Using Private Social Care Services in Finland: Free or Forced Choices for Older People?

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ABSTRACT

Use of private social care services among older people is increasing in Finland. This study aims to understand why older people choose private care in a comprehensive tax-subsidized social care system and examines whether people choose private service as a free choice or a forced choice as well as what factors contribute toward making these choices. Data for this study (N = 1,436) were gathered in 2010 from people aged 75 and above living independently at home in two Finnish cities: Tampere and Jyväskylä. Data were analyzed with several quantitative tests: chi-squared tests, multinomial regression analysis, and qualitative content analysis (for the open-ended responses from the survey questionnaire). Findings reveal that people chose private services mostly because of the effortlessness involved in its use and of the need for additional services that are unavailable through municipality; for example, cleaning. Majority of the respondents performed a free choice to use private services. People who lived in a city center with a higher level of income and who needed more services were more likely to be constrained toward using private support. Major concern, due to diminishing public service provision, is about service accessibility of economically disadvantaged groups; therefore, more research is required to understand the effects of the growing care market in Finland.

KEYWORDS
Free choice; forced choice; Finland; older people; private service

Introduction

Older people are the main consumers of health and social care services in Finland, same as they are in most European countries. With population aging, need for care increases; however, older people may often depend not on a single source of support (family/public/private) but on a combination of several sources (Kröger & Leinonen, 2012). In Nordic countries, families feel less obligation to take responsibility over the older people’s economic and social welfare than in other European countries (Daatland, 1997; Haberkern & Szydlik, 2010). According to legislation, responsibility for care of older people has been comprehensively taken up by local authorities. The municipality arranges tax-subsidized care for its residents through collaborating with neighboring municipalities, or through purchasing services from the private sector. Local authorities also offer older people some choice through tax deduction for domestic help and tax-funded service vouchers to buy private care from the market.

Private Social Care Services in Finland

By tradition, the municipalities offer social care services to their residents with some complementary support from nonprofit organizations. At present, alongside the municipality, a large number of for-profit and a few not-for-profit organizations are actively involved in providing a wide range of care support for older people. Transition from publicly provided services to privately produced or provided service can be observed following the recession of the early 1990s. This can be seen as a new public management approach adopted by the Finnish public administration to overcome the overwhelming financial crisis and to expand service coverage for older people (Tynkkynen, 2009). As part of this approach, several municipalities started to share their care responsibilities with the private sector. However, over time, the
favoring of a mixed economy of care and a strong prioritization of privatization on the political agenda have driven a rapid expansion of the for-profit sector. Thus, within two decades, privately provided care increased in quantity, whereas public coverage for older people decreased considerably (Anttonen & Häkiö, 2011). A report showed that in 2002 the private sector offered an estimated share of 16% of health care and social care (Salonen & Haverinen, 2003). A recent study (Karsio & Anttonen, 2013) observed an increase in the number of private social care units from 3,018 in 2002 to 4,350 in 2010. Although the introduction of the private sector in home care started comparatively late in Finland, it currently appears larger than in other Nordic countries (Karsio & Anttonen, 2013). The private sector is estimated to produce around one third of the care support for older people (Ministry of Social Affairs and Health, 2013). Currently, national and local authorities consider private services as an acceptable solution for meeting older people’s service demand (Karsio & Anttonen, 2013; Rissanen, Hujala, & Helisten, 2010; Rissanen & Sinkkonen, 2005).

Choice in the Care Process

Choosing care services is generally a two-stage process; initially an individual decides whether to use care services and later decides which provider to choose—that is, whether public or private or any other resource available in the market (Scott, 2000a). The second stage of the process is often crucial because it determines the service provider. People usually act rationally while choosing their care service and its provider (Anell, Rosén, & Hjortsberg, 1997; Fotaki et al., 2005; Robertson & Dixon, 2009; Scott, 2000b). However, rational thinking does not always underlie people’s choice of providers because rational thinking requires adequate information about the service availability, mental ability to compare services, and self-control in making the choice (Exworthy & Peckham, 2010; Kooreman & Prast, 2010). People often find themselves in a situation in which they feel not quite capable of making a right choice (Albada & Triemstra, 2009; Victoor, Delnoij, Friele, & Rademakers, 2012). People’s choices can also be influenced by other factors, such as affordability, availability, and accessibility of care (Exworthy & Peckham, 2010; Nordgren & Ahgren, 2011; Pechansky and Thomas, 1981). In their work, Levesque, Harris, and Russell (2013) found that people’s information about the service, trust and expectations about the service, personal and social values, and social support also influence their access to care services. Furthermore, individuals’ socioeconomic and health statuses also play an important role in determining the service provider (Burge, Devlin, Appleby, Rohr, & Grant, 2004; Exworthy & Peckham, 2010; Lako & Rosenau, 2009; Lent & Arend, 2004; Levesque et al., 2013; Mathew Puthenparambil, Kröger, & Van Aerschot, 2015; Mukamel, Weimer, Zwanziger, Gorthy, & Mushlin, 2004; Stoddart, Whitley, Harvey, & Sharp, 2002; Szebehely & Trydegard, 2012; Van Aerschot, 2014). Hence, people’s choices are not often driven by a single factor but by a combination of many factors, mainly characteristics of the individual (e.g., income, information) and of the service (e.g., price, availability, accessibility).

