Eurofound

Delivering public services: A greater role for the private sector?

An exploratory study in four countries

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Abbreviations used in the report

CCT	compulsory competitive tendering
DWP	Department for Work and Pensions (UK)
ECEC	early childhood education and care
EPEC	European Public–Private Partnership Expertise Centre
ESF	European Social Fund
GDP	gross domestic product
HSCIC	Health and Social Care Information Centre (UK)
ISCED	International Standard Classification of Education
LDB	Lithuanian Labour Exchange (Lietuvos Darbo Birža)
LOV	Act on System of Choice in the Public Sector 2008:962 (Lag of valfrihetssystem, 2008:962) (Sweden)
LTCS	Long-term Care System (Spain)
MRI	magnetic resonance imaging
NGO	non-governmental organisation
NHS	National Health Service (UK)
OECD	Organisation for Economic Co-operation and Development
PFI	private finance initiative
PIQUE	Privatisation of Public Services and the Impact on Quality, Employment and Productivity research project
PPMI	Public Policy and Management Institute
PPP	public–private partnership
SIMAP	Sindicato de Médicos de Asistencia Pública (Spain)
SNS	Sistema Nacional de Salud (Spain)
SSGI	social service of general interest
UNFPA	United Nations Population Fund
WHO	World Health Organization

Country codes EU28

AT	Austria	**IE**	Ireland
BE	Belgium	**IT**	Italy
BG	Bulgaria	**LT**	Lithuania
CY	Cyprus	**LU**	Luxembourg
CZ	Czech Republic	**LV**	Latvia
DE	Germany	**MT**	Malta
DK	Denmark	**NL**	Netherlands
EE	Estonia	**PL**	Poland
EL	Greece	**PT**	Portugal
ES	Spain	**RO**	Romania
FI	Finland	**SE**	Sweden
FR	France	**SI**	Slovenia
HR	Croatia	**SK**	Slovakia
HU	Hungary	**UK**	United Kingdom

Executive summary

Introduction

Welfare systems, whose role is to promote the well-being of citizens through high levels of social inclusion and protection, are at the heart of the European social model. Up to the 1970s, across Europe, delivery of public services was almost exclusively the responsibility of the state. Since then, many Member States have extended the role of the private sector in delivering public services in pursuit of improved choice, quality and efficiency.

This report examines how the role of the private sector has grown in the provision of public services in four EU Member States: Lithuania, Spain, Sweden and the UK. It explores the processes by which the private sector became increasingly involved and the implications for access, quality and effectiveness of services for service users. With an explicit focus on the user perspective, the report is based on case studies in these four Member States drawn from the following sectors: healthcare, long-term care, early childhood education and care (ECEC), and employment services. The report assesses developments in the delivery of these services and also addresses the impact of the economic crisis on the changing public–private sector relationship in provision.

Policy context

The role of the private for-profit and non-profit sectors in delivering public services is the subject of an ongoing debate both at EU level and within Member States. There is a need for more and better-quality services to cater for the diverse and increasingly complex needs of people who are either affected by a particular life event, such as unemployment, long-term illness or disability, or who use services during a specific life phase, such as education. The ultimate goal is to improve people's quality of life. The Social Investment Package emphasises the importance of involving private for-profit and non-profit sector resources to complement public efforts. In the context of goals for economic growth and jobs in the Europe 2020 strategy, the need to maintain welfare services amid increased pressure on budgets has prompted Member States to turn to different ways of engaging the private sector in the delivery of services. In the face of reduced public budgets, Member States need new solutions to sustain public services.

Key findings

- The main driver behind the increasing role of the private sector in the two Member States with well-established welfare systems (Sweden and the UK) has been the expectation of quality and efficiency gains. The two Member States with less-extensive welfare systems (Lithuania and Spain) have tended to increase their reliance on the private sector on the grounds of budgetary constraints.
- In Spain, Sweden and the UK, the opening of service provision to market competition has been mainly policy-driven. In Lithuania, the expansion has been more bottom-up, with private providers being established to fill gaps in public provision – in ECEC and education, for instance – before the adoption of policy on tax-paid private provision.
- Provision of public services and the role of private providers in their financing, delivery and management are regulated across Member States mostly at sector level, with no evidence of all-encompassing regulation of public services at national level in any of the case study countries.
- In recent years, the selected Member States increased their outsourcing of public services. While in Sweden this was aimed at preserving access and quality simultaneously (by solving a capacity problem in employment services when the number of recipients increased), in the other three countries outsourcing of public services led to increased co-payments on the part of service users, especially in long-term care. Employment services were an exception to this trend, remaining tax-financed across all cases.

- The private provision of public services across the selected Member States is managed through a variety of methods, including contracting out via public procurement procedures and voucher schemes that aim to maximise user choice. When contracting authorities employ procurement procedures, the established selection criteria, especially in the case of long-term care, favour price over quality in Spain and the UK. In Sweden, quality outweighs price. In Lithuania, public procurement is not used in the management of public services.

Policy pointers

Coherence and continuity

- Consider existing non-profit sector solutions for specific service needs and seek avenues to collaborate with and protect providers so as to harness the experience they have built up over the years. The case studies illustrate that organisations in the non-profit sector cannot compete for large procurement contracts against consolidated private for-profit firms that benefit from economies of scale.
- Learn from insourcing or 'remunicipalisation' exercises, as expanding the role of the private sector is not the only means of improving the quality of services.

Monitoring and evaluation

- Apply uniform performance indicators for quality of services regardless of the nature of the provider delivering them.
- Develop mechanisms for systematic monitoring, evaluation and oversight of service provision of all providers of public services at the level of the contracting authority. Ensure that the results of these mechanisms feed into public-service-related policy and practice.
- Improve the technical capacity of governments to establish mechanisms and conditions for fruitful collaboration with the private sector through sharing the findings of systematic evaluations and state-of-the-art research on public services and how they are managed. It is also important to ensure that governments and public servants have the administrative capacity to implement policy decisions.
- Develop a methodology for calculating all the costs involved when service provision is contracted to private sector organisations. This methodology should include the administrative costs related to public sector commissioners and contract managers and any cost penalties incurred for variations to agreed services or products, or as a result of early termination of underperforming contracts.

Risk aversion

- Minimise the risk of service contract failure by studying the conditions under which this has occurred in the past and identifying lessons learned. Ensure that those handling such contracts have the administrative capacity to do so.
- Ensure appropriate contingency planning, given the high societal cost of interruptions to public service delivery, so as to avoid discontinuity of public service provision in the event of contract failure.
- Ensure transparency in the financing and ownership of public service contractors, which may be backed by private equity and exposed to high levels of financial risk, so as to avoid the detrimental effects of ownership change on the end users of the service. For example, by reducing the volume of services contracted by single procurement contracts, contracting authorities would reduce the opportunity for large businesses to dominate and allow other actors to compete.

Introduction

Public services are at the heart of the European social model, the ambition of which is to achieve high levels of employment in combination with a high degree of social protection and inclusion. While historically such services were largely provided by public agencies, and often with exclusive rights, the private sector (including both non-profit and for-profit organisations) is being increasingly relied upon for the provision of social services across the EU.

These public services include social services of general interest (SSGIs), which are the focus of the Social Investment Package launched by the European Commission in 2013. The improvement of these services is also high on the agenda at Member State level. Excluding cash benefits and considering only in-kind services, SSGIs cover: healthcare, long-term care, childcare, education, social housing, and employment and training services (European Commission, 2015c). This report assesses developments in the delivery of services in aspects all of these areas apart from social housing.

While no data are available on the degree of privatisation across Member States and across sectors, trends in specific social services illustrate the extent of the private sector's role in delivery of public services. For example, in early childhood education and care (ECEC), private funding in Member States in the OECD varies from 5% or less of overall funding in the Benelux countries to upwards of 25% in Austria and Germany (OECD, 2013). As the European social model is characterised by the all-encompassing welfare state, public spending on ECEC is higher in EU Member States when compared to other member countries of the OECD (OECD, 2013).

EU Member States are increasingly adopting public–private partnerships (PPPs) in public services, including in SSGIs. PPPs are a form of private sector cooperation with government in the provision of public infrastructure and services, which may involve collaborative definition of goals and objectives and sharing of risks and responsibilities (Public–Private Partnership in Infrastructure Resource Centre, 2015). As illustrated in the healthcare case study from Spain, the role of the private sector in PPPs can go beyond delivery of services to include management and, potentially, financing, although this is less likely in contracting arrangements. Healthcare is by far the largest sector as far as PPPs in SSGIs are concerned, and comes second only to transport in terms of number of transactions and value of PPP projects. According to data from the European Public–Private Partnership Expertise Centre (EPEC), in 2014 some 15 PPP health transactions worth €2.2 billion were completed, a marked increase from 12 projects worth €1.5 billion in 2013 (EPEC, 2014). However, education – the third largest sector in terms of number of deals and fourth largest by aggregate value – has shown a 33% decrease in PPPs over 2013.

Of all EU countries, the UK has by far the largest PPP uptake; in 2014, its aggregate value of PPP projects amounted to €6 billion. Other Member States with high PPP values include Belgium, Germany, Italy and the Netherlands, among others. The countries that joined the EU since 2004 have a very low uptake of PPPs; none appears among the 10 Member States with the highest PPP uptake.

The private sector has been engaged across Member States with the apparent aim of increasing quality of services, customer choice and efficiency. This development has been partly driven by ideological views and a push for 'new public management' – a framework that emphasises the autonomous management of public services (a purchaser–provider split), leading to increased competition for the provision of these services (Larbi, 1999). The arguments in favour of this approach exerted greater influence during the economic crisis, when public funding to maintain welfare states was insufficient amid unfavourable demographic trends (such as population ageing and smaller families) and adverse economic conditions. However, it is feared that this increased role for the private sector will reduce the quality of services as an effect of cutting costs, mostly through increased pressure on workers, and that it will lead to increasingly unequal access to services for all, undermining the coverage of the welfare state.

An increasing reliance on the private provision of public services is apparent throughout Western Europe since the 1970s (Wollman, 2014). Despite this, there has been relatively little systematic and comparative analysis of this phenomenon,

particularly since the recent economic crisis. This exploratory study draws on qualitative data, gathered through interviews and existing (albeit limited) sources, to analyse the growth of the private sector in Lithuania, Spain, Sweden and the UK. (The next chapter provides a rationale for this selection of countries.) In doing so, it aims to answer the following questions.

- Has there been an increase in the role of the private sector in the delivery of public services over the past decade?
- Which sectors have been most affected and least affected?
- What are the key drivers behind the increased role of the private sector in public service provision?
- What role has the economic crisis played in the increased role of the private sector in public service provision?
- How is the private sector's role in provision of public services managed across countries and across sectors?
- How is the private sector's provision of public services financed across countries and across sectors?
- What are the main outcomes of an increase in the role of the private sector in public service provision across countries and across sectors, especially in relation to access, quality and effectiveness?

Through an analysis of the sectors most affected in four countries with different social models, the research explores the different ways in which private for-profit and non-profit actors – referred to throughout as private providers – have increased their role in service delivery. It also considers the implications of this development, most importantly as it affects the service users, particularly regarding access, quality of the services received and efficiency of service delivery.

Access relates to both affordability and availability of services, if and when needed.

Quality of services is understood as meeting the needs of the service users both in terms of responding to individual or personalised needs and in providing comprehensive cover.

Effectiveness means either success in reaching targets or cost-efficiency of public services delivered by private companies. It also relates to the extent to which targets set by legislation or specific service agreements have been achieved. Efficiency is introduced as an alternative concept to effectiveness to address the lack of disaggregated data to facilitate comparison between the effects of private and public provision of a given service.

The analysis of social policies in the four selected countries allows consideration of how different social policies met the challenges of the crisis and the role the economic downturn may have played in the increasing involvement of the private sector in public service provision. Due to the specific focus of this study on outcomes for the service user, working conditions of staff employed in private and public providers are not considered in detail.

Aims and research approach 1

This study is designed to shed light on the increased role of the private sector in the delivery of public services in four countries: Lithuania, Spain, Sweden and the UK. Each country study includes three sector-specific case studies. These case studies analyse policy and practice within specific SSGI sectors, with a focus on the implications for the service user. The inclusion of three sector-specific case studies from each country enables a comparative analysis of different sectors in one country, as well as one sector across countries. The case studies involved desk research on the role of the private sector and a minimum of three interviews per case study. Interviewees included policy-level stakeholders, service users and service providers, or associated structures representing the latter two.

The selection of these four countries reflects the exploratory and comparative nature of the research, enabling information to be gathered on the extent and effects of the private sector's role in public service delivery in contexts where different historical, political, structural and economic factors have shaped the development of the welfare state. Hence, countries with distinctive social models were chosen for analysis. The countries also differ in terms of their resilience to the economic crisis and the measures they took in response to it. This diverse sample enables an exploration of trends in the role of the private sector in public service provision in specific countries; the analysis does not claim to represent trends across the EU as a whole.

Different social models

A summary of the social models of the four case study countries follows, describing their SSGI provision and the role of the private sector.

Lithuania

Lithuania was relatively late in developing its social model, which, overall, is characterised by low public spending. Before the crisis in 2007, this Baltic state spent 14.4% of its then growing gross domestic product (GDP) on social protection, almost half the EU27 figure of 26.1%. The country has an ambitious and broad-reaching universal coverage policy, extending to all levels of care, education and health. However, as is the case with the other Baltic states, Lithuania collects less tax revenue than the EU28 average rate, which leads to a lower level of social spending. Overall, the social protection system is built on social insurance (contributory) and social assistance (non-contributory). Social dialogue is underdeveloped, and both union membership and collective bargaining coverage are low. The minimum wage, one of the lowest in the EU28, is regulated at national level by labour law and constitutes the income of over one-fifth of the workforce.

Since regaining independence, Lithuania has moved away from the all-encompassing public provision of services and towards the dismantling of monopolies and an increase in private sector participation. To some extent, however, the institutional framework's path dependence (reliance on long-standing practices and mindsets), alongside a lack of funding and skills, has prevented the entry of private service providers in areas such as long-term care, social care and childcare, among others. By 2014, private actors were starting to play a more significant role in health, employment services, elder care and, with recent reforms, higher education. However, public entities remain dominant in most SSGI sectors. In 2015, the Lithuanian government is preparing a bill on the social model, which, if accepted, will be a move towards a more liberalised labour market in line with the 2014 Council Recommendation for the national reform programme.

Spain

Due to its long history of military dictatorship, Spain also has a relatively short history of social spending and the welfare state. Here, the welfare state centres on social security, universal coverage for health and education, and unemployment benefits. The latter, however, are to some extent undermined by a steady move towards liberalised employment, which facilitates insecure casual and temporary work arrangements. In 2004, as an expansion of the welfare state amid economic growth, the country began introducing universal long-term care and early childhood education. Social

spending, slightly below the EU28 average, has been moving towards convergence with continental standards. However, due to the ageing of the population, much of this spending goes towards pensions and healthcare, with less invested in education.

Since its integration into the European Community in 1986, Spain has diversified social service provision to include private and third-sector organisations. The drivers behind this include rising public debt and the public perception of inefficient public organisation, as evidenced by poor infrastructure, matched with expectations that privatisation would bring about both essential investment and the cost-effectiveness required for sustainability. An interesting and relevant characteristic of the Spanish welfare state is its high level of decentralisation, as evidenced by over one-half of all social spending occurring at regional and local government levels.

Sweden

Sweden's social model is characterised by high levels of social spending and public sector participation in all levels of service provision. In terms of welfare policy, social protection coverage is universal. It is also egalitarian in nature, backed by strong work–life reconciliation measures. Sweden has one of the most equal income distribution levels of all Member States. Collective bargaining plays a strong role and is protected by the country's constitution and labour law. In many areas, including the regulation of the minimum wage, collective agreements actually take precedence over labour law. Employment policy in Sweden reflects a good balance between employee rights and employer flexibility and is backed by active labour market policies.

Following the banking crisis of the 1990s, Sweden opted for deregulation, liberalisation and privatisation. Previously protected activities became exposed to competition between suppliers of goods and services. In social services, this affected employment, health, education and elder care. In education, the recent introduction of a voucher system allowed publicly subsidised private schools to enter the market.

UK

Under the UK social model, the main pillars of social policy are welfare and employment. Welfare policy is mostly liberal: there is no universal coverage; unemployment benefits and pensions are low; and care services such as childcare and elder care are delivered by private actors and at least partly financed by service users. The UK's employment policy is characterised by low spending on active labour market policy measures, and poor labour organisation and social dialogue. This has resulted in inadequate employment protection rights and employer-led flexibility, as evidenced in the proliferation of low-wage casual and temporary work arrangements.

Private sector involvement in the provision of public services is well established in the UK, first driven by compulsory competitive tendering (CCT) during the 1980s and 1990s, and the government policy known as 'best value' during the 2000s, which opened up considerable parts of the civil service, local authorities and the National Health Service (NHS) to competition. Local government was particularly affected by privatisation, and direct spending on staffing costs now makes up less than 50% of total annual revenue costs across all service areas, with social services particularly reliant on the private, voluntary and independent sectors.

Services most affected

Across the four countries chosen for analysis, expert assessment of existing data on public versus private providers identified the following areas as being most affected by private sector involvement: ECEC; compulsory education; employment services; elder care and home care; and primary to tertiary healthcare. These are broad categories; the case studies focus on more specific services, described further down. Table 1 provides details on the sectors and services selected for study in each of the four countries.

Table 1: Case study sectors and services

	Lithuania	Spain	Sweden	United Kingdom
Healthcare	Primary and secondary healthcare	Tertiary healthcare		
ECEC	ECEC		ECEC and compulsory schools	ECEC
Employment services	Employment and training services		Public employment services	Employment and training for job-seekers
Long-term care		Home-help services Long-term care and social services	Municipal home-care services	Adult social care (domiciliary and home care)

Note: The choice of sectors in the case study countries was based on an expert assessment of existing data on the ratio of public versus private providers, and their users and workers.
Source: *Prepared by authors*

Key terms used in the report

Public services refer specifically to social services, which in Europe have come to be called social services of general interest (SSGIs). The services included in this research are:

- healthcare;
- employment and training services for job-seekers;
- ECEC;
- primary and secondary education;
- long-term care (European Commission, 2015c).[1]

Healthcare services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal healthcare services (WHO, 2014; WHO, 2002).[2] Healthcare delivery is categorised in three levels: primary healthcare is a patient's first point of contact with the healthcare system and may serve as the basis to further levels of care; secondary healthcare is specialised care provided by a physician on the basis of referral from a primary physician; and tertiary healthcare is highly specialised care provided in hospital settings (WHO, 2004). The case studies include primary and secondary healthcare services in Lithuania and tertiary healthcare services in Spain.

Employment and training services for job-seekers refer to all employment services provided by public authorities with an explicit or implicit 'mission of general interest' for different user groups, such as unemployed job-seekers, economically inactive people, employed job-seekers and employers (Polacek et al, 2011). Employment services examined in the current research include training and matching services in Lithuania, Sweden and the UK.

[1] Social housing, although included in SSGIs, was not analysed in any of the 12 sector-specific case studies.

[2] Non-personal health services are actions directed either towards people as a group (such as health education) or towards the non-human components of the environment (for example, basic sanitation and waste disposal). They usually produce significant positive effects or reduce possible negative effects of individual or collective actions.

