizens’ needs shall be met according to the same principles irrespective of where they live: The supply to health care as well as access and quality shall have equivalent status all over the country. (National Board of Health and Welfare 2011).

To conclude, the more precise meaning of social equality in this case is that everyone is ensured equal access to welfare services and is treated equally by the service producers. Also, need should guide access to health care, not the (different) ability to make (rational) choices. Stratifying patterns among consumers of health care may arise if groups that can be considered as having a high status make other choices than those with low status, for example if consumers with high education tend to make more active choices – and/or other choices – than those with lower education. Additionally, creaming by producers violates the principle of equal access to welfare.

**Methodology**

Consumers’ choice in health care was processed and discussed in the Swedish Parliament during 2008/2009. The government 2006-2010 (as also from 2010) was a coalition consisting of the largest right-wing party, the liberal/conservative Moderate Party, the Liberal party, the Centre party and the Christian Democratic party. These parties formed an alliance before the election 2006 and thus jointly stood behind the reform. The parties in opposition were the Social Democratic party, the Green party and the Left party.

In this paper, a tentative analysis of two indicators of the alleged change in the Scandinavian welfare state’s core value are presented. This analysis is to be further developed and expanded in a future article and the results are thus to be seen as preliminary. The empirical analysis consists of two parts. The first is a qualitative text analysis of the arguments for and against the consumers’ choice in Swedish primary health care reform. The government’s as well as the opposition’s arguments is analysed in order to establish if social equality as a value is expressed, considered and/or defended and in that case by what parties. The indicators on social equality as discussed above are used as a preliminary frame of analysis. (A fully elaborated frame of analysis based on theoretical definitions of equality will be used in the forthcoming more thorough analysis.) The material consists of public documents from the Swedish parliament (proposition, motions, debate and so on).

The main purpose of the analysis is to draw conclusions on if and how equality is expressed in the arguments. The point of departure is that how the parties express themselves rhetorically, matters. The parties’ “real” motives behind their statements for or against consumers’ choice in health care are difficult to reveal, particularly in this limited analysis, but the rhetoric should be a good indicator. For
example, if the parties think that equality is in accordance with the party’s ideas and/or important to
the voters they will probably make an effort to use equality as an argument in the debate. If and in that
case how the political parties use social equality in their arguments is thus seen as an indicator on how
important it is for them to sustain social equality as a foundation in the welfare state area.

The second empirical study is an analysis of the outcome of the health care reform, as expressed by
how Swedish citizens have used the possibility of choosing primary health care provider. The question
to be answered is if there are any tendencies of stratifying patterns of choice in this case. The method
of investigation is statistical analysis of existing survey data. The survey was sent out to a random
selection of 6000 persons in West Sweden in September 2009, including the second largest city in
Sweden (Gothenburg) and the response rate is about 60%. Since the survey was not sent to a random
selection in the whole country, it is possible that the results is not entirely representative for the whole
population in Sweden, although is has proven to be the case before that the respondents in this part of
Sweden (consisting both of larger cities, towns and country side) is in fact quite representative of the
whole country in many respects.

In the survey (consisting of a large number of questions concerning politics and media), there are two
questions concerning consumers’ choice in primary care, one which asks about the respondents’
opinion about the reform and the other if the respondent has yet made a choice of primary health care
centre. In this paper, the focus is on the second question since an analysis can say something about
tendencies of stratification among groups when it comes to patterns of choice. When the reform was
implemented, the citizens were sent a list of possible choices (all private and public health care centres
in the region). From this list, they could either choose freely among the alternatives or, by not making
any other choice, choose the health care centre they were suggested (normally the one closest to where
they lived). As it is possible to make an active choice of the suggested health care centre, this alternative
was included in the survey answers.

In the analysis, the respondents are divided into groups in order to make comparisons between groups
with different social status. The indicators on social status are subjective family class, level of education
and residential area. Subjective family class is a question where the respondents were asked about what
kind of family they thought they belonged to. The alternatives are connected to working-related class
indicators (manual worker, non-manual workers and so on). Level of education is a variable
constructed from a question where the respondents were asked about their highest level of education,
ranging from primary school to academic exam. As regards residential area, this only applies to the
citizens of Gothenburg, which is divided into local districts. In the survey, the respondents can be
grouped according to which kind of district/residential area they live in. In some districts, the
inhabitants have good income and high education, while in others the general level of education is low and the family income lower than average (and there are also districts that can be placed somewhere in between). There are, thus, some district-related segregation in Gothenburg that is used here as an indicator on social status. There are other possible indicators to measure social status, such as income, but the analysis in this case is a bit limited to the questions asked in the survey.