Free Choice, Forced Choice, and Negative Choice

In this study, the term choice is conceptualized into three categories: free choice, forced choice, and negative choice. The term free choice is often discussed in health and social care policy and is generally considered as an approach that asserts users’ autonomy as well as encourages users’ active participation in the care process (Dixon, Robertson, & Bal, 2010; Greener, 2003; Victoor, Friele, Delnoij, & Rademakers, 2012). Many scholars consider this approach as a way to increase the provider’s responsibility, to boost the consumer value, and to promote care quality (Christensen & Hewitt-Taylor, 2007; Greener, 2007). Based on a general definition, for the purpose of this study, free choice is conceptualized as operating in a situation in which an end user of service has the flexibility to select a private care service from among different options that concern quality, availability, and personal preference. The term forced choice is not frequently debated or researched in the social care setting. Dhar and Simonson (2003) indicated that a consumer is usually forced to search for an alternative resource when there is delay in existing service or there is an urgent need for service. Based on this explanation, forced choice is conceptualized as when the end user of services chooses a private provider
because of the inefficiency or the inaccessibility of public provisions. Similarly, negative choice is when end users do not choose a private provider for various reasons, such as due to receiving support from the public sectors, skepticism toward the private sector, or personal preferences.

Using the conceptualized definitions, variables are grouped into three categories (free choice, forced choice, and negative choice) to explain the core question of how older people choose private services. Although several studies had explored the use of formal social care in Finland (e.g., Blomgren, Martikainen, Martelin, & Koskinen, 2008; Kehusmaa, Autti-Rämö, Helenius, Hinkka, Valaste, & Rissanen, 2012), a lack of knowledge still persists concerning how older people perceive private social care. Therefore, the research questions of this study are (1) to examine why older people choose private care as an alternative source in a comprehensive tax-subsidized Finnish social care system, (2) to determine how people’s choices are made—that is, whether the choice is based on free choice or on forced choice, and (3) to identify factors that contribute to these choices.

Methodology
Sample and Source of Data
This study was a part of the “Everyday life, support and services” (in Finnish: Arki, apu ja palvelut) research project conducted in 2010 in collaboration between the research teams from the University of Jyväskylä and the University of Tampere in Finland. The aim of this project was to collect information about everyday life situations of older people, which comprises managing everyday life activities, providing and receiving support for others (e.g., spouse, children, and grandchildren), and using social care services (public and private services). Data were collected from people aged over 74 years, living independently at home or in sheltered housing (therefore excluding people residing in institutional care) in the two cities of Jyväskylä and Tampere. These middle-sized cities were selected because they share very similar features concerning the number of aged population, the figures for service use, and the number of private service units (National Institute for Health and Welfare, 2013) and to draw comparison between the two cities. Researchers prepared a self-administered survey questionnaire using Swedish and Finnish national survey questionnaires as examples (e.g., the Welfare and Services in Finland [HYPA] survey; see Moisio, 2007). Later, this questionnaire was pretested with 12 people in Tampere and was modified and finalized according to the feedback received from the pretest. The questionnaire covered questions related to socioeconomic and demographic background, self-reported physical and mental health, managing everyday life, providing and receiving others’ support and use of social care services. A sample of 1,000 participants from each city was considered adequate to represent the total population (Guthrie, 2010). Researchers collected the participant addresses from population registries of the cities of Tampere and Jyväskylä. These addresses were randomized by the population registry through a computer-generated method (which was beyond the control of the authors). An informed consent covering letter and a 12-page self-administered questionnaire were sent to the participants’ addresses, asking the participants to return the form after completion using the attached prepaid envelope. Initially, 959 questionnaires were received, but after sending reminders to the nonrespondents, 477 questionnaires were added. Thus, the project obtained a total of 1,436 completed questionnaires corresponding to the response rate of 71.5% (Jyväskylä 69.0% and Tampere 74.1%). The whole process of data collection was carried out between May and August 2010. Two thirds of the respondents were women, and the remaining one third were men with a mean age of 81.93 (SD = 4.75). Among the private service users, 47% bought service through out-of-pocket payment; 31% used tax deductions and tax-funded service vouchers; and the rest mixed both options for the purchase of private service.