Early childhood education and care (ECEC) includes all arrangements for providing care and education to children under the compulsory school age, regardless of setting, funding, opening hours or programme content. This study focused on 'institutionalised' ECEC in Lithuania, Sweden and the UK.

Compulsory education refers to levels 1–3 of compulsory education as defined in the International Standard Classification of Education (ISCED) in 2011. The Swedish case study on ECEC analyses pre-school and compulsory education providers as both these levels are covered by the same providers and are subject to the same legislation.

Long-term care refers to care services for older, frail, dependent or disabled people needing daily living support over a prolonged period of time (OECD, 2011b). While a variety of terms are used to refer to long-term care, a distinction can be made between domiciliary or home-help services and residential care. Domiciliary or home-help services encompass a range of home-based services to individuals whose personal independence is restricted or who are undergoing a personal or family crisis; the case studies examine these services in Sweden and the UK. Telecare – assistance from trained carers via a hands-free communication device – falls under this category. Residential care, examined in one of the UK case studies, involves the provision of services in a centralised location (outside the service user's home).

Privatisation of public services or greater private sector role in public service provision refers to expanded opportunities for the private sector to deliver public services through one of the following means:

- the contracting of private companies (regarding service, management, lease contracts or social impact bonds), but with public oversight through regulatory and monitoring mechanisms;
- PPPs;
- demand-side funding (direct funding or vouchers);
- service users' contributions (for example, fees and co-payments).

Country study: Lithuania 2

Overview

Since regaining independence in 1990, Lithuania has moved from the all-encompassing public provision of services to the dismantling of monopolies and allowing private sector participation in the economy, including provision of SSGIs. The 1996 Law on Public Organisations, which in essence decentralised public social services, initially facilitated involvement of private providers across different sectors. However, a lack of political will, funding and skills – caused by path dependency and the existing institutional framework and capacity – prevented, at least to some degree, the entry of private providers into this field. Even though private actors were starting to play a more significant role in some fields by 2014, public entities remain dominant in the provision of public social services.

The sectors analysed for Lithuania have seen the biggest increase in the role of the private sector: healthcare, adult training and employment services, and ECEC. Table 2 summarises the main trends regarding the private sector's role in these areas.

Table 2: Role of the private sector in the case studies of Lithuania

Sector	Brief description
Employment and training services	The provision of employment services to the unemployed and those about to lose their job was opened to private providers through the introduction of a voucher system for non-formal and formal training in 2012. This introduced competition and gave clients a choice of providers.
ECEC	With considerable growth in demand for kindergarten provision in cities, the role of private providers has become increasingly important. The financing for public and private providers differs in favour of the former. Two Bills have favoured competition between private and public providers through the liberalisation of requirements for establishing a kindergarten in 2010 and the introduction of a voucher scheme in 2011.
Primary and secondary healthcare	From 1990, the state financed all healthcare services. Following restructuring, however, financing of dental care and pharmaceuticals were given over almost completely to the private sector, with some compensation provided to vulnerable groups (for example, medicine for older people). Healthcare – from primary to tertiary level – is financed by the state and delivered by both public and private providers. The state has been compensating licensed private providers for approved services at primary, secondary and tertiary levels since they began providing these services. A legislative basis for this was established through case law by the Constitutional Court in 2013.

Source: *Prepared by authors*

Interestingly, none of the above sectors is considered to be a 'social service' in Lithuania. The services that fall under this definition, such as elder care, social work services, domiciliary care and social housing (Valstybės žinios, 2006) are regulated by the 2006 Law on Social Services. It established a mixed economy of care, whereby either private (for-profit or non-profit) or public providers can provide social services for different client groups, and clients can choose their service provider. There was little take-up among for-profit service providers in these sectors due to low profit margins and low levels of experience of providing these services, as the social care system only began in 1990. The market principles set out in the 2006 law did not apply to social care, as the legislation did not provide for the possibility of private sector participation (Žalimiene and Lazutka, 2009).

However, there has been extensive involvement of the third sector in delivering residential long-term care, especially through non-governmental organisations (NGOs) affiliated with parishes. In the case of social housing, the private sector is only involved in a financial capacity; that is, accredited banks provide credit for shortlisted beneficiaries of partially state-subsidised housing.

The role of private providers in terms of delivery, finance and regulation of the services provided has been limited to delivery. The private sector is engaged in financing only insofar as private providers raise their own capital for financing the services they themselves deliver, including those to publicly insured clients, for which they receive partial state compensation. Across different sectors, private providers have mostly been enabled to deliver services through voucher

systems, the transfer of choice of provider to the client, and allowing competition for securing clients. While in employment and healthcare services, financing is equal for private and public providers, in other sectors, such as childcare, private providers are eligible for less funding for the same services.

Case study 1: Employment and training services

Background and policy objectives

This case study focuses on the role of private providers in delivering training services to people who are unemployed or workers who are about to be laid off. Since the 1990s, it has been legal for private actors to provide training services for unemployed people. However, up to the introduction of a new financing scheme in 2012, their involvement in the provision of training services was moderate. Then, the Lithuanian Labour Exchange (Lietuvos Darbo Birža, LDB) used public procurement procedures to buy training services that were later provided to eligible persons identified by the LDB as being most in need. Under the new funding scheme, those eligible for training receive a voucher from the LDB enabling them to pay for selected training services from a provider of choice.

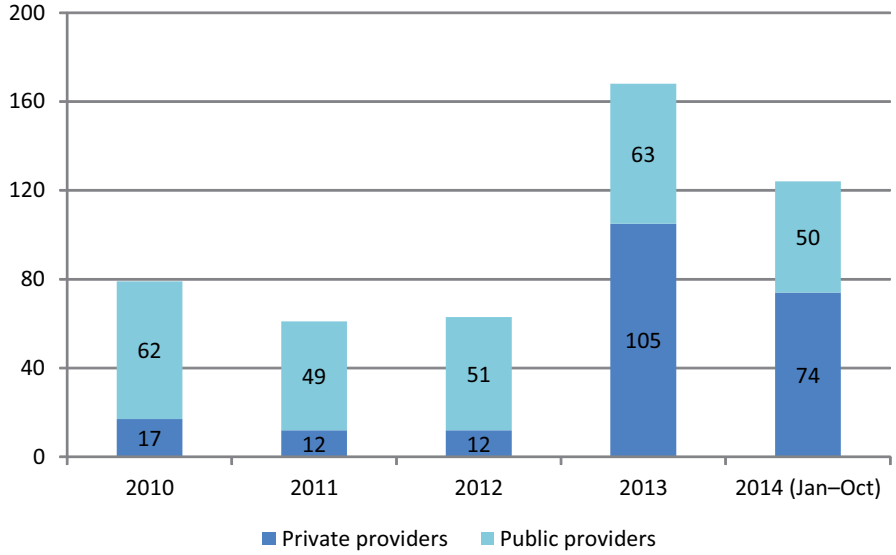
According to a policy expert interviewed for this study, although both public and private providers could participate in both schemes, the voucher scheme proved more attractive to private entities. While private service suppliers associated public procurement procedures with a high level of administrative burden, they found it was much easier to take part in the new voucher scheme. In addition, before 2012, technical specifications for training providers required at least three years' experience in the provision of training services, which was difficult to satisfy for organisations coming from the private sector. There were other disadvantages of the pre-2012 scheme:

- public procurement processes were protracted, which made it difficult to react quickly to changes in the labour market;
- the training services purchased had to be organised even when there was no demand for specific skills.

The share of people finding employment after training was low (no more than 70%), which implied an inefficient use of public finances.

Figure 1 shows how the number of private entities providing training services has increased since the establishment of the new funding scheme, while the number of public providers has stayed almost the same each year between 2010 and 2014.

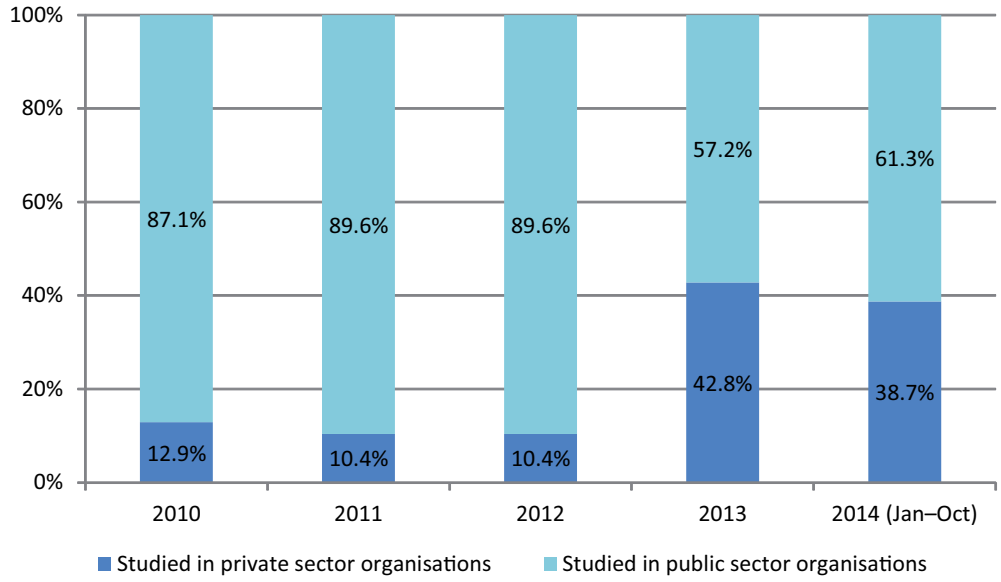
Figure 1: Number of public and private training service providers, 2010–2014



Source: *PPMI calculations based on statistical data provided by LDB*

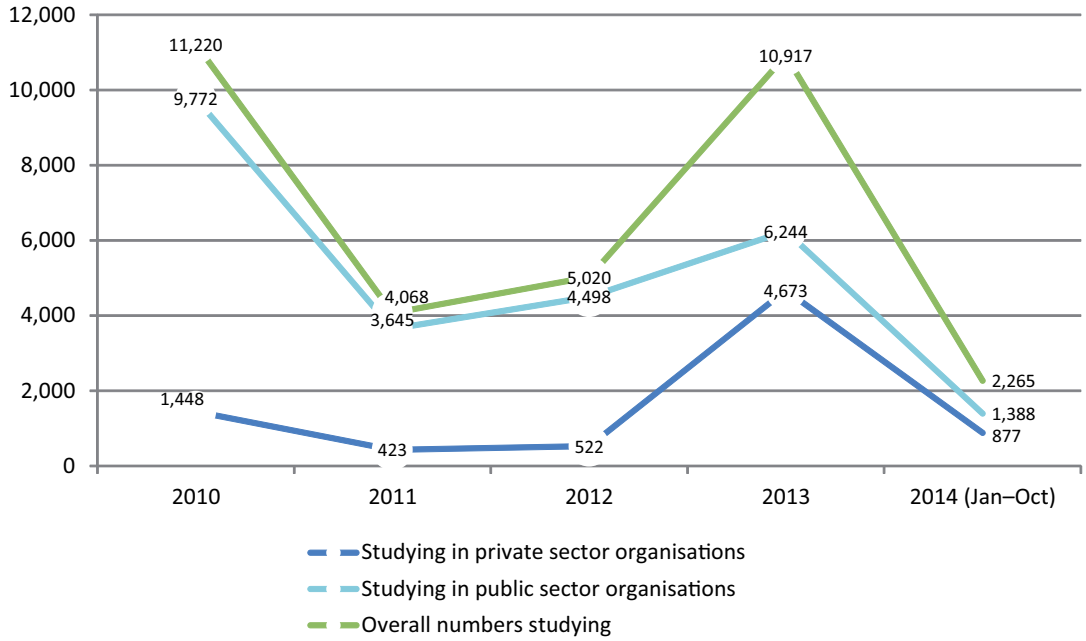
This increase in the number of private training providers has naturally translated into an increase in the proportion of people receiving training from the private sector, as shown in Figure 2. Despite this change, more people (in absolute numbers) still receive training in public sector institutions than they do in private institutions (see Figure 3).

Figure 2: Share of job-seekers receiving training in public vs private organisations, 2010–2014



Source: *PPMI calculations based on statistical data provided by LDB*

Figure 3: Numbers receiving training, 2010–2014



Source: *PPMI calculations based on the statistical data provided by LDB*

As explained by policy experts, greater involvement of private sector companies in the provision of training was a side-effect of the establishment of the new funding scheme rather than the main rationale behind it. The main policy objective was to ensure more efficient use of public money by providing training only to those who could immediately use their acquired skills in the workplace; the new scheme limited voucher access to those who had secured a contract with a future employer. The need for this policy came about during the economic crisis, which made it more difficult to find work for those completing training provided by the labour exchange. According to policy experts, in 2008 around 72% of people who received training found a job, compared to only 32% in 2010. The new voucher system brought this figure up to more than 90% in 2013.

Financing

The value of a training voucher cannot exceed €1,799, the equivalent of six monthly minimum wages. The LDB also covers other related expenses such as providing a stipend and accommodation costs (Valstybės žinios, 2012). All funding for vouchers comes from several projects financed by the European Social Fund (ESF) (LDB, 2014). As funding from the ESF became limited during the changeover of programming periods, in 2014 the cost of most training vouchers had to be covered by the national budget.[3] This explains the decrease in the number of people who received training in 2014. (According to interviewees, the cost of training is somewhat higher in the private sector due to a stronger focus on quality – by employing high-level lecturers and teachers – and profit-making.)

Implementation and management

The legal basis governing the organisation of vocational training for people who are unemployed or laid off in Lithuania is provided by the Law on Support for Employment (2006), the Law on Vocational Education and Training (1997), and the Description of the Conditions and Procedures related to the Implementation of Active Labour Market Measures, established by the decree of the Minister of Social Security and Labour on 13 August 2009.

[3] The ESF funding programmes run between 2007–2013 and 2014–2020.

In order to receive a training voucher, an applicant has to sign an agreement (usually tripartite or, rarely, bipartite) confirming that they will be employed after receiving training.[4] Those receiving training services must stay in employment for at least six months after training. If this condition is not met, the cost of the voucher and other training-related expenses must be returned to the LDB by the party who has violated the agreement (either the employee or the employer).

Training provided to people who are unemployed or due to be laid off can be formal or non-formal.[5] The Ministry of Education and Science assesses the quality of formal programmes according to the criteria defined in the relevant documents, such as the *Rules for the licensing of formal professional training*, and issues a licence for an unlimited duration to the accredited training provider. The ministry later monitors the quality of service provision and has the right to withdraw the licence due to poor performance or non-performance. Non-formal training programmes must be coordinated with regional social partners; however, beyond that they are not monitored.[6] According to interviewees, it is more common for private actors to provide non-formal training, for two reasons.

- There is a lower administrative burden for providers of non-formal training.
- Private training providers are often the future employers of those undergoing training, which motivates them to provide trainees with skills and competences that will be directly useful in their future work, as quickly as possible.

The analysis did not indicate any significant differences in the implementation and management procedures applied in the public and private sectors.

Case study 2: ECEC

Background and objectives

Two factors gave rise to an overcapacity of publicly provided ECEC in Lithuania: a widespread infrastructure of public kindergarten establishments left over from the times of the Soviet planned economy; and a decrease in the population following 1990. This led to the eventual dismantling of some of the ECEC infrastructure.

However, since the late 2000s the demand for ECEC services has been increasing, especially in bigger cities. Three key demand-side factors acted as drivers for private providers to enter the market: an increasing birth rate, encouraged in part by a generous family policy involving prolonged paid maternity leave with 100% income replacement that was introduced in 2007; the lack of an ECEC infrastructure; and the solid growth in disposable incomes since the 1990s, and especially since the 2000s, which meant that people could afford to choose more specialised childcare offered by private providers. Moreover, municipality-owned kindergartens could not keep up with the rising demand for greater diversity of early childhood education methods (Ministry of Education and Science, 2012) and curriculums as well as flexible schedules (Monkevičienė et al, 2008).

[4] Tripartite agreements are signed by the individual, the labour exchange and the future employer, whereas bipartite agreements involve only the first two parties. Bipartite agreement can be signed in two cases: (1) when, after receiving training, a person plans to start their own business; (2) when a need for a labour force with specific skills is identified in the labour market analyses carried out by the labour exchange.

[5] Formal training programmes, providing users with formal qualifications, are accredited by the Ministry of Education and Science. Non-formal training programmes aim to improve skills and competences without providing formal qualifications.

[6] However, interviewees noted that at the time this case study was being conducted (late 2014), a new law on the rules regarding the provision of non-formal training was being prepared by the Ministry of Education and Science.

However, private kindergartens did not establish rapidly to meet the increased demand, mainly because of an unfavourable legal basis for doing so, characterised by unreasonably high hygiene standards, strict requirements for buildings and premises where kindergartens could operate, as well as no possibility of receiving state funding (Ruškus et al, 2012).

The biggest impetus for the entry of private providers into this sector was legislative change, lobbied for by an association of private childcare providers and parent organisations. At the end of 2010, the Ministry of Education and Science and this association facilitated the conditions for the establishment of private kindergartens by creating a more favourable legal framework. This involved simplifying hygiene standards; introducing pre-school education vouchers, a public financing tool for both public and private service providers; and simplifying the requirements for kindergarten buildings and facilities (Valstybės žinios, 2011a).

Financing

Since the beginning of 2011, private kindergartens have been partly funded by the government, although in a different way from public kindergartens. Private kindergartens are funded by two sources: pre-school education vouchers (as of 2014 a voucher was worth €62 per child per month) and parent co-payments that vary from €144.80 to €434.40 per month, depending on location and services provided. The voucher officially covers four hours daily of kindergarten and is half of the value of the voucher subsidy available to public providers. The difference between the cost of attendance and the voucher is subsidised by parent co-payments.

The cost of attending a public kindergarten is compensated by the same pre-school education voucher, but it is for a larger amount and is intended to cover eight hours of care daily. The second half of this voucher, which is not available to private providers, is funded by local government and, according to interviewees, is also supposed to cover maintenance costs. Public kindergartens also charge parent co-payments, ranging from €58 to €87.

In the Lithuanian legal system, municipal governments are responsible for the organisation and provision of childcare and education services. Some stakeholders understand this as a duty of municipalities to ensure 100% accessibility to services for all, and they look to the municipalities for solutions in cases where demand is not met. According to a member of the association of private providers and parent organisations, parent associations in areas with an insufficient supply of public kindergartens have put this duty to the test through case law.

The strategy for addressing the lack of supply and the higher cost of attendance at private kindergartens differs from one municipality to another. In reaction to pressure in the courts, Kaunas district municipality announced in 2014 that from November 2014 it would compensate parents by €72.40 for every month they had to buy services from private providers due to a lack of public spaces. This municipality then announced support to low-income families (whose monthly income does not exceed €753) through compensation of €175 from the summer of 2015, and provided €100 compensation for higher-income families (Kauno diena, 2014).

In 2015, Vilnius municipality established one new public kindergarten, with three more being planned. Although there has been no official call for proposals, the municipality official interviewed said they are considering applications for municipal concessions from private providers on a rolling basis, with applications being considered case by case. When this case study was being conducted, two semi-private kindergartens (50–50 private–public funding) were operational in the city of Vilnius, one of which had opened its doors in January 2015. In the case of semi-private kindergartens, the municipality provides premises and owns 50% of the capital. Other conditions for the granting of concessions include parent fees being kept below a ceiling set by the municipality. In 2014, the fee was €188.25 per month per child.