**Freedom of choice in the Swedish Public Service Sector**

Consumers’ choice in primary health care builds on The Act on System of Choice in the Public Sector (“Lagen om Valfrihet”, LOV) which was implemented by the centre-right government in 2009. The Act opens the opportunity for the local municipalities to let private companies compete on equal terms with the public sector organisations for the providing of welfare services within health care and social services. The users may choose between different suppliers, both private and public. The economic compensation given to the suppliers is set by the local authorities. The service is financed publicly, through tax money. The suppliers compete on the market by offering services with as good quality as possible, not by providing the cheapest possible service. Public and private service providers must be treated equally by the authorities. A contracting authority that has decided to use the Act in one or more welfare state service areas must publish this, along with relevant document, on a national web site set up for the purpose. Every applicant meeting the demands specified in the authorities' documents is then allowed to establish themselves on the market and compete for service users. The contracting authority is obliged to inform the users of the available options.

Since The Act on System of Choice in the Public Sector is not mandatory for the local municipalities, not all municipalities have chosen to use it although the majority has at least in some service area. The intentions of the government is that every municipality should use the Act on all areas allowed, and their aim is to make the act mandatory from 2014. (Due to the somewhat tricky parliamentary situation where the government have not got a majority of the mandates in the parliament, it is not possible today to say if this will come true.)

The Act on System of Choice in the Public Sector can be characterised as a form of consumer’s choice, which is defined by that there are at least two providers for citizens to choose between in a certain service area (Edebalk and Svensson 2005). Consumer’s choice is a part of the broader idea of New Public Management, where the public sector adopts principles from the private sector such as competition between companies in order to create higher quality and freedom of choice (see for example Hood 1991). The general idea with consumers’ choice is that the politicians uses the active choice making of citizens to organise the public services, instead of deciding how these services should
be organised from the top. The citizen’s own preferences and interests affect which service providers will remain on the market. For consumer’s choice to create the freedom of choice that is intended, it is necessary that there are several actors that compete for the customers. An important feature of consumers’ choice models is that the service producers don’t compete by offering as low prices as possible, but by offering the highest quality possible for the money they get from the public finance system. The main motive for introducing consumers’ choice is to grant the citizens influence over the welfare services, the alternative being that the state (on some level) decides on what service the citizens get to use. To give citizens direct influence over the welfare state services is also put forward as a democratic argument. Another argument for consumers’ choice is based on the assumption that people are perfectly capable to decide for themselves and thus have a right to make choices when it comes to welfare services (Kastberg 2010).

Since 2010 The Act on System of Choice in the Public Sector is applied in primary health care, meaning that private and public providers of primary health care are allowed to establish in the counties, which is the local level that is responsible for health care in Sweden. This health care reform is mandatory. The county politicians decide the terms and conditions that the health care providers are to fulfil, and every provider that fulfils these conditions are allowed to compete with other providers for the patients. Every county council is allowed to determine the economic terms, including how much money the providers get for each patient and also if the economic replacement should be higher in some areas of the county in order to encourage providers to establish there. The citizens then get the possibility to choose between the public and private providers available in their county.

**Consumers’ choice in Swedish primary health care - the political arguments**

In this section, the results from the empirical analysis of the political arguments is presented. I start with the government’s motives for implementing consumers’ choice in primary health care and proceed with the political opposition’s main arguments against the reform. The present government in Sweden (from 2006) consists of a coalition between right-wing/liberal parties with the Moderate party as the largest one, while the Social Democratic party is since 2006 the largest opposition party, consisting also of the Left Party and the Green Party.

The government’s main purpose with the reform is to strengthen patients’ influence over their health care by making it possible to choose between care givers in primary health care (primary health care centres). To make this possible, it is according to the government necessary to allow both public and private care providers to establish in primary care. The competition between health care providers is additionally expected to have the positive effects of increased cost effectiveness and better quality. The
quality of health care is expected to increase as a consequence of patients’ rights to choose the health care centre they prefer, and switch to another if they are not content. By letting the economic compensation follow the patient if he or she chooses to leave one health care centre for another, the patients’ rights to choose is further strengthened and also gives the health care centres incentives to keep a good quality. Another positive effect according to the government, is that the supply of health care will increase, making it possible for patients to have access to good quality health care when they need it (proposition 2008/09:74).