Researchers did not apply for an ethical committee approval because of the minimal risk to participants emanating from the project. In Finland, researchers are required to have an ethical committee approval only if the study involves an intervention in the physical integrity of participants or deviates from the principle of informed consent or is otherwise sensitive like studies involving underage children or concerning violence (Ethical review in human sciences, n.d.). However, this project followed ethical guidelines governed by the Finnish Advisory Board of Research Ethics. For example, participants were well informed about the research project in the covering letter and were briefed that all information collected would be kept strictly confidential and anonymous.
Inclusion and Exclusion

This study included only those respondents who reported having used public or private care service \( n = 679; \ 47.2\% \) and excluded other respondents (people not needing services and missing values; \( n = 757 \)). This exclusion was required because of the proposed research objectives in this study, which focused mainly on the users of care support. The disadvantage of this exclusion approach was that it affected the total size of the sample; sample size of this study was reduced to half. However, the acquired size after exclusion remained sufficient to conduct quantitative analysis (Guthrie, 2010). Furthermore, to determine the difference between the excluded and observed respondents, a comparative analysis was conducted using independent-sample t test and chi-squared test. As expected, health-related variables such as number of Instrumental Activities of Daily Living (IADL) limitations and self-reported health showed statistically significant results \( (p < .001) \). In other words, respondents in the excluded category had very minimal health-related problems and could manage their everyday life activities without any external support. As the present study focused mainly on the service users, the exclusion of other respondents from the data analysis was reasonable.

Dependent Variables

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

Independent Variables

The independent variables include age, number of children, number of limitations in IADLs (instrumental activities of daily living: shopping, cleaning, house maintenance, transportation, managing medication, etc.), and number of social care services (as continuous variables). Area of residence (city center versus suburb/sparsely populated), marital status (married/living together versus single/independent), education (no vocational versus vocational/higher) and regular contact with children (yes versus no) were coded into dichotomous variables. Self-reported health status was classified into three categorical variants (good/quite good, fair, and quite poor/poor). Household income was a categorical variable with ten groups. To standardize income for household size, the middle value of each group was transformed into individual household income, after which, using the modified Organisation for Economic Co-operation and Development (OECD) equivalence scale (OECD, n.d.), the income variable was measured into equivalized household income by dividing the monthly income with equivalence factors (a value of 1 for the first adult in the household, a value of 0.5 for any other adults, and a value 0.3 for each child aged under 13). Equivalized income was coded into quartiles (with the cutoff points 850; 1,125; and 1,500 euros).

Data Analysis

To address the research questions, variables were analyzed using a multiple response frequency test (Table 1), one-way ANOVA, and cross tabulations with the chi-squared test (Table 2). Multinomial regression analysis (Table 3) was included because this method was identified as a suitable statistical tool to answer the third research question. In addition, this regression model had the advantage of not assuming linearity, normality, and homoscedasticity, while the assumption of multicollinearity needed to be satisfied (Hosmer & Lemeshow, 2000). However, there is no predefined technique for testing multicollinearity when using a categorical variable (Petrucci, 2009). One way of testing multicollinearity is through a collinearity diagnostic test with tolerance values < 0.1 and VIF value > 10 (Field, 2009). This technique was followed to identify any collinearity between independent variables; the outcome showed a negative result. In the multinomial analysis, free choice and forced
were considered as dependent categories and negative choice as the reference category. For the multinomial regression analysis (adjusted model), only those variables that showed a statistically significant result in the chi-squared test were included. The model results were presented as odds ratios (OR) with their confidence intervals at 95%. The data were analyzed with IBM SPSS version 19, and all missing data in the regression model were deleted using a listwise approach.