Implementation and management

In order to get established and receive public funding (in the form of pre-school education vouchers), private kindergartens have to be included on a registry of education institutions. This requires meeting the following criteria, which also apply to public kindergartens:

- meeting health and safety standards, and having a hygiene certificate, which is issued for an indefinite period of time;
- having an education curriculum that meets the requirements set by the Minister of Education and Science;
- hiring teachers with the higher education and formal qualifications of a pre-school teacher or primary school teacher, for teaching senior kindergarten groups.

Interviewees revealed that, in reality, private kindergartens face higher basic quality requirements than public ones. For instance, some public kindergartens operate without a hygiene certificate. This is because they cannot afford to improve their hygiene standards (partly because they serve more children than they have capacity for); the Seimas (Lithuanian Parliament) Ombudsman has decided that, given the need for childcare, it is better to let them operate like this than to close them down.

The municipality can supervise only public kindergartens and has no legal power to control private ones, which establish their own quality control mechanisms. Private providers are subject to basic hygiene inspections and company audits. Beyond that, quality control is implemented by parents who essentially vote with their feet by going to the best-quality kindergartens; as with every business, private providers have to attract a sufficient number of customers to stay in business. Moreover, parents tend to be actively involved in the internal governance of kindergartens, and their involvement also works as a quality insurance instrument.

Interviewees' opinions on quality, unfortunately, cannot be supported by monitoring data, as neither parent organisations nor public institutions conduct regular user satisfaction surveys or other forms of evaluation.

There is little in the way of institutionalised communication channels that would enable dialogue between service provider regulators and stakeholders concerned with the lack of childcare services. Private providers and provider–parent associations lobby for the equal financing of private and public providers, but at the time of the case study (early 2015), this has not yet been fruitful. Across the country, municipalities still feel it is preferable and more cost-effective to control childcare service provision and delivery.

Case study 3: Primary and secondary healthcare

Background and objectives

The foundation was laid for private providers' entry into primary healthcare service provision with the establishment of the Family Doctor Institution in 1995. The situation was strengthened in 2004 when general practitioners became family doctors and family medicine became a certified service. In line with restructuring, Lithuania received support from the World Bank and the EU Phare Programme. The latter helped finance the establishment of private primary healthcare providers on the eve of Lithuania's EU accession in 2004.[7] Government policy at that time was leaning towards transferring all primary healthcare to the private sector, but this did not happen.

[7] The healthcare provider categories were GP, or GP and therapist, podiatrist, GP surgeon, gynaecologist and dentist. Although the inclusion of specialised care in this concept was meant to be transitional, Lithuania has maintained this expanded definition of family healthcare, unlike, for example, Estonia, according to a representative of the Ministry of Health.

The number of private sector providers in Lithuania has been growing steadily, more than doubling from 837 private providers in 1998 to 1,882 private providers in 2013 (Gaidelytė and Tendziagolskytė, 2014 – see Table 3.6 Private healthcare institutions and their staff, 2004–2013). However, private providers range from practices involving just one family doctor to larger institutions, with the former greatly outnumbering the latter. The percentage of the population registered with private providers in 2013 accounted for 29.6% of Lithuanians registered with healthcare institutions (Gaidelytė and Tendziagolskytė, 2014).

Private providers are involved in both the funding and delivery of primary healthcare services. Besides the aforementioned support from the Phare Programme for the establishment of private practices, no government funding for infrastructure has been provided. This means that private providers operate as regular businesses and require private capital for their setup and operational costs. In terms of delivery, most private providers of primary healthcare services receive patients through the public healthcare insurance system, and may or may not charge additional fees, which vary depending on the provider. The capacity of private providers in service delivery has changed over the last decade. Their role in the delivery of publicly funded services was put before the Constitutional Court, which in May of 2013 ruled that any restriction on the participation of private providers in the provision of public health services would be unconstitutional.[8] This paved the way for all private providers to get partial compensation from the state for services provided to state-insured users (Lithuanian Constitutional Court, 2014). (See the section on financing below for further detail.) In Lithuania, all registered unemployed and working citizens, including those engaged in part-time and voucher work but excluding independent (freelance) workers – who have to pay out of their own pockets for mandatory health insurance – have health insurance.

Financing

There are two main sources of public funding available to private providers: the National Health Insurance Fund, which compensates the base prices of services provided to insured individuals; and a fixed amount per every registered patient, as well as a variable amount based on provision of recommended preventive services (such as free testing for cervical cancer). Additional sources from the state budget include fixed and variable amounts for first diagnosis of cancer, among other common diseases, although this funding mechanism was not particularly transparent according to the interviewed private provider.

Despite receiving compensation for base prices, most private providers, including an interviewee who chose to remain anonymous, have to charge co-payments, even on subsidised services, as the set base prices do not cover the cost of providing the service.[9] The issue of whether they are allowed to charge co-payments was addressed in the aforementioned Constitutional Court ruling, which said it is up to the legislators to establish the exact conditions and limitations for the funding of healthcare services for private providers.

The private sector is also involved in the provision of specialised primary healthcare services, often operating out of public hospitals and servicing both private and public patients. For example, there is a network of magnetic resonance imaging (MRI) providers in Lithuania that receives a mix of private and public patients and thus funding.

[8] Leading up to the ruling and following it, there was considerable public debate, with the emergence of different interest groups, specifically the Association of Lithuania's Private Health Care Companies on the one side, lobbying for more rights, and the Ministry of Health on the other, aiming for more control and restrictions of private medicine.

[9] Public providers are not allowed to charge co-payments for compensated services; however, the practice of topping up, financially or otherwise, is still commonplace.

Besides covering a portion of the cost of providing services included under national insurance, the state provides no additional subsidies or tax breaks to private healthcare providers. This means all infrastructure and maintenance costs have to be cross-subsidised from services within those same providers that are 100% private. For example, most offer dentistry services or invest in the development of innovative preventive healthcare services in order to be able to cover their costs.

According to a service provider interviewee, the economic crisis complicated the cross-subsidisation mechanism, as fewer people could afford paid services. For a time, private services focused on attracting more state-insured patients, as public funding, although limited, remained stable during the downturn. However, the change in administration during the crisis came with a political shift and the aforementioned Constitutional Court suit, causing many private providers to refocus their business models on completely private services. Since independence, ministers of health in Lithuania have served an average term of one year and a few months, so there has been little continuity in terms of political direction.

The cost of private healthcare grew by over 57% between 2004 and 2009, when it reached approximately €290 million. However, this increase includes pharmaceutical expenses, which are 100% private in Lithuania (Lithuanian Statistics Department, 2014).

Public funding is available for both primary and secondary levels of healthcare (and for tertiary healthcare in a very few cases). Some providers provide only primary care, which, since the 2013 Constitutional Court ruling, is partly subsidised by the state for every provider. For those that also provide secondary care, the partial subsidies may or may not be allocated based on criteria that are yet to become transparent – according to the private service provider interviewee, their centre's application for secondary-level funding was successful for the first time in 2014, after six unsuccessful attempts.

Implementation and management

Implementation and management vary considerably among private service providers. The public subsidies for primary and secondary services, which again only cover a small percentage of their costs (around 20% for the private provider interviewee), come with some conditions. These include:

- scheduled and unscheduled audits by the Territorial Health Insurance Fund, the National Health Insurance Fund and the State Health Care Accreditation Agency;
- annually renewable contracts with the National Health Insurance Fund;
- a licence from the State Health Care Accreditation Agency;
- annual check-ins from the Public Health Centre to verify that hygiene requirements are being met;
- additional check-ups based on the variety of services offered by the provider – for example, training programmes regarding emergency care and dentistry services, which are overseen by a specific body.

In line with requirements for OECD accession, Lithuania as an aspiring member has mechanisms in place for open governance – specifically, stakeholder involvement in the development, implementation and regulation of the service. Patient associations, as well as the Ministry of Health, are represented in the management and supervisory boards of regional and national insurance funds, including supervisory bodies for health-related issues such as the Commission for Compensated Medicine.

Quality criteria that apply to all healthcare providers have been set, together with the licensing mechanism both for specific providers and medical staff. Besides being subject to the abovementioned audits, both private and public providers are required to conduct basic client satisfaction surveys, although according to the health ministry official interviewed, they reveal little about the quality of services provided beyond friendliness of staff and the environment where they operate. The municipal associations also play an important role in setting the criteria.

Private providers conduct their own client satisfaction surveys; there is no overarching mechanism for all providers. There is an association of private healthcare providers that collects association-wide data; however, the cost of participation prevents some providers from taking part.

Various bodies monitor different aspects of services. Waiting times are constantly monitored. In fact, in order to institutionalise this process, in 2013 the Ministry of Health set up a new department for accessibility and suitability of health services. Both the national and regional health insurance fund bodies also conduct their own monitoring, the results of which are not widely publicised. The Hygiene Institute gathers statistical data about health services. According to the health ministry interviewee, the institute has complained about non-compliance of some private providers that fail to provide necessary data.

Importantly, state funding is not the key concern for many private providers as they have a rigorous business model that is sustainable even without public subsidies. However, if their licence with the National Health Insurance Fund were to be revoked and they were no longer part of the healthcare system (in which case referrals to other healthcare actors and prescriptions would no longer be valid), their business models would cease to be resilient.

PPPs are very uncommon. There was one example of a major health centre in Vilnius called Karoliniškių Poliklinka that was operated via a concession from Vilnius municipality by a private provider. The municipality, however, prematurely ended the concession contract and paid the respective fines for doing so, as the authorities felt it was too great a risk to trust private sector actors to manage the health of around 100,000 people who were registered with this provider.

Outcomes

Case study 1: Employment and training services

Access-related outcomes

In this case study, even though the new funding scheme uses public money efficiently by ensuring that existing job training opportunities meet market demand, it created a barrier for eligible (unemployed or laid-off) individuals to receive training. Before 2012, every unemployed person could receive any training of their choice if the LDB indicated that this would increase their employability. After the new scheme was introduced, in order to access training, users had to ensure that they would be employed immediately after the training ended. However, as illustrated in the case study, this did not affect the number of people receiving training. Greater involvement of private sector providers has increased the number of training programmes available.

Regarding access to services for people with disabilities, interviewees indicated that public sector institutions have a better infrastructure due to recent investments from EU structural funds.

Quality-related outcomes

The present analysis did not identify any significant differences in terms of quality between services provided by public and private sector bodies. In formal training, public sector institutions (such as vocational schools and labour market training centres) have an advantage over private actors in terms of quality. This is mainly because they have a lot of

experience and a long tradition in providing vocational training, as well as a high number of constantly available teachers and a good teaching infrastructure (which was recently improved by investment from EU funds).

Interviewees suggested that private sector organisations have important benefits in terms of providing quality non-formal training as compared to public sector organisations. Private training providers have a better understanding of the demand for skills in the labour market. This is especially so when the training provider is also a future employer. In such cases, the training provider is very concerned with providing the highest possible quality training as well as skills that will be immediately useful in the workplace.

Effectiveness-related outcomes

The new funding scheme, alongside the related increased involvement of private sector providers, had a positive impact on the effectiveness and efficiency of training provision. The main indicator supporting this conclusion is the number of people employed after receiving training, which increased from around 70% in 2008 to around 90% in 2013. The new scheme seems to be more effective, as most of the training recipients can immediately apply their skills in the workplace. This is in line with the main objective of training for unemployed people – to help people return to the labour market.

Case study 2: ECEC

Access-related outcomes

Access is a key issue in childcare provision in cities, where public provider capacity is insufficient, while there is overcapacity in some rural regions. For reasons discussed above, the number of private providers increased from 6 in 2008 to 75 in 2014. This still constitutes a small market share, and it is not clear how many children would be enrolled in private kindergartens if there was a sufficient supply of public alternatives, due to the higher cost of private childcare. In Vilnius, for example, the city with the biggest shortages, there are 50 private and 140 public kindergartens (Delfi, 2015). The development of the private childcare sector increased access for parents. However, accessibility is tied to ability to pay for services; families of lower-income earners need other care options. Waiting lists at public kindergartens do not take into account financial and social need.

Regarding other aspects of accessibility, private providers, unlike public providers, are not obliged to serve any child who applies. However, they are often better equipped to integrate children with special needs due to a better child-to-teacher ratio.

Quality-related outcomes

No country-wide or municipality-wide studies on quality exist. However, it became clear from the interviews conducted that even though public and private kindergartens receive similar levels of funding (all sources combined), the quality of services tends to differ in the following ways.

- There are fewer children per group in private kindergartens.
- There are two teachers per group in private kindergartens versus one per larger group in public ones.
- Extracurricular activities are included in the monthly fee for private kindergartens.
- Private kindergartens offer a wider variety of teaching methods and curricula, a more flexible work schedule, and a different educational content.

There is no systematic evidence on the effectiveness of private kindergartens compared to public ones. Among the representatives interviewed, two camps emerged: the municipality, on the one hand, and parent organisations and providers, on the other. While the municipality official in charge of ECEC held that private kindergartens are more

expensive than public ones, a representative of a parent association and head of a network of private kindergartens believed that after adding all sources available to public providers, the funding is similar while quality seems to be better, in general, among private providers.

Effectiveness-related outcomes

Some insights on cost-efficiency can be drawn from information about the quality and management of services in public and private kindergartens. As public kindergartens have a significantly higher number of children than private ones, they have a better value-for-money ratio. However, there is a trade-off between quality and costs because the student-to-teacher ratio is much worse in public than in private kindergartens. This is especially the case in a kindergarten with children with disabilities or special needs, who require much more attention from childcare providers.

Case study 3: Primary and secondary healthcare

Access-related outcomes

The national policy of free healthcare makes primary healthcare services particularly accessible via both public and private providers. Where there is a lack of supply, choice or quality of services, the private sector fills this gap with services ranging from small family doctor practices to more extensive healthcare centres.

The amount of the co-payment required from clients depends on various factors, such as the specific provider, their cost and revenue structure, their organisational form (NGO or private company) and the extent of state subsidies available to them. Some providers charge annual fees of around €450, for example, which they use to pay for various patient needs, from tests to different types of treatment, without any additional costs. Most private providers, however, charge small fees in addition to the base fee for specific services they receive from the Territorial Health Insurance Fund, which makes their services off limits to patients with the lowest income. However, while public providers do not charge co-payments, access is restricted by longer waiting lists, which at some clinics may reach two weeks to see a family doctor and longer waits for secondary-level services.

Access to information about payments is limited and complicated by the lack of coherence on state policy as regards co-payments. This legally prevents even the private providers themselves from making public on their websites the exact co-payment costs.

Quality-related outcomes

It is difficult to generalise on quality across all private providers, and no studies compare quality of services between the two different types of providers. Nonetheless, stakeholder interviewees unanimously agreed that private providers outdo public ones in terms of quality. Some benefits cited include the absence of waiting lists, a focus on client satisfaction, innovation (including state-of-the-art equipment and materials), know-how, and new products and services. All of these are related to private providers having to function as regular businesses, with the number of clients and the services they are willing to buy determining whether or not they can cover their costs. Moreover, while public providers, in purchasing equipment and materials, have to use fixed budgets as determining criteria, private providers have the room for manoeuvre to pay more for better quality, although they presumably pass on the associated costs to their service users.

Effectiveness-related outcomes

National policy does not have a goal or specific objectives regarding the role of private providers in the delivery of public healthcare services. An accurate measure of effectiveness would require access to relevant healthcare data. According to the representative from the Ministry of Health, there are various methodologies for assessing the cost-efficiency of services; however, it is not clear to what extent they are applied in the public sector. For example, in tertiary care, a profitable hospital should have no less than 200 beds, yet this is the case for few hospitals in Lithuania, and most work

at a loss. In the private sector, however, cost-efficiency is essentially built into the business model: ineffective centres will simply go bankrupt, as indeed some have.

Private healthcare centres typically hire doctors on part-time contracts, thus ensuring that they have to pay only for their doctors' active working hours, something that public providers do not do. Meanwhile, doctors work in various private and public providers simultaneously, in some extreme situations holding as many as six jobs, as witnessed by the private provider interviewed for this case study. In 2013, 33.6% of all doctors in the healthcare system were employed by a private provider, and only 9.4% of all physicians worked for private providers full time (Gaidelytė and Tendziagolskytė, 2014).

Availability of services also relates to effectiveness. Opening hours tend to be longer among private providers, and some offer services over weekends. For example, the MRI clinics that private companies operate under service agreements within public hospitals remain open on Saturdays and Sundays when all other planned services in these institutions are closed. In this way, private providers maximise their use of equipment, thus ensuring profitability while also increasing access for patients, including public patients.

Conclusions

Private sector participation in the delivery of public services in Lithuania grew slowly but steadily in the decade leading up to 2015. The most marked changes have taken place since 2010, with legislative developments favouring open competition between public and private providers in all three sectors analysed in this country study. That said, the private sector is not seen as a solution to the inadequate capacity of existing public provision, as in the case of ECEC, and there is little incentive for private providers to enter the market for these services.

According to the government representative interviewed, there is no coherent national policy on private sector involvement in the delivery of public social services. This means regulation takes place at sector level (involving specific ministries), and there are considerable fluctuations in the nature of this regulation, relating to the different political ideologies of different governments. While in some sectors there are attempts to prevent the entry of private providers (for example, healthcare), in others private actors are encouraged to enter the market in order to increase the variety of services (for example, employment services). This lack of consistency in the policy as regards private sector involvement is a key concern for existing private providers in the country, especially in healthcare (see the earlier mention of the Constitutional Court case regarding the health ministry's attempt to exclude private companies from providing tax-financed services).

Legally, municipality governments are in charge of ensuring the provision of SSGIs to residents by assessing needs, planning and organising, and controlling service quality. The level of decentralisation varies, however, and while municipalities are in charge of ECEC provision across the board, the management of healthcare involves a mix of municipal, private and state-run centres and hospitals.

Clients have mixed preferences when it comes to private and public providers because the former charge larger co-payments (in healthcare and ECEC). Even so, private providers have been gaining an increasing market share as they offer different, more innovative and more client-focused services, or are able to accommodate demand in the face of public provider shortages (ECEC) or long waiting lists (healthcare).

In 2015, dual standards are applied to public and private providers in Lithuania, especially in ECEC, where private providers are eligible for less state money than public ones for the same service, and higher operational standards are expected of private providers than of public providers.

The economic crisis did not have a uniform effect on different public services. Regarding employment services, the lack of effectiveness of public provider training for unemployed people during the crisis led to competition being opened to private providers. In healthcare, private providers had to increasingly rely on privately insured clients as demand for paid services plummeted amid the downturn.

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Country study: Spain 3

Overview

From the mid-1980s onwards, the Spanish government, at all levels and in all sectors, began to rely increasingly on the involvement of the private sector for the delivery of public goods and services, in various ways and forms. These ranged from the privatisation of public services to innovative PPP mechanisms. They also included more traditional measures such as contracting with private companies or the third sector, which sometimes involved the participation of users in co-payment schemes.