Even though the reform is mandatory for the county councils, they are allowed to formulate rules as well as how the economic compensation to the care givers will be organised. In order to create the desired right for everyone to have a choice in primary health care, the government allows the county councils to adjust the economic compensation to local and regional needs. Even though private and public caregivers are to be treated equally as to economic compensation, it is not necessary to apply the same economic compensation in the whole area. The government points out that it might be a good idea to for example pay more to those providers that establish in more sparsely populated parts of the area, to encourage establishment there (proposition 2008/09:74).

The government’s arguments refer to values such as citizens’ right to freedom of choice and influence when it comes to health care, as well as the positive effects of competition such as lower costs and higher quality. There are few direct references to equality, other than general statements, for example that it is important that all citizens have access to good health care, wherever they live (equal access). There is, however, one instance where the government more specifically discusses equality issues. In the proposition they conclude that it is vital that every citizens get the opportunity to choose between care givers. The citizens must be given the possibility to make rational choices according to his or her preferences. If this is to be fulfilled, it is important that the information about the available alternatives is good and available for everyone. Since all patients don’t have the abilities to make choices of their own (for example very sick older persons), it is the county council’s obligation to make information accessible to all groups and also to make sure that those that can’t or don’t want to choose is directed to an alternative which is known beforehand. This can be interpreted as a way to trying to prevent inequalities between groups with different abilities to choose.

The opposition parties (Social Democratic Party, Green Party and Left Party) all suggest in motions as well as reservations in the Committee of Health and Welfare and in the debate in the parliament, that the government’s proposition should be turned down. Several of their arguments refers to equality. Apart from this, these parties also criticises that the consumers’ choice model is made mandatory for
the county councils since this violates the principle of local self-government, but this is not discussed further here since this argument doesn’t relate to equality.

The main argument against the government’s proposition is that the new law will allow (private) care givers to establish where ever they want in the county council’s geographical area. This will, according to several Social democrats in a party motion, lead to a risk that the supply of primary care units will depend on how costly or profitable it is to carry on business in different areas of the counties and for different groups. In these areas and in the country side the supply will probably be limited and/or of lower quality according to the Social Democrats. In a publicly financed area like health care the market should not decide the distribution of the common resources. The local county councils should therefore be allowed to steer the resources and establishments to the areas where there is need for health care. (motion 2008/09:So10). This opinion is also brought forward by four Social Democrats in a motion where they refer to the situation in Stockholm, where several health care centres have established in the city centre where there are already enough such units. Their point is that tax money should not be wasted on over-establishing health care where it is not needed. The resources should instead be allocated according to need and justice. Patients’ right to high quality health care must be more important than the providers right to establish where they find it most profitable (motion 2008/09:So11).

The Left Party is clearly the most critical towards the reform and also the party that most strongly emphasises the principle of social equality. In their opinion, publicly financed health care should be provided by public health care units - not private companies. They are against competition and private profits in the welfare sector. They point out that health is closely related to social status, where those with lower incomes suffer from bad health in a higher degree than those with higher incomes. As a consequence, the need for health care looks very different in different living areas and different parts of the country. The party think that the government’s reform will deepen the cleavages between social groups. One reason is that it is more profitable to establish health care centres in areas with high social status, thereby deliberately choosing the patient groups living there. In their opinion, the government’s proposition takes no consideration of the fact that the need for health care differs across the country and between groups, and thus the reform will contribute to increased health cleavages. (motion 2008/09:So12).

In the Committe on Health and Welfare, where the proposition is discussed and prepared, the three opposition parties join in a reservation, focusing on the question of free establishment with the same arguments as above. They fear that the governments proposition will lead to increased cleavages when
it comes to health. They emphasize that it is the politicians’ responsibility to ensure that citizens have equal access to health care, and that health care have equally good quality everywhere. Health care is to be considered a social right, not a commodity on a market (Committee on Health and Welfare, 2008/09:SoU9).