In addition, qualitative content analysis was performed to explore other reasons contributing to the use of private service. For this purpose, the open-ended question “why do you use private service, other reason?” from the survey questionnaire was coded into two main categories, free choice and forced choice, with three subcategories in each. References to price, trust, and autonomy were grouped under free choice while, themes of availability, information, and income were annexed with forced choice. Themes that could not be coded under the above categories (e.g.,

Table 1. Descriptive statistics of the dependent variable choosing private service.

| Variable | Private service users | | | | | |
|----------|-----------------------|---|---|---|---|---|
| A. Private service users | | | | | | |
| Free choice | | | | | | |
| Effortless to use private service | 163 | 34.8 | | | | |
| Private services are of better quality | 67 | 14.3 | | | | |
| Personal preference of private service | 46 | 9.8 | | | | |
| Forced choice | | | | | | |
| Need for additional services that are not available through the municipality | 87 | 18.6 | | | | |
| Services from the municipality are not fast enough | 57 | 12.2 | | | | |
| Services from the municipality not offered | 48 | 10.3 | | | | |
| Total Count | 468 | 100 | | | | |
| B. Nonusers of private service | | | | | | |
| Negative choice | | | | | | |
| Private services are too expensive | 234 | 42.3 | | | | |
| Prefer public service to private service | 134 | 24.2 | | | | |
| Received all services from the municipality | 123 | 22.2 | | | | |
| Do not know how to access private services | 42 | 7.6 | | | | |
| Difficulty to obtain private services | 13 | 2.3 | | | | |
| Services not available from private providers | 6 | 1.0 | | | | |
| Total count | 552 | 100 | | | | |

Note. NS = Nonsignificant; M = Mean; SD = Standard deviation. Numbers within categories within a variable might not add up to total because of missing values. Missing data in the following variables (% of the total sample [n = 679]): Age, 3.1%; Number of children, 2.8%; Self-reported health, 1.9%; Equivalized household income, 11.8%. Missing values less than 1% in the variables were not reported.

Table 2. Descriptive statistics of choice.

| Variable | Total n = 679 | Free choice n = 167 (24.6) | Forced choice n = 117 (17.2) | Negative choice n = 395 (58.2) | p value |
|----------|--------------|--------------------------|-----------------------------|-----------------------------|--------|
| Age in years | M (SD) or % | M (SD) or % | M (SD) or % | M (SD) or % | ** |
| Number of children | 82.36 (4.93) | 82.17 (4.59) | 83.92 (5.22) | 82.45 (4.94) | |
| No. of IADL limitations | 3.39 (2.81) | 2.65 (2.47) | 4.25 (2.83) | 3.44 (2.86) | *** |
| Number of services used | 2.08 (2.46) | 1.84 (1.82) | 3.48 (2.99) | 1.77 (2.39) | *** |
| Gender | | | | | |
| Female | 65.9 | 66.9 | 65.8 | 65.6 | NS |
| Male | 34.1 | 33.1 | 34.2 | 34.4 | |
| Area of residence | | | | | |
| City center | 48.4 | 59.8 | 56.0 | 41.4 | *** |
| Suburb/sparsely populated area | 51.6 | 40.2 | 44.0 | 58.6 | |
| Marital status | | | | | |
| Married/living together | 41.2 | 40.1 | 37.1 | 42.8 | NS |
| Single/independent | 58.8 | 59.9 | 62.9 | 57.2 | |
| Education | | | | | |
| No vocational education | 42.0 | 29.7 | 42.1 | 47.2 | ** |
| Vocational or higher education | 58.0 | 70.3 | 57.9 | 52.8 | |
| Regular contact with children | | | | | |
| Yes | 82.0 | 78.4 | 87.2 | 82.0 | NS |
| No | 18.0 | 21.6 | 12.8 | 18.0 | |
| Self-reported health | | | | | |
| Good | 21.9 | 27.5 | 19.6 | 20.2 | ** |
| Fair | 47.7 | 52.7 | 40.2 | 47.8 | |
| Poor | 30.3 | 19.8 | 40.2 | 32.0 | |
| Equivalized household income | | | | | |
| Quartile (4th/lowest) | 33.4 | 24.3 | 20.4 | 41.0 | *** |
| Quartile (3rd) | 21.7 | 20.7 | 30.6 | 19.4 | |
| Quartile (2nd) | 28.5 | 23.6 | 27.7 | 20.8 | |
| Quartile (1st/highest) | 16.4 | 31.4 | 21.3 | 8.8 | |

Note. NS = Nonsignificant; M = Mean; SD = Standard deviation. Numbers within categories within a variable might not add up to total because of missing values. Missing data in the following variables (% of the total sample [n = 679]): Age, 3.1%; Number of children, 2.8%; Self-reported health, 1.9%; Equivalized household income, 11.8%. Missing values less than 1% in the variables were not reported.