In the late 1990s, Spain's use of PPPs expanded. This happened at the three levels of government: the state, autonomous communities and local level (which may be further distinguished into provincial and municipal levels). More recently, the Spanish government's interest in PPPs appears to have decreased due to the economic crisis. Nonetheless, in both volume and diversification, Spain is one of the EU Member States most committed to this form of public–private sector cooperation (Allard and Trabant, 2008a). From 1998 to 2006, regional administrations accounted for the highest number of different kinds of PPPs (where private sector involvement ranged across functions, from design and financing to operation and management); they comprised 69% of completed projects (Allard and Trabant, 2008a; see, for example, IMF, 2004, for the different modalities of PPPs).

Unlike the UK, where most collaboration occurs in the fields of education and health, in Spain it has mostly occurred in the infrastructure sector (especially ports and roads). This sector accounts for more than half of all PPPs awarded and pending (Allard and Trabant, 2008a). Since 2000, Spain has also witnessed a diffusion of public–private collaboration across various policy sectors; this is especially so in healthcare but has also been seen in sectors such as renewable energy, defence and prisons, and more recently (2010–2012) in employment services.

Since 1986, Spain has enjoyed a universal national health service (Sistema Nacional de Salud, SNS) funded through general taxation, through which the mainly public provision of services is managed by regional governments. Reforms that altered the principle of universality for healthcare were enacted only in 2011 (Del Pino, 2013). However, experimentation with new organisational forms began with a 1997 Act that enabled new forms of management of the SNS, which was supported in parliament by the two main Spanish political parties, among others (Abellán, 2013, p. 282). While direct public provision was preserved, some new public management practices were incorporated with the aim of increasing the flexibility of management. These increasingly relied on a variety of organisational types with their own distinct legal personality. In terms of indirect management of services, a series of varied formulas have been utilised; examples include health personnel hired as independent professionals and the use of non-profit organisations or commercial companies (Martín, 2003; Abellán, 2013; Sánchez Bayle, 2013). PPPs have become increasingly important, especially in some regions, such as the Community of Valencia, where 20% of the population receives healthcare through them (Mendoza, 2013, p. 86), as will be seen in the case study of the Ribera Hospital. One study identified 25 health PPPs in Spain between 1995 and 2012 (Acerete et al, 2013).

In addition to PPPs, traditional collaboration with the private sector occurs in some fields, such as compulsory education and social services. This is because the first democratic governments after the transition to democracy in the 1970s relied on the existing private networks to continue providing these services. Such collaboration involves contracting both private companies and the third sector; examples of the latter include cooperatives, mutual societies, non-profit associations, foundations and social enterprises.

In the EU, Spain has the second highest level (after Belgium) of private provision of services. Around 30% of childhood education (for those aged 3–16 years) is funded by the government but provided by the private sector (OECD, 2011a, p. 306). The participation of the third sector and the private sector in the provision of social services and long-term care

has consolidated since the 1990s, with public provision of these services largely disappearing. The for-profit sector gradually gained ground over the third sector in these fields, especially regarding elder care: in 1995, private employment in this sector reached 50%, while by 2010 this figure was close to 80%. Similarly, by the mid-2000s, only 30% of social service centres were publicly owned, while 70% were privately owned, with the non-profit sector playing a bigger role here (Fantova, 2007).[10]

Some factors have been driving this greater private sector role in the delivery of public services in Spain. They include:

- the need to modernise the industrial and service sectors after years of dictatorship;
- the dissemination of new public management ideas;
- rising government debt;
- the need for additional investment to develop infrastructure and services that would otherwise have been postponed for many years;
- the pressure of transnational corporations to access investment opportunities in new areas;
- EU membership, as the application of Community legislation has influenced the traditional operation of service provision (such as contracting out);
- the extensive decentralisation of government power, by which 17 regions (autonomous communities) were recognised and granted power (Bel and Costas, 2001; Cabeza and Gómez, 2007; Allard and Trabant, 2008a and 2008b; Acerete et al, 2011).

It is still too early to assess whether or not the economic crisis has had an impact on the growth of PPPs in Spain. As will be seen later in this report, certain factors may be slowing down this trend: a decrease in economic activity, some significant cases of corruption linked to public–private contracting, and strong public opinion regarding the privatisation processes in the field of social policy.

Eurostat acknowledges that, under certain conditions, some PPP transactions are not taken into account for the purposes of debt and deficit figures, which makes them attractive to governments struggling with budget consolidation (Acerete et al, 2011, 2013; Arrufat, 2011; Araujo, 2013).

Analysis of the private sector's involvement in the provision of SSGIs shows strengths and weaknesses (see the review by Cabeza and Gómez, 2007). At local level, initial savings in areas such as municipal solid waste disposal and the water distribution service were not sustained over time. However, the threat of privatisation has indirectly contributed to modernisation in the municipal public sector across a wide range of services including SSGIs, as well as the promotion of inter-municipal cooperation and the creation of public or public–private corporations, creating gains in efficiencies and costs (Bel, 2009). Despite Spain having one of the highest rates of PPP use, a 2008 report warned of substantial risks given the speed and intensity with which the state apparatus was relying on them. Considering the situation in Spain against a series of criteria of the UN Economic Commission for Europe, some authors suggested that PPP projects should have been promoted and managed effectively, concluding that 'it is clear that in Spain the government has not assumed a minimal role' (Allard and Trabant, 2008a, p. 84).

[10] In this case, ownership is the same as delivery.

Some politicians assume that criticisms by the Spanish public of the welfare state reveals a desire to privatise the provision of welfare programmes. However, according to a 2008 survey by the Spanish Sociological Research Centre, a majority of citizens preferred public funding and public provision of education, health and social services care, at 87%, 86% and 70% respectively (Calzada and Del Pino, 2008). All the retrenchment measures adopted by the government in the context of the economic crisis have faced opposition from the public. Alongside the so-called 'white tide' movement defending public and universal healthcare, this has had an important impact especially in the region of Madrid, where the regional government has made further attempts to privatise services (Fernández Ruiz et al, 2013).

Table 3 summarises the main trends regarding the private sector's role in the case studies chosen for Spain.

Table 3: Role of the private sector in the case studies of Spain

Sector	Brief description
Home-help services	The Dependency Act of 2006 consolidated home-help services and made them universal. Social economy organisations and small companies that were traditionally active in this sector became displaced by competition from large companies. These changes have affected both workers and users in different ways regarding the coverage, quality and effectiveness of services.
Long-term care and social services	Due to the economic crisis, long-term care services underwent several adjustments between 2010 and 2014. For example, terms of access to benefits and services were tightened, the scope of services and the amount of benefits were reduced, and services and benefits that were previously compatible were made incompatible.
Tertiary healthcare	Ribera Hospital, which opened in 1999 in the town of Alzira in Valencia, was the first Spanish hospital to involve a PPP model, known as the Alzira administrative concession model. The regional government partnered in a joint venture with a consortium comprising a healthcare services company, three regional savings banks and two construction companies, supervised by a healthcare commissioner designated by the regional government. The consortium constructed the hospital and was contracted to manage it, including its clinical services, for 10 years. The Alzira model came under intense political and professional opposition, yet the Valencia government has become hampered by it, finding it difficult to openly acknowledge the problems that have arisen.

Source: *Prepared by authors*

Case study 1: Home-help services

Background and objectives

Home-help services are one of the most important public support schemes for dependent or disabled people. Home help involves the provision of personal help or specific housekeeping services, or both, in the home for those whose personal independence is restricted or who are undergoing a personal or family crisis.

Acute demographic ageing has made the population of Spain the oldest in the world (UNFPA, 2014), and this has been one important driver in the growth of home-help services. Although these services have been provided by the Spanish government since 1979, Act 39/2006 on the Promotion of Personal Autonomy and Care for Dependent Persons (otherwise known as the Dependency Act) consolidated them and made them universal.

Despite a difficult economic environment, governments have been forced to increase home-help services and, as will be shown, to modify the involvement of the private sector. A commitment of new public funding from the three levels of government, alongside the increasing number of older citizens, has been seen by some as a promising business opportunity. Moreover, the loss of business in areas such as construction, industrial cleaning and security as a consequence of the crisis has attracted well-established and large companies to this sector that previously had not considered becoming involved in home-help services (see, for example, several reports by consulting firms such as Deloitte, 2008).

This case study focuses on the region of Madrid.

Financing, implementation and management

Social economy organisations and small companies that were traditionally active in this sector have been displaced by competition from large companies. The former are particularly critical of European legislation that has been applied to date (Directive 2004/18/EC), as well as Spanish procurement rules (the Act on Contracts in the Public Sector, 14 November 2011). They also complain of the way subnational authorities are managing the bidding processes in home-help services, which involves four requirements that are very complex and difficult for small organisations to meet.

Firstly, the Madrid City Council has increased both the length of contracts of home-help services (to 2.5 years) and their volume; with the growth in the number of users, the council decided to group its bid packages [11] to a greater extent than before, when they used to be offered in a more fragmented way. The need to provide a guarantee or bond of around 5% of the bid has driven some companies out of the market.

Secondly, new rules have increased the weight of price as a selection criterion in the bidding processes, to the detriment of technical specifications and quality criteria (which are established and controlled by the city council). Since most companies claim to meet the technical specifications, the price is the final criterion that decides the results of bidding. In Madrid since 2012, the price counts for at least 65% of the bidding criteria. Obviously, large companies can be more competitive here, thanks to a lower cost structure. Smaller companies complain that sometimes large companies compete by providing recklessly low prices, which succeed in expelling the other companies from the market permanently.

Thirdly, and largely as a reaction to some cases of corruption, anonymity is required from companies involved in bidding, so as to avoid pressure on those who decide the outcome. In practice, this has hurt companies that traditionally occupied the sector because anonymity prevents them from showcasing their extensive experience in the sector, as this is not one of the selection criteria.

Fourthly, during the economic crisis, the length of time it took the council to process invoices grew well beyond the limits established in relevant regulations. While this situation has improved in recent years, reaching a processing time of only 30 days in 2014, this situation proved unaffordable for some companies.

New EU legislation on public procurement may partially improve this situation, in particular Directive 2014/23/EU concerning the award of concession contracts and Directive 2014/24/EU on public procurement. Both Directives have to be transposed into the Spanish system before 18 April 2016; individual aspects of them may be delayed by as much as two more years.

Case study 2: Long-term care and social services

Background and objectives

The long-term care policy that was embodied in the 2006 Dependency Act launched the Long-term Care System (LTCS). Access to LTCS means a citizen entitlement or right to a basic level of protection and occurs at the request of the beneficiary. A range of cash benefits and services are involved, with home-help services and telecare being especially important. Telecare is a technological device that enables hands-free communication from home, via a remote control, with a contact centre that operates 24 hours a day, 365 days a year. The home-help service provides a specialised home-care assistant who is responsible for personal and domestic care. These services are provided through social organisations, as well as small and big companies.

[11] *Paquetes de licitación* are a group of home-help services to be provided in a cluster of districts.

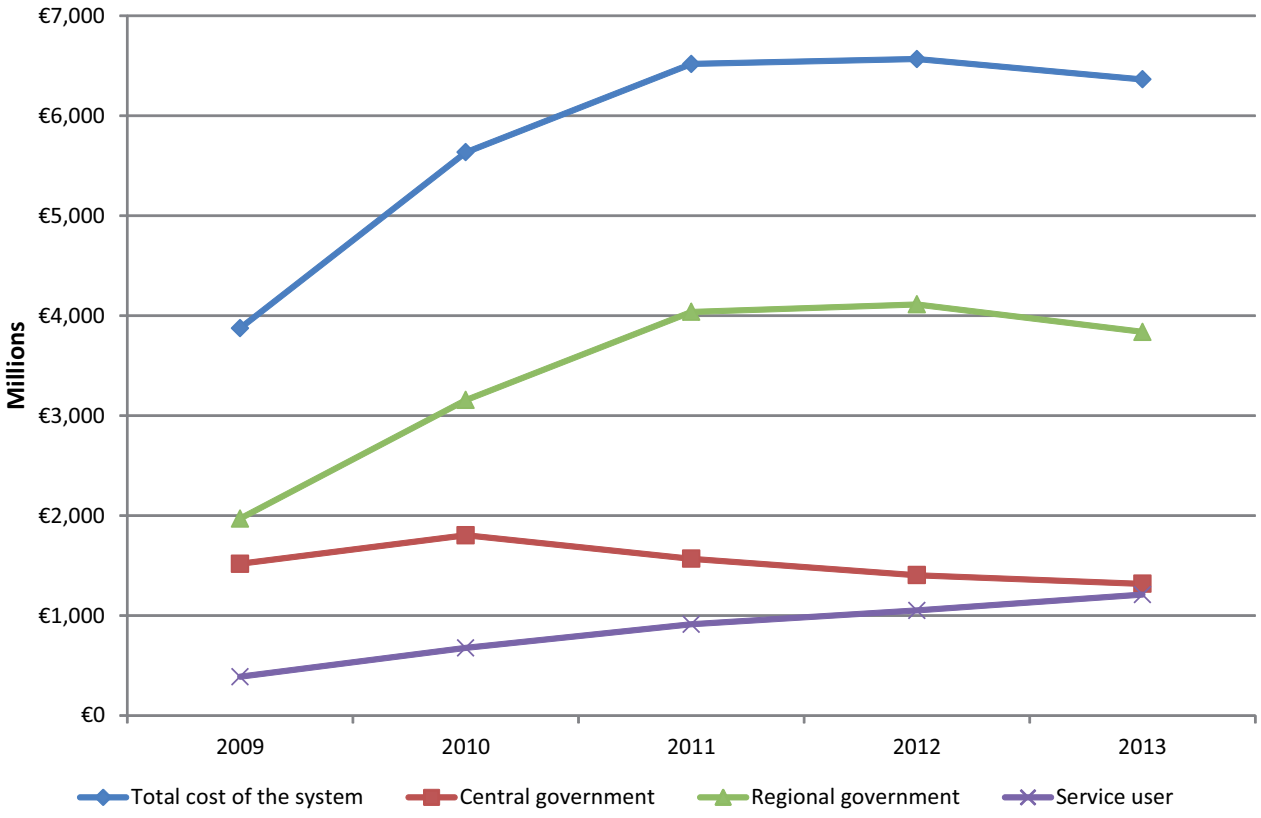
Nationally, both services represent a modest share (about 28.6%) of all total benefits and services associated with LTCS (CES, 2014). However, the public values these services because they allow individuals to be cared for and to live in their home environment with a certain degree of autonomy. LTCS services underwent several adjustments between 2010 and 2014, mostly due to the economic crisis (Marbán and Rodríguez Cabrero, 2013; Moreno Fuentes, 2015). Among other changes, terms of access to benefits and services were tightened; the scope of services and the amount of benefits were reduced (the latter by 15%); services and benefits that were previously compatible were made incompatible; and the financial contribution required from users was increased.

This case study analyses the impact of these changes on users of home care and telecare in the jurisdiction of Madrid City Council.

Financing

Madrid City Council justified an increase in co-payments for the services as a necessary measure given the difficult economic situation. The remaining cost is paid by the central government, which guarantees the transfer of certain funds to regional governments to ensure a minimum level of protection. Using the criteria established to calculate co-payment contributions in a national executive decree of 2012, one expert calculated that the average amount of revenue raised through the implementation of co-payment contributions may represent an increase from 10% to 50% in the real cost of services (Montserrat Codorniú and Montejo, 2013). Another study found that co-payment by users of the long-term care system represented 10% of contributions in 2009, rising to 19% in 2013 (Barriga et al, 2014 – see Figure 4). For some specific services provided by this system, the co-payment rose to 34%.

Figure 4: Change in the distribution of contributions to payment of long-term care services, Spain, 2009–2013



Source: *Authors' analysis, based on data by Barriga et al (2014)*

Recent years have seen three changes in rates and co-payment for telecare. Until March 2013, only pensioners under 80 years and with the biggest pensions (about €2,500 monthly) paid for the service provided by the city council. However, as of March 2013, the co-payment was also applied to new users of telecare, due to the adaptation of the national executive decree of 2012, which implemented the amendment on co-payment in the Dependency Act, but was not applied by other regional governments. All these measures apply to the new users of the system. From January 2014, those who were already using the service and who received a pension higher than €460.29 have also been required to make co-payments. This measure affected nearly 66% of pensioners using the service. The co-payment for telecare ranges from €0 to €12 per month, depending on earnings. Since October 2014, exemption from co-payment has been extended to those with a monthly income under €614.29. According to the city authorities, this was enabled by revenues gathered from the previous increase in co-payment rates. According to the opposition, this is an example of electioneering, given the proximity of municipal elections.

In 2013, there were around 50,000 beneficiaries of the home-help service provided by the city council. In that year, the Dependency Act led to about 4,000 new users, who up to then had been served by the regional government, joining the city council beneficiaries. For some of these users, the transition from one system to another meant a substantial increase in co-payment obligations, as the Madrid regional government charged €1.31 per hour while the council charged between €0.57 and €7.31, depending on the users' income. For users who require many hours of home help (which can be up to 70 hours per month, depending on need), the cost can be significant.

Implementation and management

Each beneficiary of long-term care is assessed by the regional government according to a scale, which attributes a 'dependence rating' to each recipient. Each rating gives entitlement to a series of services and benefits.

Case study 3: Tertiary healthcare

Background and objectives

In 1997, the government of the Valencia region took advantage of a national Act that enabled new forms of management of the national health service to introduce a new PPP model, which became known the Alzira model, to build and operate a hospital. The Alzira model takes its name from the town in which the Ribera Hospital opened in 1999, the first Spanish hospital to involve an administrative concession. Under this model, a partnership is established between the regional government and a private body, which is responsible for constructing the hospital and managing it, including the clinical services, for a period of time, after which the building reverts to government ownership. This is different from other PPP models, such as private finance initiatives (PFIs), where the concession holder builds the infrastructure in exchange for the management of non-medical services (such as cleaning, laundry or parking).

The government opted for an administrative concession due to the economic situation and, to some extent, for ideological reasons. Proponents of this type of model assert its ability to modernise management and produce innovation. However, this model has faced intense political, professional and public opposition. The Valencia government cannot rid itself of the arrangement, finding it difficult to openly acknowledge the problems that have arisen.

Management and implementation

The consortium that won the contract to build and manage the hospital comprises a healthcare services company (51%), three regional saving banks and two construction companies. A commissioner of healthcare designated by the regional government controls the concession holders.

Financing

The project was to be funded by a yearly capitation fee of €204 per resident, which has been rising each year according to the consumer price index. In the initial contract, the government paid €47 million per year on behalf of 230,000 residents. The hospital opened in January 1999, but the contract terminated in 2003, several years before the scheduled termination date. The regional government paid €69.3 million for this joint venture, of which €43.3 million was for the purchase of infrastructure assets and €26 million for compensation of lost profit. Immediately, another bidding process was convened. As with the first bidding process, there was only the one bidder, the same consortium that had won the first contract.

Under the terms of the new contract, the consortium was to pay the regional government a premium of €72 million for the new contract, which included taking over the infrastructure assets just bought back by the government (Acerete et al, 2011). The consortium could afford this thanks to the payment of €69 million that the government had just made to its predecessor, which had the same parent entities. This huge sum could be seen as a way of discouraging other bidders, therefore guaranteeing that the previous consortium would win the new contract. The new contract was also to cover primary as well as specialist healthcare and involved an increase in the capitation fee, from €234 to €379.