In the debate in the parliament, the arguments from both sides are further emphasised and sharpened. One Social Democratic Parliamentarian stresses that the principle of need should guide the health care politics, not market principles. The principle of need is in danger since health care providers will choose to establish health care centers where it’s most profitable, not where there is need for health care such as areas with many old and sick people. The representantative of the Left Party goes even further and argues that the reform will allow profit to be the guiding principle for Swedish health care. Also, she critiques the government for not taking into consideration the fact that bad health and the need for health care is something that is very unequally distributed among the people. This means that health care companies probably will choose to establish health care centers in areas with high social status thereby trying to attract high status groups, while no one will want to establish health care centers in low status areas. This can be interpreted as an equality argument, since she argues that the health care reform will lead to inequalities. And the risk is that underprivileged people will have another (and not as good) health care as others.

The representative of the Green party agrees that freedom of choice is an important right in a democracy. In the party’s opinion there is a clear risk that the supply of health care will be smaller and of less good quality in areas where there can be expected to be a lot of costly health care, and also in areas that is sparsely populated. Also this representative points to inequality as an unwanted consequence of the governments’ reform. He asks how the government is to ensure that all patients get the health care to which they are entitled, especially in the country side and in the suburban areas surrounding the bigger cities. Since the providers decide where to establish, it is in fact they who gets to choose patients instead of the other way around. Also, he points out the risk that the reform will in fact mean that there will be a transfer of resources from groups with a high need of health care, to groups that the need is not as great. The consumers’ choice in health care can thus lead to that inequality between groups with different needs of health care increases.

Discussion

A general conclusion from the analysis is that equality arguments are still expressed by Swedish politicians, but to a different extent depending on the ideological position of the party. The strongest defenders of equality is the Left Party, while the Social Democrats and the Green Party seem to worry a bit less about social cleavages although they strongly emphasize the principle of equal access. In their...
opinion, it is possible to combine equality and freedom of choice, while this is problematic according to the Left Party. Also the government parties express some concern about social equality, but emphasize other values (such as freedom of choice) more strongly in their argumentation. The difference between left and right when it comes to NPM-reforms thus seems to prevail in Swedish Politics. To note in general is that for the Social Democratic Party, the notion of freedom of choice for citizens is considered as a positive thing, so also for the Green Party. The only party that does not confess clearly to this principle, is the Left Party.

The main equality problem with the reform is, according to the opposition parties, that providers are allowed to establish where they want. This is argued to lead to problems when it comes to the right to equal access to good quality health care for all citizens since the providers will choose to establish mainly in “good” areas. This will lead to an indirect form of creaming according to the opposition, since the health care companies by choosing a special geographical area also chooses the kind of (well-off and healthy) people that live there. To avoid this, the establishment should be controlled politically. According to the government, it is enough to allow the county council to organise the economic compensation in order to give health care providers incentives to establish in certain areas. Thus, they are against the idea that politicians should interfere with the market too much in this respect but still express some concern about equal access to health care by allowing county councils to vary the economic compensation.

The principle of need as a precondition for equality is also expressed in the debate, mainly by the Left Party but also by Social Democrats. This principle is considered to be in danger for the same reason as the principle of equal access, namely because of health care providers’ right to establish where they find it most profitable instead of where there is need.

The opposition parties express the risk for social cleavages among groups, most clearly by the Left Party. As pointed out above, a difference between this party and the others is that they don’t think freedom of choice is a good principle in the welfare state area. The Social Democrats and the Green Party agrees with the government in that freedom of choice is positive, and they don’t vocalise any worries that the possibility to choose in itself would lead to inequality.

To be noted is that all parties, except for the Left Party, is positive towards letting private companies establish on the health care market. For the Social Democrats and the Green Party, the problem with the reform is not that it allows private actors in to a traditionally publicly provided service area. The difference between them and the government parties are instead related to how much and in what way the market is to be controlled by politics. This represents, as is pointed out by previous research, a
significant change in the Social Democratic party’s ideas about how the welfare services should be organised. In this respect, this party has moved closer to the liberal/right ideas and this is clearly confirmed by the party’s argumentation in the case of consumers’ choice in health care where the former arguments against private actors in welfare services are totally absent.

Consumers’ choice in health care: choice patterns among citizens

How has the possibility to choose between primary health care providers been used by the citizens? In the table below, results concerning all respondents as well as a division into three kinds of groups are shown. The groupings show differences between respondents as regards indicators on social stratification: subjective family class, level of education and residential area.