*p < .05; **p < .01; ***p < .001.
Reference to bureaucracy) were placed under a different subcategory, other issues, under each main category. Of the 95 open-ended responses, only 43 were included, while the other responses were excluded due to irrelevant answers (e.g., “I don’t need private services”; “I do not use”). Of the selected responses, 23 were grouped within free choice under different themes and others within forced choice. An author translated the open-ended responses from Finnish to English with the help of a research colleague and crosschecked with the co-author to ensure all textual activities were constructed. This table also shows the different reasons the respondents gave for using or not using private services. Effortlessness to use private service (34.8%), additional need for service (18.6%), and better quality (14.3%) were reported as the main reasons for using private social care support. Reasons stated for not using private services were their expensiveness (42.3%), personal preferences for public service (24.2%), and extensive support received from the public sector (22.2%).

Of the total population (n = 679), 24.6% reported using private service as a free choice, and 17.2% reported it as a forced choice (Table 2). Most of the respondents were female (65.9%). On average, the respondents were aged 82.36 years, had 2.20 children, had difficulty in 3.39 IADL activities, and used 2.08 services. The forced choice group had a higher mean age (M = 83.92, SD = 5.22), a higher number of difficulties in IADL activities (M = 4.25, SD = 2.83), and a higher number of services used (M = 3.48, SD = 2.99) than the other two groups.

In both the free choice and the forced choice groups, the majority of the respondents lived in the city center, had vocational or higher education, and had a similar level of income distribution. The respondents who used private services through free choice were largely in the good and fair health categories. From Figure 1, it can be observed that respondents in the free choice and forced choice categories were overall highly satisfied with the price, quality, and other components of private care. However, compared to the free choice group, the forced choice group showed a higher level of disagreement in all five components, particularly in the price and the quality.

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

| Variable                                      | Free choice |                       | Forced choice |                       |
|-----------------------------------------------|-------------|------------------------|---------------|------------------------|
|                                               | Estimate (SE) | OR |                     | Estimate (SE) | OR |
| Age                                           | -0.00 (0.02) | 0.99 |                     | -0.00 (0.02) | 0.99 |
| Number of services used                       | 0.02 (0.05) | 1.02 |                     | 0.24 (0.05) | 1.27*** |
| Gender (ref: male)                            | 0.49 (0.27) | 1.63 |                     | 0.06 (0.29) | 1.06 |
| Female                                        | -0.16 (0.27) | 0.84 |                     | -0.07 (0.31) | 0.93 |
| Married/living together                       | 0.65 (0.22) | 1.92**                  |               | 0.66 (0.24) | 1.94** |
| Area of residence (ref: suburb/sparsely populated area) | -0.24 (0.23) | 0.78 |                     | -0.05 (0.26) | 0.95 |
| City center                                   | 0.72 (0.32) | 2.07*                    | 0.05 (0.35) | 1.05 |
| Education (ref: vocational or higher education) | 0.55 (0.27) | 1.74*                    | -0.06 (0.27) | 0.94 |
| No vocational education                       | -1.84 (0.33) | 0.15**                   | -1.61 (0.40) | 0.20*** |
| Self-reported health (ref: poor)              | -1.27 (0.35) | 0.28***                  | -0.63 (0.39) | 0.53 |
| Good                                          | -1.39 (0.32) | 0.24***                  | -0.91 (0.37) | 0.39* |
| Fair                                          | -0.34 (2.22) |                     | -0.51 (2.29) |                     |
| Equivalent household income (ref: 1st/highest quartile) | -0.91 (0.37) | 0.39*  |                     | -0.51 (2.29) | 0.39* |
| Quartile 4th/lowest                           | 0.51 (2.29) | 0.39*                    |               | 0.51 (2.29) | 0.39* |
| Chi-square (x²)                               | 113.773     | 0.001                    |               | 113.773     | 0.001 |
| Intercept                                     | 954.690     | 0.89; p < 0.001          |               | 954.690     | 0.89; p < 0.001 |
| Degree of freedom (df)                        | 22          |                          |               | 22          |                          |
| Nagelkerke R²                                 | 0.214       |                          |               | 0.214       |                          |

Note. OR = adjusted odds ratio; SE = standard error of estimate. Goodness-of-fit statistics indicate the model is adequate (deviance = 938.055; degree of freedom [df] = 1050; value/degree of freedom [x²] = 0.09; p = 0.99). Negative choice was used as reference category in the analysis. Reference groups (ref.) for categorical variables listed in parentheses. Model was adjusted for all variables.