Outcomes

Case study 1: Home-help services

The expansion of large multinational companies in the context of the situation described above creates enormous pressure in the social economy in several respects. It forces organisations to make internal structural adjustments. The response of the third sector has been to grow in size and catchment area, particularly through social initiative cooperatives. In around 47% of cases, this involves business collaboration through the establishment of shared services, joint ventures, strategic alliances, commercial and central purchasing networks, collaborations in outsourcing services, and the development of social markets promoted by social enterprises that do not require the exchange of money for their operation (Coceta, 2010; Morales, 2011; Rodríguez Cabrero, 2013). Yet, in Spain, the weight of employment in the social economy (including cooperatives, mutual societies, non-profit associations, foundations and social enterprises) is 6.7 compared to 7.4 in the EU (Rodríguez Cabrero and Marbán, 2013; Monzón and Chaves, 2012).

Access-related outcomes

The number of users of the home help service has increased thanks to a greater commitment of public funding, which since 2007 has been attracting bigger companies. In 1999, the service coverage for those over 65 years was 1.7%; in 2008, this had reached 4.7%. No restrictions in access, arising from the change in the profile of companies providing the service, were apparent.

Quality-related outcomes

In this sector, cooperatives are particularly likely to argue that involvement of private providers has had a negative impact on both workers and service users. In their view, workers in large firms have the worst salaries and generally poorer working conditions as companies are not forced to reinvest part of their profits in the training of workers. It is also their view that service users received better care when they were served by bodies such as cooperatives, foundations, non-profit associations and social economy companies. However, service users are generally satisfied with services: a survey carried out by Madrid City Council (2012) found that, on a scale of 1 to 10, the average satisfaction level was 8.29. At the same time, service users who were interviewed shared some concerns about the working conditions of the employees who care for them, and 30% of service users complained of excessive staff turnover.

Effectiveness-related outcomes

Madrid City Council is considering imposing a financial penalty for poor performance of home-help services. Home help is a sensitive service, with limited publicly available data. The extent of the proposed penalty may range from mild to severe or very severe. It may be imposed for various reasons, such as inadequate care for service users or loss of confidential documents.

Spanish third-sector organisations demand improvements to the mechanisms that facilitate collaboration with public administrations. Proposed measures include: simplifying legal and administrative requirements, for example in processing and justifying subsidies; developing a specific coordination system for the sector; applying social clauses in public bidding and scoring systems to ensure the quality and solvency of social services; and ensuring that taxation and VAT regulations do not discriminate against them, for example when entering public bidding processes.

Case study 2: Long-term care and social services

It is almost impossible to estimate, in national terms, the impact of co-payment variations on service users across regions. This is because, although national law implies a subjective right to access to long-term care and social services, regions and municipalities can set co-payment contributions (Monserrat Cordorniú, 2009b, p. 135; Vilaplana Prieto, 2011; Montserrat Codorniú and Montejo, 2013). However, a micro analysis of changes to co-payments reveals that some service users have to increasingly rely on the market to meet their needs in this sector, which can cause problems regarding equitable access and quality of services.

Access-related outcomes

Before the increases in co-payments in March 2013, telecare had about 133,000 beneficiaries, which itself could be regarded as a feature of 'privatisation' or re-commodification. According to the calculations of the municipality, following the increase, about 34.3% of service users were exempt from payment because their income fell below €460. Hence, 87,609 people were paying part of the cost of telecare, compared to only 2,650 people before the increase. Following the introduction of co-payments, some service users stopped using telecare. The municipality decided that some people considered to be at risk were exempt from the payment even if they could afford it. Nonetheless, around 3,400 service users stopped using it due to co-payment.

Regarding home help, the city council recognises that some cancellations occurred due to co-payment and that some service users had reduced the number of hours they engaged the service. Of the nearly 8,000 cancellations in 2013, 21% were due to service users cancelling the service, but the council does not collect information on the reasons behind these cancellations. Without reliable data, the service manager estimates that around 400 cancellations were due to co-payment. Numerous complaints were made to the council about the co-payment scheme.

Quality-related outcomes

Increased co-payment demands and the reduction in the number of home-help hours as a result of cost-cutting measures have been problematic for some beneficiaries of this service. They complain that the standard of their care has fallen because home-help assistants spend less time in their home, sometimes only minutes. Service users have been forced to pay for extra staff time, sometimes from the company that provides the home-help service. It is now possible to find households where the home-help assistants are paid for a few minutes by the city council and the service user (via their co-payment) and for some extra minutes solely by the service user. People prefer to use the services of the same home-help assistant, rather than hire an additional, unknown assistant, who may be much cheaper but may also greatly complicate the logistics of home care, thus negatively affecting the well-being of the person receiving care.

Effectiveness-related outcomes

According to a manager of the municipality, huge administrative effort was involved in the implementation of the co-payment scheme for telecare. There are no data about the cost of this implementation. However, co-payments generated revenue of €4.5 million in 2014, which represents nearly 19% of the total cost of home-help services in Madrid (€24 million).

Case study 3: Tertiary healthcare

Several conditions must be met in order for PPPs to achieve key outcomes regarding quality, access and effectiveness, and to be truly profitable for the government, services users and businesses, all of whom initially have competing interests. These relate to risk transfer, competition, control and regulator independence (Torchia et al, 2013; Abellán, 2013; Barlow and Roehrich, 2013).

Access-related outcomes

Ribera Hospital pays the regional government 100% of the treatment costs of patients from Alzira treated in other hospitals, such as Alzira residents who choose to seek care in other hospitals. In turn, it charges for 85% of the costs involved in treating patients from other healthcare areas (Sekhri et al, 2011). However, the flow control between patients and among hospitals is poor and insufficiently transparent, and inter-hospital billing is difficult (Mendoza, 2013; Acerete et al, 2013; EXPH, 2014). Moreover, according to some authors, technological and medical developments for patients in public hospitals in this area have been deliberately restricted to favour Ribera Hospital (Mendoza, 2013; Acerete et al, 2013). Mendoza found an increase of 37.3% in the number of births in Ribera Hospital, compared to 2.4% in other public hospitals, due to the fact that epidural anaesthesia was offered in this private hospital and was restricted in public ones. A further criticism is that this model encourages campaigns to attract patients, which goes against one of the founding principles of the SNS – territorial planning and access to healthcare.

Quality-related outcomes

In the Alzira model, the existence of a capita fee transfers risk to the concession holder, meaning that it encourages the concession holder to protect the health of citizens as it receives a fixed sum for every insured service user. However, in the opinion of some observers, this alleged advantage can lead the concession holder to reduce the quality and the quantity of services, with the aim of ensuring a profit.

Patients of the Alzira model are largely satisfied both with staff support and with their healthcare, according to a survey by the regional Ministry of Health and the University Miguel Hernández (Redacción Médica, 2014). Satisfaction rates are similar to those regarding the SNS generally (Acerete et al, 2013). In spite of this, complaints have been made about the cost of parking, gaps in human resources at certain times, the state of some aspects of infrastructure (such as walls not being painted), and two patients having to share a room designed for one person, which occurs in 40% of cases according to Sindicato de Médicos de Asistencia Pública (SIMAP, undated). Regarding health outcomes, existing data do not allow definitive conclusions to be drawn about the relative merits of Ribera Hospital when compared to other hospitals in the Valencia region.

The management of human resources is a key factor affecting this hospital's profit margins (Rosado, 2010). A survey of job satisfaction, in which 43% of the workforce took part, showed that job satisfaction improved in recent years, reaching 4.33 points on a scale of 1 to 6.[12] However, SIMAP has criticised its working conditions, payment of the workforce and a reduction in the number of workers, as in the case of doctors on call (Acerete et al, 2011; SIMAP, undated).

[12] Unfortunately, there are no data available on how this compares with staff in other hospitals.

Effectiveness-related outcomes

The termination of the first contract of the joint venture between the regional government and the private company was justified on the grounds that it would improve efficiency. In their view, this was to be achieved by including primary care in the new contract, as the concession holder would have an incentive to improve comprehensive healthcare. However, analyses show that serious losses were made during the first years of hospital management (Acerete et al, 2011). This was due to three factors. Firstly, the capitation fee of €204 in the first contract was recklessly low, well below the other Spanish benchmarks. This made it difficult for the contractor to provide the clinical services required and to make a profit for its shareholders. Secondly, profits were supposed to cover the cost of the hospital, which was ultimately much higher than anticipated. This money was to be returned to the building companies and banks involved before the infrastructure was to revert to the regional public administration. As the concession had been granted for a very short period of time (10 years), the cost of this was significant. Thirdly, the Regional Audit Office noticed some irregularities in the way the contract was terminated, specifically the way compensation paid to the company was calculated and the fact its final amount was very similar to the amount required for companies wishing to bid (Sindicatura de Comptes, 2007).

In relation to the transfer of risk, it can be argued that it was very limited, at least in the first phase of the Alzira model, as it ended in a financial rescue. The SIMAP union claims capital increased between 2011 and 2014 from €620 per capita to €678 in Ribera Hospital.

Regarding the cost of the concession and its efficiency compared with direct management of public hospitals, several analyses show very different and even contradictory results. Arena and Alberto (2013) conclude:

> *the average full departmental health expenditure (primary and specialty care) by the regional Health Department in privately run concessions in 2012 is lower than its expenditure on direct public management, by 11.7%. Some departments with direct public management have a spending per capita lower than concessions, especially two of nineteen.*
>
> (Arena and Alberto, 2013, p. 12)

The concession holding company, however, estimates that if it were possible to calculate the differences between the concession model and direct public management, the former would be shown as superior in its savings, by 25%, as some studies had suggested, according to an interview with the manager of Ribera Salud Group.

However, some studies also suggest other substantial costs such as the 'hidden costs' derived from a number of factors: government supervision or control that cannot be properly estimated; the absence in the concession hospitals of most of the specialised clinical services that are usually the most expensive; and the fact that the capitation fee does not include some outpatient costs, such as pharmacy costs or medical transport. Peiró and Meneu (2012) state that there is no clear evidence that the health administrative concessions in the Valencia region can improve the costs of hospitalisation in hospitals with direct public management. According to Acerete et al (2011, p. 25), 'the available figures lead us to the conclusion that the second contract [in the Alzira case] is not as good a deal for Valencia's Department of Health as the current official narrative claims'. (For analyses of similar concerns regarding PPPs in other contexts, see Alonso et al, 2015; Abellán, 2013; Iasist, 2012; Sánchez et al, 2013; McKee et al, 2006.)

Finally, all respondents agree about the high risk related to the choice of suitable partners in administrative concessions. The alleged advantage of choosing private companies specialising in healthcare vanishes if they end up selling their share of the business to private venture capital funds, as has happened recently in some concessions in Valencia.

Conclusions

No single factor can explain the increasing involvement of the private sector in the delivery of goods and services of general interest in Spain since the mid-1980s and how this involvement has developed. The three jurisdictional levels in Spain have made use of a wide array of public governance models for the provision of public services. Some of these mechanisms are presented in the three selected cases analysed in this report.

Perhaps the most important conclusion from this analysis is that there is a need to strengthen monitoring instruments and, especially, the technical capacity of governments to establish new and appropriate conditions to collaborate with the private sector and achieve the desired results for citizens, as service users, taxpayers and workers. One of the main reasons for this requirement is that the relationship between the state and the private and third sectors has changed; for example, one of these changes relates to organisational innovation occurring in the third sector. However, the most important transformation consists of the entry into the SSGI sector of large corporations (as seen in the cases of healthcare, social and long-term care services).

The potential advantages of greater private sector involvement cannot be achieved if governments are not able to guarantee some operating conditions in relation to factors such as the transfer of risk, competition, independence of regulators, bureaucratic control and expertise, and monitoring of visible and hidden costs. All this is required from public administrations that up until now have not been accustomed to dealing with this type of private organisation in this sensitive area of social policy. Public administrations should also evaluate the results of these experiences of collaboration, but this appears to be far from an easy task. If governments are not yet used to analysing the impacts of the programmes they design and implement, they now also face the challenge of evaluating policies being implemented by other actors, outside public administration. However, if conditions are not guaranteed regarding risk transfer, competition, independence of regulators, bureaucratic control, public expertise and impact evaluation, there may be some risks. Drawing on examples from the case studies, the increased presence of large corporations in providing social services appears to have questionable effects on working conditions. In the case of the co-payment model for long-term care, citizens will be more dependent on the market to satisfy their care needs. It is not at all certain that administrative concessions in healthcare really represent savings for the taxpayers. In addition, there is uncertainty about the actual owners of these corporations; problems can arise regarding the degree of their commitment to citizenship, equity and continuity of services.

The potential benefit of these forms of PPPs in SSGI sectors, in terms of legal, administrative, economic, political and social conditions, and their impacts on equity and economic performance for public finances, still require a great deal of further research and evaluation.

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Country study: Sweden 4

Overview

Since the end of the 1980s, the Swedish welfare state, in general, and the public sector, in particular, have undergone a series of transformations and structural reforms. Initiated during the first half of the 1990s, these structural reforms have, among other things, encompassed a wave of deregulation and privatisation aimed at exposing previously protected public activities to competition. The implementation of these reforms has involved the dismantling of public monopolies and an increase in for-profit private suppliers. The drive for efficiency-enhancing competition has been manifested not only in a somewhat increasing role for private providers and an increase in outsourcing of publicly financed welfare services, but also in organisational reforms intended to achieve more competition between different agencies within the public sector. Prominent examples of the first wave of liberalisation were selected for the Swedish case studies and are summarised in Table 4 below.

Table 4: Role of the private sector in the case studies of Sweden

Sector	Brief description
Public employment services	The monopoly of public employment services ended in 1993. Private employment agencies developed, and labour market training started to be outsourced to private providers within the framework of the active labour market policy.
ECEC and compulsory schools	In 1992, a voucher system was introduced favouring the entry of private primary and upper secondary schools into the education sector, with public subsidies. In 1995, a new law enabled local government to conclude contracts with private day-care centres. The right to choose a school or pre-school has transferred from the public authorities to individual families. This system has increased competition somewhat between schools, both for the recruitment of pupils and teachers.
Municipal home-care services	The 1990s saw privatisation and outsourcing through procurement of services from private providers. In some municipalities, once the care needs have been established and recognised by the local authority, senior citizens may choose between in-house public providers and private home-care providers.

Source: *Prepared by authors*

The centre-right government that took office in September 2006 took further measures to increase the role of the private sector through outsourcing and public contracting through the establishment of a choice system, which allows service users to choose their providers among a list established by the public authorities. Against this background, a new law, the Act on System of Choice in the Public Sector (the LOV Act), took effect in 2009. This Act applies when a contracting public authority (municipality, county council or state authority) decides to apply a system of choice within health and social services (elder care and support for the people with disabilities, disadvantaged young people and people suffering from addiction). According to this Act, the 'system of choice' means that an individual is entitled to choose any service supplier (private or public) that has been approved by the contracting authority. For primary healthcare (outpatient care), the choice of local healthcare centres is regulated by the law of free choice, and all municipalities have to comply with the regulation.[13] By contrast, the implementation of a 'free-choice option' for other welfare services and care activities, such as elder care, is left to the discretion of the municipalities. In order to facilitate individual choice, local authorities are obliged to provide detailed information about the various private providers.

In April 2015, 155 of the 290 Swedish municipalities (53%) had implemented an extended system of free choice mainly for elder and home care; 21 municipalities intended to introduce it in the near future (Sveriges Landsting och Kommuner, 2015).

[13] At the municipal level, the primary healthcare system is responsible for all healthcare and medical treatment that does not require special resources in hospitals. Primary healthcare is mainly provided through the local healthcare centres.

The extent of outsourcing in terms of expenditure varies significantly by activity. In 2011, the percentage of services purchased from private for-profit and non-profit suppliers was 32% for primary healthcare, 30% for secondary schools, 17% for day care and nursery schools (pre-schools), 15% for elder care and 14% for primary schools (Statistics Sweden, 2014).

The trend towards increased outsourcing of tax-financed services through public procurement and the introduction of the free-choice option for health, welfare and care services has led to an increase in the number of private suppliers of publicly financed services. According to the latest available official statistics, private companies accounted for around 18% of total employment in education, healthcare and social services in 2012 – see Table 5 below – up from 8% in 2000 (Statistics Sweden, 2014). The highest proportion of employees in for-profit private companies is found in social services.

Table 5: Employment by sector and organisation type, 2012 (%)

	Central government	County councils	Municipalities	State-owned	Private firms	Non-profit
Education	12.0	0.6	66.8	1.9	13.7	5.0
Healthcare	0.1	75.0	0.8	4.9	18.4	0.8
Social services	0.9	0.1	72.1	0.6	23.3	3.1
All	5.1	18.7	52.5	2.2	18.3	3.3

Source: *Statistics Sweden, 2014*

In spite of the increase in the share of employees working in private firms in the welfare sector, Sweden remains, by international standards, a country with large public employment, reflecting a continuing and very strong public and political involvement in the in-house provision of a wide range of services. The public sector maintains its role as the main provider for crucial service activities – notably childcare, elder care, healthcare, education (including higher education) and services for people with disabilities. According to the law, local authorities are also responsible for the monitoring and control of private providers. They are legally obliged to ensure that the outsourced activities conform to current objectives and regulations at national and local levels.

A 2011 report by the Swedish Centre for Business and Policy Studies provides background on the major restructuring of welfare services carried out in Sweden over the previous 20 years (Hartman, 2011). (Up to the end of 2014, no scientific evaluations of the expected beneficial impact of increased competition on economic efficiency and growth have been undertaken.) By analysing a range of studies that have investigated privatisation and liberalisation across several different services, the report concludes that the major challenge that remains for researchers is that of accurately measuring the quality of a service being provided, especially when assessing services dealing with users with different characteristics and requirements (Hartman, 2011).

In the course of this case study research, only one opinion survey was found in Sweden regarding the public debate on the outsourcing of public services to private providers: the Novus survey (SVT, 2012). According to this, a large majority of respondents (88% in 2012) were against for-profit providers in tax-financed welfare services (education, healthcare and social services). Some differences existed according to the political preferences of the respondent, with traditional right-wing voters being more likely to accept for-profit private providers within tax-financed services (25%) than traditional left-wing voters (2%). It is also interesting to note that among right-wing voters in favour of for-profit companies, a clear majority (more than 60%) declared that the profit should be re-invested in the company.

Case study 1: Public employment services

Background and objectives

The choice of first case study – placement activities administered by the public employment service – is primarily justified by the central role played by labour market policy in Swedish stabilisation policies, and also by the increasing outsourcing of placement activities and other active labour market policy measures, and the growing share of private providers in this sector. In 2007, the former Swedish centre-right government gave the public employment service instructions to use private contractors more actively (as an alternative to in-house job placement provision). The explicit aim was to improve matching efficiency through improved technology and by strengthening groups with weak attachment in the labour market by using more personalised services, such as job coaching, which is aimed at enhancing job-seekers' chances of getting a job. According to the government, stronger competition was also expected to induce an increase in productivity and efficiency of both public and private providers. Between 2009 and 2013, the number of private providers increased from 30 to 112, and the number of participants enrolled in job placement activities or rehabilitation programmes conducted by these private contractors grew from around 15,000 in 2009 to 121,000 in 2012.