Table 1: The choice of Primary health care centre in West Sweden (percent)

<table>
<thead>
<tr>
<th>Chose the suggested centre</th>
<th>Chose another centre</th>
<th>No active choice</th>
<th>Waiting with choice</th>
<th>Not familiar with the reform/ don’t know</th>
<th>Sum percent</th>
<th>Sum Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>All respondents</td>
<td>56</td>
<td>20</td>
<td>18</td>
<td>3</td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

Subjective Family class

- Workers
  - Lower non-manual employees: 58, 17, 19, 3, 3, 100, 1291
  - Higher non-manual employees: 54, 24, 17, 2, 2, 100, 1006
- Self-employed/business: 52, 20, 20, 4, 4, 100, 282

Education

- Low: 64, 12, 18, 2, 2, 100, 669
- Middle to low: 55, 20, 18, 2, 5, 100, 960
- Middle to high: 54, 24, 17, 3, 2, 100, 650
- High: 50, 26, 19, 4, 2, 100, 752

Residential Area (Gothenburg)

- High status: 44, 33, 17, 3, 3, 100, 230
- Middle high status: 52, 27, 13, 3, 5, 100, 280
- Middle low status: 45, 30, 18, 5, 2, 100, 240
- Low status: 38, 28, 23, 4, 6, 100, 159

Comment: Question Subjective Family Class: “Which of the following categories best describes your family?” Question Education: Variable constructed from question about what kind of education the respondent has. Residential area: Variable constructed from objective data on in which district of the city of Gothenburg the respondents live, the districts are grouped according to for example average income.
About half of the respondents chose the health care centre that they were suggested, but at the same time only 18 percent didn’t make an active choice. This means that a clear majority exercised their right to choose. About one fifth chose another health care centre than suggested.

The analysis shows that there are some differences between groups when it comes to choice patterns. One indicator on social status is the level of education. Though there are no significant differences between people with different levels of education when it comes to shares of respondents that does not makes active choices (about 17-19 percent irrespective of education), people with higher levels of education states that they have chosen another health care centre than suggested to a higher extent than those with lower levels of education (26 respectively 12 percent). This might be interpreted as that the higher educated have taken more care in their choice, perhaps by taking part of information about the available health care centres to a greater extent than the lower educated. On the other hand, the result might only indicate that respondents with lower education is more content with the alternative they were suggested (probably the health care centre closest to where they live).

Another indicator on social status is what kind of social class the respondent identifies with. In the survey, this is measured by a question about “subjective family class”, where the respondents chose the alternative he or she identifies with as regards work-related groups. The analysis shows that respondents that define themselves as workers makes an active choice to a lesser extent than those defining themselves as belonging to the non-manual employees. These categories corresponds partly with education, but to note is that the differences between groups are smaller than between education groups.

Also when it comes to type of living area/residential area, there are some differences that indicates some, but small, effects. Gothenburg (Sweden’s second largest city which is a part of the survey population) consisted until 2011 of 21 local city councils (from 2011, 10), which can be grouped according to resource levels. In the districts which is characterized as high-resource areas (where the residents in general have a good living standard with high incomes), there is a slightly higher share that makes active choices of health care centres compared to people in low-resource areas. Additionally, those in high-resource areas more often chooses another health care centre than the one suggested. The difference between these groups are quite small (about 5 percent units in both cases). To note is that residents in low status areas choose the suggested centre to a slightly lower degree than residents in high status areas. This might be explained by the fact that residents in low status areas were more discontent with the existing health care centre in their area, than residents in high status areas. This indicates that the reform is seen as an opportunity to choose a better quality health care centre by these groups – and if this becomes the case this would have a de-stratifying effect since the choice of health
care centre would be made according to preferences, not depending on where you live. Although, since the reform is still new, this is too soon to say.

Does consumers’ choice in health care lead to social stratification? Since this survey was sent out while consumers’ choice in health care was still very new, the results have to be interpreted with caution. It is possible that the results from the survey that was sent out a year later may show different patterns since it probably will be more people that have made their choice of health care centre. An important result is that in all categories, irrespective of social status, a clear majority answer that they have made an active choice of health care centre. It is thus not the case that the possibility to choose is used only by the high status groups among the citizens. At the same time, those with higher social status (higher education, higher social class and living in good areas) tend to make active choices to a larger extent than those with lower social status (this is also compatible with previous research results, see for example Kastberg 2010). And those groups also tend to choose other alternatives than the ones suggested by the authorities to a higher extent than lower status groups. As mentioned above, this might indicate that citizens with higher status tend to be more careful with their choices, perhaps reading information about alternative health care centres and so on before they make their choice. This is, though, not possible to know for sure from the survey data available which means that the result can emanate from other explanations.