*p < .05; **p < .01; ***p < .001.
The multinomial regression model (Table 3) was performed to investigate the relationship of socio-economic and other variables with the dependent variable choice (free choice and forced choice as dependent categories and negative choice as reference category). The results show many statistical similarities between the free choice and the forced choice groups. In both, people living in the city center and with higher income level had higher odds in favor of choosing private care services compared to members of the negative choice group. The variables that differentiated the free choice group from the forced choice group were self-reported health status and the number of services used. In other words, people were more likely to choose private social care services through free choice if they lived in an urban area, had higher income, and were in good or fair health. Correspondingly, the forced choice group used private care if they required more care services (OR = 1.27; p < .001), along with other significant variables associated with the free choice group except self-reported health. Moreover, a new multinomial regression model was analyzed using free choice as the reference group (considering space limitation, the results were not reported as a table). The model presented a comparison between free choice and forced choice. The result showed a statistically significant association only in the number of services used (OR = 1.24; p < .01) while all other variables remained nonsignificant (p > .05). In other words, people in the forced choice group are more likely to choose private care if they require more care support than are people in the free choice group.

Other reasons for choosing private services were further explored through a qualitative content analysis from the open-ended question “Why do you choose private service, other reason?” (Table 4). Respondents in the forced choice category reported unavailability of public service as an important factor that influenced them to choose private service: “I have not received the health service I need from the city”; “the only possibility.” Lack of information about public provision appeared to be a significant issue for the forced group, as well: “I do not know whether it would be possible to receive services from the city.” Personal income came out strongly in this analysis. It seemed that a person with higher income, including persons with a higher pension, were in practice no longer entitled to public-funded provision: “Pension and that is why I will not receive support, i.e. too high income”; “Due to my income I do not get the service from the city.” In the free choice category, respondents gave ample importance to service cost as well as to trust toward the provider when choosing service provider, “the service was not very expensive”; “the service person is always the same—in municipal [service] they will always be different.”

Few participants thought that the private sector provided more autonomy than the public provider during and after product selection: “I think the services are right for me, when I order them myself I pay for them myself and receive a tax deduction; I will change the firm/company if necessary.” Other reasons for using private services were related to reliability, place of residence (“I live in private sheltered housing”), and information (“I have not been up to finding out about all the service”). Only one person reported a high level of bureaucracy in the public sector as a reason for choosing private care.
Discussions

Understanding why older people choose private care rather than public support has crucial importance in the Finnish welfare state. Finding out these reasons will explain how older people perceive and access private services. This information is needed due to the rapid reconstruction of the Finnish welfare model of care for older people from a public-centered model toward a dual mechanism of public–private partnership. Among the reasons, effortlessness in using private service had the highest response in the quantitative analysis followed by need for additional service. These results are as expected because, from the early 1990s onward, Finland has experienced a profound change, not only in coverage level but also in the whole concept of home care (i.e., the integration of home help and home nursing). In the Finnish context, home help refers to tasks related to daily life activities such as cleaning, meal preparation, and other household tasks while home nursing is associated with medically related procedures such as performing medical tests, cleaning and dressing wounds, giving injections, and so on. Consequently, local authorities shifted their focus within home care from taking care of the home to taking care of bodily and medical needs (as cited in Kröger & Leinonen, 2012). Thus, several municipalities dropped some of the home-care services from their care package, particularly cleaning and shopping service. Even in this study, the respondents who identified themselves as private-care recipients are largely using less-intensive services like cleaning, shopping, and home maintenance services. Quality of private service stands in the third position, which indicates that for some respondents, private services are of better quality. However, in the light of the current situation in the public and private sectors, it could be assumed that there would not be any major difference in the quality of service they offer; a recent study by Noro (as cited in Karsio & Anttonen, 2013) showed a statistically nonsignificant association between the quality of service and the type of provider.

Apart from the closed-ended answers, qualitative results (see Table 4) provide additional insight enabling one to explore other reasons for choosing private care. Several end users consider private care as a cheaper option due to the expensive user fees charged by the local authority. This is not surprising because user fees are usually set on the basis of the individual’s income level (Karsio & Anttonen, 2013). Consequently, higher income earners need to pay higher fees for public services, but the same recipient may be able to buy the private service cheaper from the market as there they need to pay only a fixed price (Kröger & Leinonen, 2012; Szebehely & Trydegård, 2012). Another outcome from the analysis was the meaning of personal income: “…pension and that is why I will not receive support, i.e. too high income.”