Financing

In Sweden, all active labour market measures (labour market training, employment subsidies and job placement activities) are financed through the state budget. Private contractors are selected and financed via the local public employment service budget, and the coaching and placement activities are, irrespective of the type of provider, free of charge for the registered unemployed job-seeker. The payment of the private contractors is largely based on successful placements. Contractors are paid 40% when the job-seeker starts the programme, 30% when the job-seeker has signed a full-time employment contract with a duration of at least three months, and 30% when the job-seeker has been employed for three months.

Implementation and management

Since 2009, the Swedish public employment service at local level makes use of the abovementioned LOV Act for putting together a list of private providers that can be chosen by registered job-seekers. The selection of private providers is based on formal criteria regarding the competence and experience of the company concerned. As previously mentioned, job coaching and placement activities can be provided directly by the public employment service or by private suppliers. Firstly, the caseworker at the public employment service decides if the job-seeker is in need of an intensified job placement. Following this, the job-seeker might choose in-house or private coaching from the list of providers. Both public and private job coaches help job-seekers to develop job application documents and set short-term and long-term goals. Each job coach simultaneously provides support to about 20 job-seekers. According to the person interviewed at the public employment service, the increased outsourcing of search and coaching activities to private actors has made it possible to stabilise the number of job-seekers per caseworker and reduce the workload. In other words, the outsourcing of part of job placement activities previously performed in-house was partly aimed at solving a capacity problem related to an increase in registered unemployed job-seekers in the aftermath of the 2008 economic crisis. The public employment service is in charge of the monitoring and control of the service provided by the private suppliers, and follow-up studies have been performed by the public employment service at central level (see Outcomes section below).

Case study 2: ECEC and compulsory schools

Background and objectives

The choice of the second case study – pre-schools and schools – was motivated by the major transformations of the Swedish educational system over the last two decades, with a particularly clear trend towards an increasing role for independent providers. In parallel to an increase in the number of private schools, in the early 1990s Sweden also underwent a clear decentralisation of governance. The decentralisation reform of pre-school, compulsory school and

upper secondary school from central government (the state) to the local municipalities was launched by the social-democratic government and implemented in 1991. Since then, municipalities have been responsible for running and financing pre-school education (1–5 years: *Förskola*), compulsory schooling (6–9 years: *Grundskola*), as well as upper secondary education (16–19 years: *Gymnasieskola*).

Since 1992, local schools can also be owned and run by private providers. In 1995, this was extended to pre-schools, and the fact that private childcare centres could benefit from the same state subsidies as public childcare centres has had a determining effect on the subsequent development of publicly financed private pre-schools. The 'school market' that emerged after this reform transferred the right to choose a school from the public authorities to individual families. This system has increased competition somewhat between schools, both for the recruitment of pupils and teachers.

In 2013, there were independent pre-schools in 239 of Sweden's 290 municipalities. In that year, a total of approximately 489,300 children were enrolled in pre-schools (Skolverket, 2014), constituting 84% of all children aged one to five years. A large majority of pre-school children are enrolled in pre-schools with municipal education providers, although private pre-schools became more common in Sweden during the 1990s and continued to increase during the 2000s. The share of pre-school children enrolled in private pre-schools increased from 15% in 2000 to 20% (97,400 children) in 2013. That year, there were 7,350 municipal pre-schools and around 2,580 independent pre-school providers (cooperatives, foundations and limited companies); in other words, around 35% of pre-schools were run by private providers. It should be noted that it is relatively common for providers of pre-schools to also run compulsory schools. Approximately 1 in 10 private education providers was active in both types of schools in 2013. The most common form of operation in pre-schools remains cooperatives, often run by parents. Of all independent pre-schools in 2013, around 43% were cooperatives, 38% limited companies and 12% non-profit associations or foundations.

Since the educational policy reforms introduced in the 1990s, the number and the share of private compulsory schools has also been increasing gradually. In 2013, 16% of all compulsory schools were owned and run by private bodies, covering 13.6% of pupils (130,000 approximately). Of these pupils, around two-thirds attend compulsory schools run by limited companies. Between 2009 and 2013, the number of private compulsory schools increased by 12% and the number of pupils in independent primary schools rose by 31%. Since 2009, an increasing number and a growing proportion of pupils attend compulsory schools run by limited companies (Skolverket, 2014).

Regarding employment developments at the pre-school level, the number and proportion of teachers working for independent schools has been increasing during the last decade. The share of full-time equivalent employees working in private childcare increased from 15.2% in 2000 to 20.3% in 2013. The number of pupils per pre-school teacher has significantly decreased from around 8.6% in 2000 to 6.2% in 2013 (Skolverket, 2014), with no difference according to type of provider. At the compulsory level, there has been a trend of decreasing employment, with the number of teachers falling from around 86,300 in 2001 to 78,100 in 2013; however, the number of teachers per 100 pupils has remained fairly constant (around 8 teachers per 100 pupils). During this period, the share of teachers employed in the public sector decreased from 93.2% to 85.8%, reflecting the expansion of private schools.

Financing

Childcare in Sweden is highly subsidised and financed by local authorities. At the pre-school level, parents co-finance childcare activities by paying a fee. Regardless of the form of ownership, the fee is fixed by the municipality and dependent on household income and the age of the child. In the local authority that participated in this case study (Göteborg city), the maximum monthly fee is SEK 1,260 (€131 as at 12 August 2015) for children younger than three years and SEK 840 (€87) for children aged between three and five years. Private pre-schools are not allowed to charge additional fees.

Since 1992, at the compulsory level, each municipality is obliged to finance each pupil by a voucher (*Skolpeng*), regardless of the form of ownership. In other words, compulsory schools are free of charge, and private schools receive the same amount of money per pupil as public schools and are not allowed to charge additional fees.[14]

Implementation and management

The Swedish parliament (Riksdag) and the government set out the goals and guidelines for pre-schools and schools through the Education and Curricula Act. A special state agency, the Swedish National Agency for Education (Skolverket) is responsible for the attainment of the established goals. Another state agency, the Swedish Schools Inspectorate (Skolinspektion) assesses applications to run a private school and is in charge of the accreditation of private schools. Skolinspektion performs regular follow-up and evaluation surveys targeted at pupils, parents and teachers in both public and private schools to ensure that they follow regulations regarding curricula, quality of education, school environment, and other criteria of school achievement.[15] The parents are free to choose a school for their children based on a predetermined list managed by the municipality in the case of pre-schools and the Skolverket in the case of compulsory and upper secondary schools.

Case study 3: Municipal home-care services

Background and objectives

Over the past decade, the Swedish home-care system for older people has experienced major organisational changes regarding both the provision of services, with the expansion of private for-profit providers, and changes in work organisation (involving the rationalisation of tasks). A growing number of municipalities have abandoned the previous system of direct administrative control of service provision and have introduced a purchaser–provider system. As previously mentioned, the LOV Act leaves implementation of a free-choice option for care activities other than primary healthcare to the discretion of the municipalities. Some municipalities have therefore extended this free-choice option to home care, implying that once the care needs have been established and recognised by the local authority, senior citizens may choose between in-house public providers and private home-care providers. In other words, actual home-care services are provided either by municipal employees (in-house) or private organisations (mainly for-profit companies) on the basis of contractual agreements.

Since 2000, there has been a clear trend of falling numbers of senior citizens in residential care and a corresponding increase in home-care services. While this reallocation of resources might be partly ascribed to changes in individual preferences for being cared for at home, it also responds to cost-minimising considerations, the cost of home-care services being much lower than residential care. Typical home-care services include help with getting dressed, help during meal times and support during walks, as well as cleaning, washing and shopping activities in the household.

The 2008 LOV Act has also had an impact on the development of outsourcing of home care to private providers. In 2013, 121 municipalities (42% of all Swedish municipalities) outsourced part of their home-care services to private providers (Socialstyrelsen, 2014). The share of care hours for older people provided by private companies has increased continuously, from 7% in 2000 to 23% in 2013 (see Socialstyrelsen, 2013).

[14] The Swedish school voucher programme was introduced in 1992 by the then centre-right government. First, the Social Democrats opposed the reform, but after having returned to power in 1994 they not only accepted it but also expanded the legislated compensation level of the voucher.

[15] Authorisation for starting and running a pre-school is left to the local authorities. This role is also performed by a special administrative unit at the municipal level.

Växjö municipality was chosen for this case study because it is one of the 84 municipalities that have extended the LOV Act to encompass other social care services such as elder care. Furthermore, over the past three years, Växjö municipality has experienced an increase in the privatisation and outsourcing of elder care (both residential and home-care services) to private suppliers. The main motives local politicians had for increasing outsourcing and contracting out to private providers were, as expected, enhanced freedom of choice for senior citizens and the potential beneficial impact of increased competition on cost and economic efficiency. Currently, private for-profit companies provide around 30% of residential and home-care services, the remainder being provided by the municipality. In 2013, around 1,200 employees worked in the municipal elder care sector (comprising 1,100 auxiliary nurses and 100 nurses).

Financing

The municipalities finance home-care services, but part of the cost, independent of type of provider, is co-financed by the user in a form of a monthly fee. The amount of this fee depends on household income and the extent of home-care services being used. In 2014, the maximum monthly fee per person in the Växjö municipality was SEK 1,776 (€185), and the hourly fee cannot exceed SEK 330 (€34). For senior citizens with a low net disposable income, home care is free of charge.[16] The hourly fee is paid directly to the municipality and not to the private company. It should be noted that in the case of home care, private providers cannot compete on price since it is the local authority that determines the unit cost for home-care services.

Implementation and management

Elected local politicians establish the selection criteria for the choice of private providers during the procurement and selection process. In the municipality of Växjö, the criteria for selecting private providers are based solely on the quality of the service provided and not on price competition.[17] The municipality conducts follow-up surveys and evaluation studies each year to check whether quality requirements and regulations are being followed by the private service providers. The municipality also conducts a yearly follow-up opinion survey among the customers of both municipal and private home care in order to monitor service quality.

Decisions about eligibility and the amount of home care granted remain the responsibility of local authorities. Senior citizens have to apply to the municipality for home care. Once the care needs have been established by the administrative officer and granted by the local authority, senior citizens may choose between the in-house public provider and private home-care providers. The list of private providers is available on the municipality home page. If the user does not choose, municipal employees will deliver care in-house. The user has the right to switch providers.

Outcomes

Case study 1: Public employment services

Access-related outcomes

No problems arise regarding access to the public services in Sweden included in this case study. Access to private (for-profit and non-profit) and public providers is equitable. Moreover, public employment services are free of charge for service users, as is the case in all case study countries, regardless of the nature of the provider.

[16] Single people aged over 65 years pay a home-care fee if their net income after basic consumption costs exceeds SEK 5,023 (€524) per month. Such costs include food, clothing, shoes, hygiene, housing costs (such as electricity), home insurance, television fees, hospital and dental care, telephone, travel and furniture.

[17] This is alongside the requirements regarding the formal qualification of employees – auxiliary nurses and nurses.

Quality-related outcomes

Two recent evaluation studies have been conducted to analyse the impact of outsourcing coaching and placement activities. The first study was an attempt to evaluate the outcome of the job-coaching programme (Gartell, 2011). One of its objectives was to compare the likelihood of individuals who received public (in-house) coaching getting a job versus those who had private job coaching. The author found that, overall, the probability of participants getting a job was not related to having been coached by a private or public provider.

The second study also aimed to empirically assess whether private contractors are more efficient than public providers, in this case in relation to placing unemployed people, and to establish whether the satisfaction of these job-seekers differs by type of provider (Bennmarker et al, 2013). The study used an experimental approach involving a random assignment of participants. The authors found that private job placement agencies tend to use a more labour-intensive technology, more personalised services and were more successful at motivating job-seekers to search more thoroughly for work. Compared to job-seekers at the public employment service, unemployed job-seekers enrolled in job placement activities with private providers spent more time with their case officer, received more help in improving their job search strategies and exhibited, on average, a greater search intensity. Furthermore, the job-seekers enrolled with private providers said that they were more satisfied with their caseworker and the service received.

Effectiveness-related outcomes

The higher level of interaction between job-seekers and caseworkers in private placement agencies and the related increase in job-seekers' job search intensity did not improve their overall chances of finding a job. These results suggest that in the case of Sweden's public employment service services, there are no large efficiency gains to be made from outsourcing job placement activities to private providers.

Case study 2: ECEC and compulsory schools

Access-related outcomes

As noted in the outcomes on quality and effectiveness below, students in private schools fare better than their counterparts in public schools. This has raised questions about equity of access to the two different types of providers. However, the capacity of private schools to discriminate and pre-select pupils seems, according to the Skolinspektionen, extremely limited at the pre-school and primary school levels.[18] Generally, admission to both private and municipal schools depends mainly on a waiting list, or queue system. In other words, there are strong reasons to believe that the difference in the socioeconomic composition of pupils across different providers is the outcome of a self-selection process,[19] with well-educated parents being more inclined to place their children in private independent schools, and cannot be ascribed to discriminating behaviour by private providers, in particular behaviour favouring pupils from higher socioeconomic groups.

[18] The selection criteria are the same for municipal and private schools. The most common criteria are geographical proximity, date of application, and whether or not a pupil already has a sibling attending the school. The Swedish School Inspectorate controls adherence to these rules.

[19] Another possible explanation could be housing segregation, with private schools being established in more affluent areas.

Quality- and effectiveness-related outcomes

In recent years, one issue that has generated lively debate in Sweden is whether the right to choose a school has contributed to the significant increase in the spread of pupils' performance and results across education providers. As shown by empirical evidence, school performance and pupil achievement are positively correlated with parental educational attainment. In 2014, Skolverket conducted a study comparing the family socioeconomic backgrounds of pupils across different providers. Compared with pupils attending municipal schools, pupils in private schools are more likely to come from families with more favourable socioeconomic status and levels of educational attainment. Some differences exist among the various types of private providers. Foundations and non-profit associations have the highest proportion of pupils with parents with higher educational attainment (three-quarters with tertiary education), while limited companies display the lowest share among private schools.

Case study 3: Municipal home-care services

Access-related outcomes

As in all the case study sectors in Sweden, access to home-care services is universal and equitable in terms of both private and public providers. The main concern and potential drawback of private elder care is the potential for a lack of continuity in the provision of services; this was the view of a municipality official interviewed for the case study, who was in charge of outsourcing, supervision and monitoring of private elder care and home care, based on a survey on quality conducted by the municipality.

Quality-related outcomes

According to the last follow-up and satisfaction survey conducted by the National Board of Health and Welfare, there has been an increase in the proportion of older people who use private providers expressing satisfaction with their care (Socialstyrelsen, 2014). Specifically, there has been an increase in the proportion reporting that they have greater influence on the time their home-care service is delivered and that the private provider takes into account their opinion and requests for help (Socialstyrelsen, 2014). On the other hand, the results of the survey show that users of private providers of home-care services are not more satisfied than users of public home-care services.

Effectiveness-related outcomes

During the research for this case study, no scientific evaluation studies or cost–benefit analyses was identified. It is therefore difficult to assess the potential efficiency and cost–benefit gains associated with the outsourcing of tax-financed home-care services to private providers.

Conclusions

Over the past two decades, Sweden has undergone major structural and institutional reforms that have, among other things, led to a dismantling of existing public monopolies and an increase in for-profit private suppliers. The related increase in outsourcing of tax-financed services should therefore be put in its broader context: a tendency towards market deregulation and privatisation initiated in the early 1990s. Four main reasons have been advanced in Sweden justifying the increased outsourcing of tax-financed services:

- fiscal consolidation and reduction of public expenditure;
- the development of competition due to the increased diversity of private providers;
- the expected related improvement in economic efficiency;
- greater freedom of choice for citizens.

Therefore, one central issue and policy question debated in Sweden has been to assess the extent to which private contractors are better and more efficient at providing welfare services than public providers. The few Swedish scientific evaluations cited in this report tend to show that efficiency gains associated with outsourcing of tax-financed services remain questionable. It is not clear, particularly when taking into account procedural, follow-up and monitoring costs, that the increased outsourcing of tax-financed services is cost-efficient and welfare-enhancing, while not directly having an impact on access or quality. As shown in Anxo and Ericson (2012), regional variation in municipalities' use of outsourcing seems to reflect political and ideological choices rather than a quest for economic efficiency. On the other hand, the fact that several public agencies exercise strict control to ensure that both public and private providers follow current regulations and respect the quality requirements might constitute a guarantee that the outsourcing of public services does not lead to a deterioration in quality. In addition, the fact that the criteria for the selection of private providers are based mainly on the quality of service provided and not on price competition further reduces the risk of a decrease in quality. Furthermore, private providers cannot compete on wage levels as they have to follow the employment conditions agreed for the sector as a whole.

The Swedish experience tends to show that potential problems regarding affordability and accessibility are limited because private suppliers are not allowed to charge additional fees, the price of welfare services is regulated and fixed by the state or local authorities and is highly subsidised, and co-financing by users depends on their household income. The fact that private providers have limited room for manoeuvre in selecting users of their services can also constitute a good guarantee for equal treatment (of workers and service users) by reducing their capacity to engage in discriminatory behaviour. Last but not least, the large majority of follow-up and opinion surveys performed by the authorities show that users are, as a whole, satisfied with the services supplied by both private and public providers. As shown in Anxo and Ericson (2012), due to the specificity of the industrial relations system (high union density and high coverage of collective agreements), the increased outsourcing of public services in Sweden has up to now not entailed a deterioration in pay or working conditions nor increased labour market segmentation, as has been the case in many other EU Member States.

However, the recent bankruptcy of a number of private schools in Sweden as well as some problems in large residential care homes owned by multinational venture capital companies demonstrate the need for a long-term and broad evaluation of the risks and impact of outsourcing public services. These developments also show that more control should be exercised regarding the financial transactions of private providers and that there is a need for greater economic transparency of private entities in order to better insure the continuity of service provision, in particular for sensitive activities such as childcare and elder care. This would require legislative steps to reduce the right to 'commercial confidentiality' enjoyed by private companies.

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Country study: United Kingdom 5

Overview

The trend towards privatisation in the UK public sector reflects a general 'marketisation' of services and the mainstreaming of commissioning into public sector activity. This has been carried out through the policies of 'compulsory competitive tendering' during the 1980s and 1990s and 'best value' during the 2000s (Whitfield, 2012). The clearly stated ambition of the Conservative–Liberal coalition administration of 2010–2015 was to break the monopoly of state provision in health and social care, making commissioners receptive to 'any qualified provider' (HM Government Cabinet Office, 2011). Since the start of the economic and financial crisis, the UK has undertaken an ambitious programme of macroeconomic restructuring involving direct reductions in public sector expenditure and the erosion of welfare entitlements. It is also believed that there is significant scope for efficiency and productivity gains in welfare services through better targeting and strengthening of the commitment to a 'mixed economy' of provision (in public, private and independent sectors), underpinned by a lightly regulated pro-business environment.

The use of private sector provision is predicated on the notion of 'customer choice', and the assumed inherently higher levels of efficiency and productivity driven by the profit motive: cost savings of around 20% are assumed possible with each contract placed with the private sector (Whitfield, 2012). This faith in private sector markets tends to underestimate the increased administrative burden of contract management, and earlier studies suggest that many of the cost savings are derived from job losses, changes to working practices, and cuts to pay and conditions (Halford, 1982; Escott and Whitfield, 1995).