Conclusions/discussion

This investigation does not cover how the establishment of health care centres actually looks like, the reason being that the data is as yet limited due to the fact that the reform is very recently implemented. Given the political debate analysed above this is however an interesting issue, and there are some indications on the subject that I want to present shortly. According to the National Board on Health and Welfare there has been an increase in private health care centres, more than every third health care centre is now run by private companies. Since the reform was implemented, 213 private health care centres have established over the country (also, six new public health care centres have started). They have not, though, established evenly: the majority have chosen to establish in the bigger cities. In the sparsely populated country side, there are very few private health care centres. In West Sweden, 61 new private health care centres opened in the region since the reform was implemented (as well as two new public ones), which probably mean that a higher share of the population uses private health care centres than before.

The Act on Systems of Choice in the Public Sector brings a change of the mix of public and private welfare service providers where the private providers have grown in number, a development that can
be expected to continue during the coming years. To let private companies in on the welfare service markets represents a change in the values guiding the Welfare state since the balance or trade-off between equality and market-oriented values like efficiency and higher quality through competition are altered. Although mediated by a will to ensure social equality, the entrance of private welfare service providers is accompanied by a lower ambition when it comes to political control over the market.

A point of departure in the paper is that values need to be embraced and expressed by actors to have any real influence over the policy. As discussed above, there are some evidence pointing to the fact that privatisation is an ideological issue in Sweden, even though the former so dominating Social Democratic Party is less reluctant towards Market-Oriented reforms than before. At the same time, the institutional structure of the Social Democratic welfare state can be expected to mediate the policy decisions. Clearly, there is an ideological difference between the parties in the case of consumers' choice in health care where the opposition parties use equality arguments to argue against the government’s proposition. All parties except the Left Party is, however, positive towards the principle of freedom of choice and do not argue against letting private companies provide welfare services. Instead, the difference between the government parties and the Social Democrats and the Green party concerns the question of to what extent politics should control the market. The government is reluctant to exercise control over where private companies should establish, while the opposition parties wants to politically control where health care centres should establish, according to need. This can be interpreted as a way to defend and promote social equality. The Centre/right government instead delegate the decision to the city councils, by letting them decide if and how to create an incentive structure for the health care centres to establish in certain areas, by means of differentiated economic compensation. This means that the economic compensation structure may differ between city councils, and for example depend on which kind of political majority that rules the county. But still, the possibility to adjust economic compensation can be interpreted as a way of creating a possibility for the counties to form an incentive structure that promotes equality. In this respect, the government expresses a will to safeguard equality.

Does the reform studied in this paper bring the Swedish Social Democratic Welfare state further away from the ideal typical regime? One could perhaps argue that any Market-oriented reform of the welfare state services is a deviation from the ideal typical regime, since market values is hard to combine with equality. But this is a bit too simple since there are several possible indicators on potential changes in the values underpinning this welfare state. The results show that the decision makers consider social equality in the construction of the reform, even though there are differences between the parties. This means that the core value at least have some significance as an ideational guideline in the political decisions. As to the effects on stratification the results indicates that it is far from self-evident that
NPM-inspired reforms in the welfare service sector leads to inequalities although there are some tendencies in that direction. To be able to answer the question above, a more extensive analysis is needed. At least, the consumers’ choice in health care is hardly reversing the impression that the development since the 1980’s represents a general policy re-orientation of the Swedish Welfare State.

To be further discussed, is what this development means for how we look at the Social Democratic Welfare state in a comparative perspective. That one of this welfare state’s main characteristics – the publicly provided welfare services – is replaced by a mix of public and private service providers should at least have some consequences in this respect. And the policy re-orientation that is illustrated (and reinforced) by the reform analysed in this paper is most certainly to be considered as a change of character that should put the Social Democratic welfare state in a different position related to the Conservative and Liberal Welfare regime. The question is is these changes place the Social Democratic Welfare regime closer to the other regimes, or just in a different place.

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