Table 4. Other reason for choosing private care services: Qualitative findings from the open-ended question (n = 43).

| Free choice (n = 23) | Forced choice (n = 20) |
|---------------------|-----------------------|
| **Price**           | **Availability**       |
| • Advertisement just came in the right time and the service was not very expensive. | • I have not received the health service I need from the city. |
| • Expensive city services. | • The only possibility. |
| • Cheaper. | • I do not expect to receive the service I desire from the city. |
| **Trust**           | **Information**        |
| • The service person is always the same; in municipal [services] they will always be different. | • Cleaning is not a municipal service. |
| • Home-based worker will change almost every day. | • Changed over from the city of Tampere to the private sector. |
| • An old familiar cleaner. A neighbor friend of another. | **Income** |
| • I have a reliable cleaner for 2 years. | • I do not know whether it would be possible to receive services from the city. |
| • I think the services are right for me; when I order them myself, I pay for them myself and receive a tax deduction. I will change the firm if necessary. | • I do not know all the possibilities. |
| • You get to choose. | • Have been forced to pay for yourself when no one has explained the position who gets what. |
| **Autonomy**        | **Other issues**       |
| • I have not been able to find out about all the service. | • Lot of bureaucracy. |
| • Tiresome/stressful. | |
| • I have heard bad things about public services. | |
| • I live in a private sheltered housing. | |
This statement emphasizes the inaccessibility of public support for a certain section, largely the higher income group in the society. Nevertheless, this finding goes against the notion of the universal welfare model in which all social groups receive care in a uniform way without anyone being marginalized. In this context, it could be argued that the Finnish welfare model is slowly drifting away from the core idea of universalism, but such a conclusion would need support from future studies. Information is another theme that emerged from the analysis. Information about services is always important; lack of information could create unnecessary consequences for the user (Bent, 2009). Here, users reported that they chose private support due to inadequacy of available information concerning public provision: “I do not know whether it would be possible to receive services from the city.” This response raises a question about the relationship between the local authorities and the service users: whether it is the authorities that show less interest in providing information to their residents or the users who lack interest in seeking information from the local authorities. It will be hard to give a correct answer, but older people are not always active consumers in the care market (Roberts, 2001). As a consequence, people may purchase private services for a higher price even though they are eligible for public services; meanwhile, those people who cannot afford the price may either rely more on their family and friends to compensate for the public support or even leave their care needs unmet. Another reason mentioned by the respondents is the possibility of autonomy. An earlier study conducted in Sweden showed that older people gave much importance to autonomy (i.e., choosing services themselves) when they needed to select health-care support (Nordgren & Ahgren, 2011). Some of the reasons emerging from our quantitative and qualitative analysis are familiar in countries with a strong private market, but for Finland, these results are new because of very limited studies in this area. Thus, almost similar results can be expected if an identical study is conducted in other Finnish municipalities or even in other Nordic countries.

The second research question was to explore whether older people choose private service on the basis of free choice or forced choice. Although the majority of the respondents made a free choice, a considerable number had chosen private service by forced choice (see Table 1). Common reasons described by the forced group were the unavailability of public services and delay in municipal support. Using private support even for a service like cleaning demands additional resources from both free and forced choice groups; that is, users need to pay out of pocket for the supplementary support. The forced choice model cannot be ignored because of the rapid expansion of privatization in the care sector. For example, if people have to pay a considerable amount of money even after receiving some financial support from the public authority, then low-income people within the forced group are more likely to end in a situation where income determines whether they can use the service. Furthermore, if having a good income becomes the only way to gain private support, then it will probably be a matter of time for the gap between social groups to widen, bringing about income-based health inequality in the society. Such a development cannot be proved from this study alone but requires further attention because several existing studies do show an increase in income-based health inequality (Van Aerdschot 2014; Van Doorslaer, Masseria, & Koolman, 2006; Wahlbeck et al., 2008).