Including capital spend, the public services market is worth almost GBP 200 billion (approximately €280 billion) per year, covering service areas such as facilities management, prisons, information and communications technology (ICT), community health and helping the unemployed back to work (NAO, 2013). Local government spends close to GBP 40 billion (€56 billion) every year on both goods and services supplied by external providers, making extensive use of the private, voluntary and community sectors for a range of core functions such as waste management and environmental and leisure services, along with children's services and social care for older people (LGA, 2014). In contrast, service areas such as social housing are not typically labour intensive, and private sector control represents just 2% of total market value (primarily in the management and maintenance of housing stock) (CBI, 2012).

Social investment in welfare is seen as a means of reducing social exclusion and improving the development of human capital: for example, the provision of high-quality affordable childcare complements labour market activation policies and supports the early educational attainment of children (particularly those from disadvantaged backgrounds). But, despite some changes to the tax system and an increase in the supply of childcare places, the UK has made limited progress on addressing child poverty and the cost of childcare (European Commission, 2015).

In the view of a national officer at the public service trade union UNISON, there is a fundamental tension between the profit motive and high-quality public services, particularly where providers subcontract. Building in multiple profit layers is neither cost-effective nor in the best interests of the service users, and inevitably leads to the worsening of employee pay and conditions, which bears heavily on an already low-paid, part-time female workforce.

Also of concern is the lack of transparency around the financing and ownership of large private sector providers (for example, care firms backed by overseas hedge funds) and the accountability to local citizens. The collapse of the Southern Cross chain of nursing homes in 2011 revealed extensive problems associated with the labyrinthine financial structure of the company, which was backed by private equity. Southern Cross used the sale and leaseback of care-home properties to expand during the 2000s, but this left the company highly exposed to financial risk resulting from a combination of rising rents and decreasing incomes when local authorities cut back on social care spending after 2009. The majority of the 750 homes operated by Southern Cross were transferred to new ownership during 2011 and 2012,

but there was a significant period of uncertainty for the 30,000 residents. Around the same time, evidence surfaced of serious mistreatment of residents at one of the company's care homes, which was attributed to systemic mismanagement (The Guardian, 2011). UNISON emphasised the success of insourcing (or 'remunicipalisation') exercises in a number of local authorities, which, it was argued, had helped to minimise the risks associated with contract failure and poor performance, while also lowering running costs through better staff management and reduced turnover.

A public sector policy expert suggested that all UK political parties fundamentally accept private provision of public services, and, while there may be some minor variations in the pace and scope of outsourcing, there was no appetite to return all services to public ownership. The issue that ministers and senior civil servants had failed to grasp was the complexity of large contracts, particularly in areas such as ICT. Such contracts invariably ended up being hugely expensive and inflexible, with multinational companies offering standardised products at inflated prices, with little of the innovation or creativity expected of the private sector. It was recognised that large firms could streamline transactional tasks and cut back office costs. However, it was argued that this was not radically different from the economies of scale that could be achieved in the public sector, and payment-by-results systems had not delivered a step change in performance. Although some parts of central government were exploring new ways of delivering public services through cooperative structures and online 'self-service', the approach to outsourcing across much of the public sector was much more traditional, often based on long-term buyer–supplier relationships, with high costs for variations to agreed outputs.

Table 6 summarises the main trends in the private sector's role in the case studies chosen for the UK.

Table 6: Role of the private sector in the case studies of the UK

Sector	Brief description
Adult training and employment services	The state now acts as the first point of contact and referral only for the first three months of unemployment. Since 2012, responsibility for the main elements of adult training and employment (such as job search and brokerage) are wholly managed by large private sector firms known as prime contractors.
ECEC	There is no universal entitlement to full-time free childcare for children under two years old, although the state offers subsidies in the form of: (1) additional tax credits for low-income parents to cover the costs of childcare; and (2) childcare vouchers available to employer-administered salary sacrifice schemes. The private sector tends to provide the majority of nursery care for children under school age (five years), along with private childminders.
Adult social care	Many social care services for older people were transferred out of direct state ownership during the 1990s and 2000s as comparatively high pay and conditions made in-house services increasingly uncompetitive. The vast majority of residential and nursing home places are supplied by private for-profit providers.

Source: *Prepared by authors*

Case study 1: Employment and training for job-seekers

Background and objectives

Reforming welfare and 'making work pay' was a flagship policy reform of the Conservative–Liberal coalition. Whereas the public sector used to directly support unemployed people with benefits advice, training, job searches and referrals to other agencies, Job Centre Plus, part of the Department for Work and Pensions (DWP), now acts only as the first point of contact and referral for the first three months of unemployment. The rest is outsourced under a government welfare-to-work programme known as the Work Programme. The substantive elements of the Work Programme, such as training, job search and brokerage, are now wholly managed by large private sector firms known as prime contractors, for example A4e, which holds contracts worth GBP 200 million (€280 million) per year.

Financing

The Work Programme costs around GBP 1.2 billion (€1.7 billion) per annum to run, and the majority of prime contractors' income is derived from a payment-by-results system that incentivises the achievement of sustainable work

outcomes for clients. The proportion of payments for new entrants to the Work Programme ('attachments') has declined over time, although there are few controls that the DWP can exercise over the content of support and intervention packages (IPPR, 2014). It appears that the Work Programme is cheaper than the state-run New Deal scheme, which operated up until 2010; however, by definition, a payment-by-results system means the worse the outcomes, the lower the cost, so it is not yet clear whether it represents good value for money (IPPR, 2014). Support and training are notionally free for job-seekers, although there are penalties for non-compliance with agreed interventions and job searches, such as the freezing or withdrawal of welfare payments.

Implementation and management

One element of the Work Programme that has come under significant scrutiny is assessments of eligibility for incapacity benefit ('fitness-for-work tests'). These were introduced in 2008 and performed by the private sector under contract to the DWP. The rapid tightening of eligibility criteria after 2010 has led to an increasing number of apparently arbitrary decisions to disallow disability benefits, as evidenced by high rates of successful appeals from claimants. In the wake of sustained public criticism over the assessment process, the French outsourcing firm Atos bought itself out of the remaining 12 months of a contract to provide these assessments in early 2014 (The Guardian, 2014). The pressure to implement change quickly appears to have led to a rushed transition to the new arrangements, creating problems with staffing levels, a strained relationship between job centres and prime contractors, and weak performance measurement, despite the fact that the payment-by-results system was introduced to explicitly prevent rewards for failure (Grimshaw, 2012).

Case study 2: ECEC

Background and objectives

The evolution of childcare and early education policy in the UK reflects the long-standing ambitions of central government to:

- augment welfare with private services;
- raise educational attainment;
- increase labour market participation by offering targeted state transfers to working parents.

There is no universal entitlement to full-time, free childcare for children under two years old, but once children reach the age of two years, they are entitled to 15 hours of free 'early education' provision each week for 38 weeks of the year, until statutory school age (the next academic term after they turn five). Places in full day care make up over 60% of the pre-school market, day care in children's centres 2%, sessional care[20] just under 20% and private childminders around 18%. The private sector tends to provide the majority of full day care, while the state-maintained sector provides most of the childcare through children's centres, and the not-for-profit sector tends to provide the majority of sessional care. The private sector is therefore a key player in the UK ECEC market.

[20] Sessional care is pre-school care limited to a maximum of 3.5 hours per day.

Financing

The state offers subsidies in the form of additional tax credits for low-income parents to cover the costs of childcare and childcare vouchers accessed via employer-administered salary sacrifice schemes. Since 2010, there have been mixed messages from central government: there has been an expansion of free early education places for disadvantaged two-year-olds, but at the same time there has been a reduction in the childcare element of working tax credits. The policy expert argued that while tax credits were important for some parents (particularly single parents), at present the childcare voucher scheme has faults. It is poorly targeted (all parents are entitled to them regardless of earnings) and limited in scope, as not all employers offer them, not all providers accept them, and at most they would reduce bills by GBP 1,000 (€1,406) per year (although this is due to increase in 2015 to a maximum of GBP 2,000 (€2,812)).[21] Average occupancy rates for places for those aged 0–4 years in day nurseries are broadly stable at around 75% (just above break-even), but this is largely driven by children accessing free early education places rather than privately paid-for childcare (NDNA, 2014). In London and the south-east of the country, some providers are losing on average GBP 900 (€1,265) per child per year enrolled for a free early education place, meaning that the cost is increasingly transferred onto childcare fees for non-funded hours.

Implementation and management

Fundamentally, the Department for Education sees a much reduced role for local authorities in shaping the range, accessibility and affordability of private and independent provision. Market forces should clearly be allowed to operate unfettered: 'Local authorities should not intervene in providers' private businesses outside of a child's early education place' (Department for Education, 2013, p. 4).

The role of the state therefore is to offer a light-touch form of market management that:

- ensures sufficient childcare places for children of working parents;
- secures free early education places for eligible children aged two, three and four years;
- provides information to parents.

According to the local authority interviewed for this case study, which wished to remain anonymous, there was a delicate balance to be found between the stimulation of supply and demand within the market. Historically, many parents relied on informal childcare, but the ambition to raise educational attainment made the expansion of high-quality and affordable childcare a priority. Providers in this authority area received comparatively high rates for funded early education places (higher than the regional average), meaning that financial viability was not as much of a problem as it was in the south-east region.

Case study 3: Adult social care

Background and objectives

Services such as residential and nursing home care (short-term, long-term and palliative) and domiciliary care services in the client's own home are core functions of local authorities, making up around GBP 19 billion (€27 billion) of annual spending. Many services and premises were transferred out of direct local authority control during the 1990s and 2000s, as comparatively generous pay and conditions made in-house services increasingly uncompetitive. As of 2010, the proportion of residential and nursing home placements in the independent sector stood at 90%, the vast majority of which is supplied by private for-profit providers (Forder and Allan, 2011).

[21] This is based on earnings and the value of vouchers purchased.

Financing

Local authorities fund 52% of placements in independent sector residential and nursing homes, whereas the NHS funds just 8%, with self-funding making up the remaining 40%. Although fees can vary significantly by provider and geographical area, average weekly rates have increased in real terms by around 70% since 1998 (Forder and Allan, 2011). Residential care can cost close to GBP 1,000 (€1,406) per week, and the cap on care fee contributions is being increased from GBP 35,000 (€49,178) to GBP 72,000 (€101,160) in 2016 (excluding any charges for food and general accommodation), meaning that individuals may still be liable for significant expenses (Age UK, 2014). It has been estimated that the minimum hourly rate needed to provide good-quality domiciliary care with allowances for staff training travel time is GBP 15.19 (€21.34). However, less than 5% of local authorities are thought to pay this amount, with the average at just over GBP 12 (€16.86) per hour (BBC News, 2015b).

Implementation and management

The local authority in this case study provides the majority of intermediate care (support for those with short-term care requirements and those leaving hospital), but there was no particular commitment to an in-house model of service delivery. This was reflected in the decision to outsource all care homes in the early 2000s, along with the majority of home-care services. Although the private and not-for-profit market provides the bulk of residential, day-care and home-care services, the local authority is committed to a fully qualified social work function that oversees care packages and safeguarding issues. The only area where there is a lack of capacity in the private market is the provision of specialist services for clients with learning difficulties, but at the time of interview, discussions were under way to stimulate the market: the remaining in-house services were due to be put out to tender within the next 12 months and staff would transfer to the successful bidder.

Outcomes

Case study 1: Employment and training for job-seekers

Access-related outcomes

Nearly 1.5 million people have joined the Work Programme in the past two and a-half years, and around 17.5% of these have found sustained employment (IPPR, 2014). It was the view of the policy expert that the private sector copes reasonably well with routine job searches and support packages for clients who are ‘work-ready’, but adequate resources were not available to support job-seekers with more complex requirements, such as drug and alcohol treatment, mental health problems or offending behaviour (which job centres were better equipped to deal with). It was recognised that there have been some improvements in the aggregate number of successful job outcomes, but these are generally in the groups closer to the labour market, and the proportion of clients securing sustained work within 12 months of entering the programme is now falling. The payment-by-results system for the Work Programme was thought to encourage contractors to prioritise ‘work-ready’ clients for acceptance onto the programme, thereby inflating successful outcomes and filtering out those with greater support needs, who may not be able to access the services they require.

Quality-related outcomes

From the contractor’s perspective, the upturn in the labour market over the last 12–18 months meant a decline in the number of new referrals from the job centre (as clients with relatively minimal support needs were finding work quicker) and an increase in the proportion of clients with complex requirements. Each contractor has its own ‘supply chain’ and works with specialist providers and a range of not-for-profit organisations to meet the specific needs of clients. This could be to provide basic skills training (literacy, numeracy or ICT), as well as vocational skills courses (for example, catering and book-keeping). In terms of managing clients, the contractor has some discretion when agreeing a package of support for clients, but if the client does not engage with services, the contractor is obliged to notify the DWP of a breach in the relationship, following which welfare sanctions are applied. The contractor interviewed for this case study

argued that the payment-by-results system was effective, as payments for new referrals had decreased over time, and the contractor's income was now primarily determined by the achievement of sustained work outcomes (payments increase at three and six months). In order to keep the contract viable, it was in the interests of the contractor to build clients' skills and find them suitable, long-term work, although no aggregate data are available about the type or quality of the employment obtained, or the match with a client's skill set and interests.

Effectiveness-related outcomes

From the perspective of staff and volunteers at a job club interviewed for this case study, there was a mismatch between the skills and experiences of job-seekers and the jobs on offer. It was argued that job-seekers were being channelled towards entry-level jobs (low-paid and temporary work with limited prospects), irrespective of their work history or skill set. This meant that experienced and knowledgeable workers had to start their careers all over again, with no real career pathway owing to their age. The competition from younger workers (university graduates and school leavers) meant that employers were able to pick the most highly qualified candidates regardless of the demands of the job, and the incentives to take on younger workers (for example, through apprenticeships) disadvantaged older workers with non-linear work histories.

The pressure to apply for and obtain work was an ever-present concern for job-seekers themselves. The 'work first' approach meant that the main priority was finding work through job searches, completing applications and engaging with employers. Job-seekers reported significant pressures to apply for all the jobs that were available (up to 25 applications per week for one client). This in turn led to a lack of time to engage in training, development and confidence-building, which they felt could make employment more sustainable in the long term. A number suggested that contractors pushed them to apply for jobs before they were ready, which could jeopardise their chances of sustaining the job and make them more likely to pass through the programme again in the future. The contrast between the interaction with staff and services at the prime private sector contractor and that with staff and services at the not-for-profit job club was clear: one client reported feeling 'like a number' when attending appointments at the private sector contractor and that the interaction with individual staff members there was cold and impersonal.

Case study 2: ECEC

Access-related outcomes

According to both the advice and guidance specialist at the local authority and the national policy expert, the cost of childcare was consistently identified by parents as a barrier to accessing good-quality formal childcare: a family with two children in full-time care could spend up to GBP 11,000 (€15,466) per year (higher than the annual average cost of a house mortgage). This in turn was a barrier to labour market participation, particularly for those with limited access to informal care. According to local authority representatives interviewed, an increasing awareness of the free early education programme along with the financial support available (for example, tax credits and childcare vouchers) had made formal childcare more affordable, and as a consequence, the uptake of subsidised places had steadily increased. The increased uptake by parents does not represent an increase in places, however.

Quality-related outcomes

According to the local authority, the market for childcare in non-deprived areas had always been broadly self-regulating in that competition between providers stabilised cost and quality, and there was a high degree of parental choice. However, in deprived areas, capacity, quality and choice were all problematic: some areas might be limited to one or two providers, and the lack of competition meant that quality was adequate but no more. The provider interviewed here prioritised professional development and formal qualifications for staff, with a number having reached degree-level early years professional status. This commitment to staff was reflected in low levels of turnover, with some staff having been in the post for 10 years or more.

The provider has several sites across a number of local authority areas and had been able to expand on the back of a good reputation and positive quality ratings from the independent education inspectorate (Ofsted). The take-up of early education places varied between areas, which, when combined with new entrants to the market, had made some locations less profitable than others. Although the provider could afford to cross-subsidise, this would be much more challenging for small providers with only one location and a narrow range of activities. Childcare is not a high-paying sector, and the provider noted that staffing issues such as recruitment and retention are generally managed through good human resources practices such as training and development. The local council had historically been heavily involved in quality initiatives and staff training, but this was now generally left to the discretion of individual providers.

Effectiveness-related outcomes

The policy expert argued that in her opinion there was a clear link between the quality of ECEC provision and educational attainment outcomes. However, in contrast with the statutory education sector, the low degree of professionalisation of childcare careers reinforced the pattern of low wages and underinvestment in staff training. It was also argued that while a market-based model might work reasonably well for higher-income parents, choice, quality and effectiveness in more deprived areas were poor, an issue that was compounded by the 'colonisation' of universal services such as children's centres by higher-earning parents. Geographical disparities in a relatively unregulated market only served to reinforce the gap between good-quality and poor-quality care, and with limited choice, parents may be forced to rely on informal childcare, with the attendant risks of poor learning and development outcomes.

Case study 3: Adult social care

Access-related outcomes

Eligibility criteria for all state-provided and subsidised care are generally determined by local authorities as commissioning bodies (rather than individual providers). There is evidence that local councils are restricting access to care to the highest levels of need, such as those who cannot perform any vital personal care tasks. This means that many clients who need help with routine tasks such as washing and dressing pay for all of their care (Fernández et al, 2013). Under the financial pressures of austerity policies, discussions within the local authority focused on eligibility, service standards and quality. An ageing population means that demand management strategies have become increasingly important to divert people away from hospital admissions and local authority care services (particularly residential stays). This includes more integrated working with health services, assertive in-reach work to agree lower-level interventions in the client's own home, and a restriction on eligibility criteria for some services. Historically, there has been broad commitment to a 'platinum' standard of service, but under continued budget pressures, it was suggested that this would be revised down to a 'bronze' standard.

Quality-related outcomes

Recent data suggest that one in five care homes are failing to meet minimum care standards set by the Care Quality Commission, the UK's statutory regulator of care, but there is currently little in the way of systematic analysis of the effect of private sector provision on the quality of care provided (BBC News, 2015a). A combination of falling hourly rates (in real terms) along with the heavy reliance on contracted services means that issues of quality often fall into the gap between the responsibility of the state as a commissioning body and that of providers contracted to deliver an agreed volume of care at a specific price point. According to a local UNISON official, the lower pay and poorer conditions in the private sector offer significant cost savings to local authorities, which, when combined with a squeeze on contract costs, disincentivises the enforcement of higher-quality standards throughout the supply chain. Although companies had initially absorbed declining margins, it had reached the stage where some providers were no longer willing to take council-funded clients on the basis of low profitability. Pay rates for care staff in private sector firms in the local area were reasonably good compared with regional and national averages, but the volatility created by local authority budget cuts and an increasingly crowded marketplace perhaps contributed to comparatively high sickness and turnover rates.

Continued cuts to social care budgets appear to be creating significant recruitment and retention problems across the sector, which is compromising the ability of the market to meet the ever-growing demand for services (Community Care, 2015).[22] The home-care provider stressed that investment in the workforce was important to create better standards of care, and consequently it had ensured that:

- rates of pay were competitive for the local area;
- a training and development programme was in place;
- management had signed a single recognition deal with a local branch of UNISON.