It is also necessary to examine why users apply free choice while purchasing private support. One of the main reasons mentioned in the analysis is the cited effortless involved in choosing private service, rather than better quality or personal preference. This response might have surfaced because of longer waiting times or a higher level of bureaucracy prevailing within local authority. Hirschman (1970) and Le Grand (2006), in their notable works, indicate that when people experience dissatisfaction (e.g., delay, poor quality) with the product of an organization, they may either exit, by not buying the product or by leaving the firm, or look for other alternatives in the market. Here, the free choice group might not necessarily be dissatisfied with the municipal service, but, as suggested by Tynkkynen et al. (as cited in Karsio & Anttonen, 2013), they could be directed by municipal care managers to use tax rebates for domestic help and service vouchers that are easily available to all social groups. Furthermore, both the free choice and forced choice groups seem highly satisfied with the price, quality, and other components of the private provision (Figure 1), although the forced choice group shows more dissatisfaction than the other group. This suggests that a considerable number of people are not happy with the present situation and the new model
of choice. A clear explanation cannot be provided for this outcome, but the dissatisfied forced choice group members may come from the less advantaged group. For example, economically disadvantaged people are probably more likely to express dissatisfaction when they need to pay a higher price for the services they use that they often consider unaffordable. Therefore, more research is needed to understand and further explore this finding.

The third research question was to identify the attributes that explain membership in the free choice and the forced choice groups and to explore how these two groups differ from each other. The multinomial regression analysis (Table 3) shows that people who live in the city center and have higher income are strongly associated with membership in both free- and forced choice groups. These results are not surprising since, often, private providers are located in the urban areas and people with higher income have a higher probability of choosing private service (Burge et al., 2004; Exworthy & Peckham, 2010; Lako & Rosenau, 2009; Mukamel et al., 2004). Another outcome from the regression analysis (forced choice versus negative choice and forced choice versus free choice) indicates that, with increasing service needs, people are more likely to be forced to use the market-based care. The exact reason cannot be pinpointed, but this could be part of new public management’s approach in confronting overwhelming service demand or rising costs or in reducing the scope of the state (Green-Pedersen, 2002). Further investigation is required to identify particular reasons behind privatization in the Jyväskylä and Tampere municipalities and in other Finnish municipalities.

It is not surprising that, because of its expensiveness, people do not choose private service. However, if the municipalities are restricting their care provision (which is increasingly happening) and at the same time the alternative option seems too expensive for many, how can people with limited incomes meet their needs? This requires a rethinking at the policy level to redesign home care in a more user-centered way and to increase coordination between the public and private partnerships to minimize user dropout, something often seen in the quasi market (Le Grand, 2011). Moreover, it is also necessary to ensure that older people enjoy their constitutional rights to receive care without being marginalized merely on the grounds of their fiscal situation. Furthermore, policies need to be strengthened to provide adequate information and quality services in the market because older people are not always active consumers (Roberts, 2001).

**Limitations**

This study is limited in several ways. First, this study includes only two cities in Finland, which might not represent the entire country; second, the way free choice, forced choice, and negative choice are defined can influence the result because variables included in the grouping might have some correlation with each other. Finally, the samples, which represent private users, are not sufficiently large to warrant generalization of the study outcome. Our survey data were collected from the general population, of whom the majority were nonusers of services; therefore, further studies are required, conducted with a higher representation of service users. Apart from these, some older people might have incorrectly reported their service usage. For example, older people may misinterpret private services as public support if their kin are paying for the services and they are unaware about that situation. In addition, outsourced municipal services, provided by companies, are easily mistaken by older people to be private services even though they are funded by the public sector. Therefore, the findings of this study must be interpreted with some caution. Despite these limitations, there are several strengths to this study. First, this study is among the few conducted in the Nordic countries that have tried to examine the reasons influencing older people in choosing private social care services. Although the survey data come from 2010, the outcome is still relevant because of the continuing and increasing privatization and marketization in the Finnish health and social care sector. The qualitative findings from open-ended answers serve as an extra asset to this study by providing additional insight apart from the quantitative outcomes.

**Conclusion**

Private services as an alternative source of care have recently gained much more importance among older people in Finland. Reasons for choosing private care provision include accessibility and availability of private services, additional needs of older people, and inadequate availability of information concerning
public provisions. The results of this study not only disclose the reasons for using private services but also raise some questions about the efficiency of municipally organized public care services, requiring further evaluation. Especially, many nonusers of private services considered private support as too expensive. This in turn raises some concern over service needs of the disadvantaged group because, at present, several local authorities are showing more enthusiasm in promoting privately organized care provision. There is also some concern about the escalating class gap among the service users; that is, the well-off group often receives adequate support because of their purchasing capability, while the lower income group suffers from inadequate support mostly due to the unaffordable service price tag encountered in the market. Most often, the lower income group either rely more on their family or friends to get additional support or even leave their care needs unmet, which will eventually affect the well-being of this group. Therefore, more studies are needed to identify the effects of privatization and marketization on older people and to understand more deeply how older people perceive this new source of care in Finland.

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