The provider had also adopted various 'ethical care' standards, including 30-minute minimum visits (instead of the 15-minute visits favoured by many local authorities and private sector firms to reduce costs); payment for travel time and expenses; and the use of guaranteed hours contracts for staff. It was felt that all of these measures had helped to keep staff turnover low and quality high.

According to the provider interviewed, the switch from large local authority 'block' contracts to personalised budgets has introduced new dynamics to the market. In addition, traditional contracting has been replaced by a system of smaller-scale 'brokerage', where the local authority designs packages of care for individual clients. While standard contracts brought stability in terms of volume, working more closely with brokers creates the opportunity to emphasise the quality of care rather than just the lowest price. Competition in the market is becoming increasingly cut-throat as national chains can afford to outbid smaller providers as a result of cross-subsidisation, but word of mouth is still an important driver of new business, based on positive user feedback and a good reputation. With margins tight, the provider suggested that if hourly fees paid by local authorities were squeezed further, they would rather see the company 'go under' than offer a poor-quality service.

Effectiveness-related outcomes

Interestingly, despite cost pressures across the sector, service user feedback gathered by the Health and Social Care Information Centre suggests that overall satisfaction levels are high (HSCIC, 2014). In the 2013–2014 survey, close to 90% of service users reported that they were satisfied with the care services they received (delivered by the local authority directly or under contract by the private sector). Users of residential home care (with no nursing facilities) and nursing home care (with trained nursing staff for those with recognised medical requirements) were slightly more satisfied with the care they received than users of home-care services (95%, 92% and 90% respectively). At the local authority, satisfaction levels in 2013–2014 were higher than average and had shown improvement since 2010–2011 (HSCIC, 2012; 2014). With regard to paid care from the private and independent sector, a slightly higher proportion of respondents reported paying for some or all of their care than the national average (over 40% compared with an average of 38% for England). However, the local authority still brokers care packages on behalf of many clients in receipt of direct funding, which lowers the risk of using poor-quality providers.

[22] In 2009–2010, there were already severe problems regarding recruitment and retention in adult social care private sector providers, with turnover rates of 31%; 69% recorded staff shortages to cover unsocial and weekend hours (Rubery et al, 2015). This was before further rounds of budget cuts, which have tightened commissioning conditions.

Conclusions

In respect of the Work Programme, there appear to be problems with performance management. This means that in addition to difficulties tracking aggregate outcomes, the structure of the payment-by-results system does not do enough to address the poor outcomes of specific contractors or for specific groups with more complex needs. There are still question marks over the 'work first' model, which places total emphasis on job searches and not enough on the quality and sustainability of employment outcomes. Employment outcomes could be better achieved through tailored and intensive programmes of skills training and confidence-building. Central government appears willing to accept the modest outcomes of what is a comparatively cheap programme (IPPR, 2014).

In the ECEC sector, there are relatively few direct market controls, which is reflected in differential patterns of access, affordability and quality of provision reported by the policy expert. A market model may deliver choice for better-off families, but there is significant evidence of limited local competition between providers in deprived areas, which can reduce standards and inflate costs. The rollout of the early education pilot for two-year-old children appears to be having an impact on the take-up of places by deprived families, but informal childcare remains important for many low-income families.

In the adult social care sector, there is evidence of innovation in demand management and partnership working, but cost is a dominant concern, and the sustainability of the current model is highly questionable. There is something of a paradox in this sector, in that problems of cost, quality and accessibility are often raised by service users and their families but overall satisfaction levels are consistently high. Where providers are willing to invest in the workforce, staff retention, morale and productivity can increase, but the contracting approach of local authorities can reduce the scope for progressive human resources management strategies.

Future research in this area needs to take account of the growing complexity of contracting arrangements in public services, particularly where partnership-based, mutual and cooperative structures are developed with a range for-profit and non-profit organisations. The implications of these partnerships and joint ventures are often poorly understood at the design stage, and the withdrawal of private sector firms from large contracts in healthcare and local authority services often leaves the public sector highly exposed to financial and operational risks (The Guardian, 2015).

Generally speaking, it is not the involvement of the private sector that is creating many of the problems reported here. Rather, it is a combination of policy, market management and funding pressures, which appear to create pervasive issues with cost, accessibility and quality. The following problems were identified:

1. a general lack of funds for high-quality provision and investment in the workforce, leading to a downward spiral of cost-cutting and low employment standards;
2. limited regulatory powers for state agencies to correct for market failure, to promote choice and drive up quality;
3. skewed performance management systems that do not represent the interests of the most disadvantaged and excluded groups.

Large-scale privatisation policies such as the Work Programme formulated at ministerial level and effectively imposed on state agencies appear to create the greatest rigidities in respect of implementing, running and monitoring services. High-volume contracts combined with weak performance management of large private sector providers are in danger of effectively replacing one form of producer-driven monopoly with another. In contrast, where funding and quality control is devolved to a local authority level (as is the case in childcare and adult care to an extent), there appears to be greater scope for public servants to innovate and manage standards effectively using local knowledge of both supply and demand.

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Main findings 6

Reliance on private sector for public service provision

Key finding: Case study Member States are increasingly relying on the private sector for the provision of public services.

In all case study countries, the private sector has played an increasingly important role in the provision of SSGIs. This process started as far back as the 1980s in Sweden and the UK and, to a lesser extent, in Spain. Lithuania has seen an increase in the marketisation of service provision since the 1990s. Over the past decade, the role of the private sector in the provision of SSGIs has expanded further in all four countries, as evidenced by a growing ratio of users and staff in private versus public providers in the selected sectors. In Sweden, private providers (including non-profit organisations) employ around 20% of staff in different SSGI sectors. In all countries, such developments were stimulated by legislative adjustments at sector level, explaining considerable variation in the prevalence of private provision across sectors. In the UK, perhaps reflecting that country's long-established market model of public service delivery, there is some evidence of a return to public ownership, where contracts in the private sector have proved to be more expensive and less effective than anticipated. Insourcing exercises in local government suggest that risk management is better controlled through direct ownership, along with lower administrative costs once legal and contract management resources are accounted for.

With regard to the capacity in which the private sector is engaged, in all sectors examined, the private sector role was mostly in delivery and, to a lesser extent, financing (see the section on the public and private financing of SSGI services in this chapter); involvement in management was even less common. The Spanish healthcare case study focused on a PPP in tertiary healthcare, where the private sector had a role in all three levels – from raising capital to delivery and management. In the UK, perhaps mainly due to the specific sectors in the UK cases, there are examples of private providers managing facilities in health and compulsory education.

Active role for the private sector

Key finding: The private sector is active in the provision of services across all SSGI sectors.

The case study sectors were selected based on the extent to which they have been affected by a greater private sector role: the four chosen were those most affected by this trend in the countries analysed.

Employment services

Employment services were analysed in Lithuania, Sweden and the UK, all three of which have seen a particularly marked increase in private provision. For example, in Sweden, from 2009 to 2013 the number of private providers increased from 30 to 112, with a corresponding increase in users of private provision from 15,000 in 2009 to 121,000 in 2012. In Spain, although employment services were not among the case study sectors for this country, private provision began as far back as 1993 and the market was liberalised in 2010.

Elder care

This category of care, which includes services such as residential care, home help and telecare, was studied in Spain, Sweden and the UK. It has also been substantially affected by the trend towards a greater role for the private sector. In Spain, as of 2010, private employment in this sector reached close to 80%, while in the UK, 90% of residential and nursing home placements are provided by the private sector.

Healthcare

Healthcare was analysed in Lithuania (primary and secondary care) and Spain (primary and tertiary care). In Lithuania, following the 1990s, entire sectors of healthcare, such as dentistry and pharmaceuticals, were transferred to the private

sector, and private provision in primary to tertiary care has been growing substantially ever since. In the Valencia region in Spain, which has had more experience with private provision of public health services than other regions, 20% of the population receives healthcare from providers established and run as PPPs, with the private sector participating in financing, delivery and management of these services.

ECEC

Private providers are playing a greater role in the provision of ECEC in Lithuania, Sweden and the UK through the use of education vouchers, which leaves the choice of provider up to the consumer. In Sweden, the share of pre-school children enrolled in private pre-schools increased from 15% in 2000 to 20% in 2013. In both Lithuania and Sweden, the same voucher system that applies to ECEC also applies to compulsory primary education; however, while there has been little uptake of private provision in Lithuania, the opposite is true for Sweden.

Secondary education

Secondary education is not included in this country study analysis, but in all four countries the role of the private sector in this area has increased to varying degrees. In Lithuania and Sweden, the same financing rules apply to ECEC and compulsory schools. In the UK, there has been a major increase in private sector involvement in public sector provision through the conversion of schools to academies that are often sponsored by private organisations.[23] In Spain, 28% of compulsory secondary education is tax-financed and delivered by private providers, compared to 23% in the UK (OECD, 2011a).

Social housing

Perhaps due to the fact that it is less labour intensive than other SSGIs, social housing has been the least affected by a greater private sector role. It was not included in any of the country case studies.

Key drivers behind increased role of the private sector

Key finding: Key drivers behind the increased role of the private sector include the aim for greater efficiency and the inadequate supply of public services.

The main driver behind the increased role of the private sector has been the desire for increased efficiency and quality, both in SSGIs in general as well as specific SSGI sectors. This goal has usually been addressed by increasing competition in the provision of services. The main means to achieve this end in the case study countries has been a shift away from centralised bodies being direct providers of services to a situation where they are funders and regulators between the users and providers, which can be either public or private. In most cases, competition has become predicated on user choice. In all countries, these shifts came with a mix of ideological intentions (a key driver in Spain) and cost-saving intentions (a key driver in the UK). In some cases, most markedly in Spain and Sweden, the greater role for private provision was expected to modernise the relevant sectors, through a corresponding investment in infrastructure. For Lithuania, to some extent, membership of the EU was a driver for fostering competition and, in turn, quality in the provision of SSGIs.

[23] In the UK, the conversion of (usually failing) schools to academies takes them outside of direct local authority control and gives greater scope for private sector involvement in the form of 'sponsorship'. Data published by the Department for Education suggest that about one-half of all the 3,000 academy schools in England and Wales are sponsored by a mixture of private sector businesses, private sector academy school chains (often based in the US), and charitable trusts and not-for-profit organisations. The number of sponsored academies opening each year jumped from less than 100 in 2011–2012 to over 300 each year since then.

Employment services

In the three employment sector case studies – in Lithuania, Sweden and the UK – the role of central government agencies has been transformed from providing training support and job-matching services to unemployed people to becoming the first point of contact that connects users with private providers of employment services. A common rationale behind decentralisation and increased competition is to increase productivity and efficiency in both public and private providers.[24] While in the UK the main driver was to cut costs (welfare benefits as well as operational costs), in Lithuania and Sweden employment services were decentralised in order to better match labour market demand and supply. In Sweden, the efficiency of matching people to jobs was meant to increase with improved technology and more personalised services that private providers are better equipped to deliver, while in Lithuania it was enforced by making training contingent on a future employment contract.

Elder care

With ageing populations across the EU, one common driver is an increased need for elder care (both residential and home care), and governments are looking for new solutions. In Spain, the growing demand led the government to consolidate elder care services and make them universal. As the move happened in 2006, on the eve of the economic crisis, the government subsequently reduced benefits or services provided both by the public sector and the private sector, and introduced or increased co-payments. As a result, families rely more on their own resources to care for older relatives. As the Madrid case study illustrates, the 'universality' of elder care was reversed by the increase in the co-payment rate required of users between 2009 and 2013, which rose from 10% to 34% of the real cost of services. In Sweden, there has been a shift away from residential care towards home care, reflected in an increase in both public and private home-care provision. This has been driven by both the motive of lower cost and user preference.

Healthcare

In Spain, PPPs were introduced in healthcare for ideological and cost-saving purposes, as well as the hope that private provision would help modernise management and produce innovation. In Lithuania, private sector participation in the delivery of healthcare services was not top-down, involving regulations to encourage private providers, but bottom–up, driven by a mix of insufficient capacity and inadequate quality in public provision.

ECEC

Across the four countries studied here, various drivers explain the increasing role of private providers in the delivery of ECEC services. In Lithuania, increasing birth rates and population growth in cities without strategic planning to increase the capacity of the public ECEC infrastructure, as well as rising demand for high-quality childcare, left public kindergartens unable to meet demand. In the UK, private provision of ECEC services is in line with the overall ambition to augment welfare provision using private services. In Sweden, the 'school market', including ECEC and secondary education, has been experiencing steady decentralisation and increasing competition since the 1990s, with choice of school being left up to the end users – the families.

[24] Spain is one example where, as described earlier, decentralisation and the new public management reforms led to a bigger role of the private sector in some regions.

Impact of the economic crisis

Key finding: The role of the private sector in the provision of SSGIs grew during the economic crisis, but not necessarily because of it.

One of the criteria in selecting countries for this study was to include countries that were affected by the economic crisis in different ways. Government debt and budgetary concerns were more prevalent in Lithuania, Spain and the UK (although privatisation preceded the cuts here) than they were in Sweden. That said, the effect of the crisis on the public–private dynamic in the provision of SSGIs also varied considerably across sectors within the same countries. It is impossible to discern the effect of the crisis in the context of an already changing relationship between the public and private sectors in the provision of public services, but certain changes are relevant.

In **Lithuania**, the impact of the crisis varied by SSGI sector. In employment policy, the lack of effectiveness of the training for unemployed people provided by public providers during the crisis played a role in the move towards opening competition to private providers. In healthcare and ECEC, private providers had to increasingly rely on public users, as fewer people were able to afford the more expensive private services, especially in the wake of the crisis.

Of the four countries, the crisis hit **Spain** most severely, and some services that were previously provided by the state had to be retrenched, as was the case with long-term care. For users, this meant the introduction of co-payments for services and restricted eligibility criteria for access to them. The most immediate effect this had on the dynamic of public–private provision was that a much heavier emphasis was placed on price rather than on quality in the procurement process for public service providers. This pushed experienced yet small non-profit providers out of the market and attracted well-established, large companies. This was the case for all sectors studied in Spain – home help, elder care and healthcare.

In the **UK**, it is difficult to distinguish between changes that happened as a result of the crisis and those that related to a long-standing tradition of decentralising provision of services and prioritising economy and efficiency over quality. During the economic crisis, the government accelerated programmes of privatisation and drove down spending on existing contracts (particularly in adult social care). A worrying proportion of care provision does not meet the minimum quality standards set by statutory regulators, but this appears to be driven as much by the squeeze on local authority care budgets as the significant involvement of for-profit providers of care in the market (The Guardian, 2011; 2014). Without reliable comparative data across different local authority areas and provider types, it is difficult to draw more detailed conclusions about the 'value for money' offered by private providers, which balance unit cost against quality and effectiveness measures. Despite aspirations for a stronger mixed economy with a greater role for charitable and voluntary groups, new forms of public–private ownership through cooperative and mutual structures have so far failed to take root in many parts of the country.

In **Sweden**, in the aftermath of the crisis, a dramatic rise in unemployment levels led the public employment service to increasingly outsource placement services that were previously performed by in-house caseworkers. The increase in the number of private placement providers was therefore principally aimed at solving a capacity problem due to the notable increase in job-seekers per caseworker.

Public and private financing of SSGIs

Key finding: The financing of SSGIs by public and private agencies varies across case study countries.

As SSGI provision is either universal or at least partly compensated by the state in all case study countries, there is an element of state funding for all private provision of SSGIs. However, the extent of this funding was found to vary across both countries and sectors. Importantly, the mechanism for financing is regulated at sector level. The only example of centralised regulation of financing applicable to various SSGIs was found in Sweden, where the Act on System of Choice in the Public Sector that took effect in 2009 applies to health and social services, which include elder care.

Employment services

In the three countries with case studies on employment, relevant services – matching, job searches, training and coaching – are fully subsidised by the government and free of charge to service users. Private contractors that meet selection criteria are financed via work programmes or public employment services. In all three countries, financing for employment services has become based on payment for results. In Lithuania, this was ensured in 2012, when service users became obliged to secure an employment contract with a future employer or commit to self-employment for one year prior to entering non-formal or formal training paid for by the state and delivered by a public or private provider of choice. In the UK, service providers receive payments contingent on new entrants to the Work Programme and on clients sustaining employment for more than six months. In Sweden, funding to contractors depends on successful placements, and payment is made in three stages – 40% as a job-seeker starts the programme, 30% upon signing an employment contract of three months or longer, and 30% after the job-seeker retains employment for more than three months.

One marked difference between countries in this respect is the nature of the providers: while in Lithuania private providers are small and not consolidated, in the UK large multinational firms are the main providers in this GBP 1.2 billion (€1.7 billion) per year market.

Elder care

Elder care and home help, studied in Spain, Sweden and the UK, are financed by a mix of public subsidies and user co-payments. Home-help services in Spain were made universal by the Dependency Act of 2006, which considerably increased the amount of public spending available for this sector and attracted companies from other sectors that at the time were experiencing considerable loss of business. The public procurement mechanism applied to the contracting process, which required applicants to come up with a bid bond or guarantee of around 5% of the bid, drove some small companies out of the market and allowed for large companies to become established as prime providers.

User co-payments are based on the income of the service user and their relatives and the nature of the service. The principle of access for those in need is applied. In the city of Madrid, the financing of long-term care is more reliant on user co-payments as a direct result of the economic crisis. According to some calculations, these payments represent 10%–50% of the real cost of services. In Sweden, home-care services are partly financed by municipalities and partly by co-payments from service users in the form of monthly fees; the rates depend on household income and the extent of home-care services being used. Finally, in the UK, the cost of the burden of care has been shifted onto service users through a combination of increased co-payments at higher weekly rates (self-funding now accounts for 40% of all placements) along with restrictions on access to funded care based on higher eligibility criteria.

Healthcare

Two of the country case studies looked at healthcare and different mechanisms of private–public cooperation within this sector – primary and secondary healthcare in Lithuania and tertiary healthcare in Spain.

In Spain, the case study was a PPP in tertiary healthcare in the autonomous community of Valencia. Given the need for considerable up-front capital to secure the bid to establish and run a hospital, the only eligible bidder was a consortium comprising a large healthcare company, three regional savings banks and two construction companies. The project was initially to be financed through a capitation fee of €204 per resident per annum and adjusted annually based on a consumer prices index. This proved to be recklessly low and after a reconvened bidding process was raised to €379.

In Lithuania, private providers are able to compete for state-insured clients, which constitute the majority of the population. They get compensation for specific services provided as well as a fixed amount for every registered patient and variable additional amounts in the form of bonuses based on specified services, such as disease prevention or first diagnosis of common diseases. The compensation rates are based on the basic cost of the specified services, as calculated by the ministry. These rates do not correspond to the actual cost of providing the service, however, which means private providers rely on cross-subsidisation from paid services, most often dental, preventive care and innovative services not available through public providers.

ECEC

Universal ECEC coverage is not found in all the case study countries. In the UK, working parents are eligible for subsidies in the form of childcare vouchers accessed through employer-administered salary sacrifice schemes. In addition to this, low-income parents can avail of tax credits, but together, these two sources do not cover the cost of ECEC. The delivery of ECEC services in the UK occurs through both private and public providers, with the latter prominent in the provision of full day care, which makes up over 60% of the pre-school market. In Lithuania, ECEC is financed through vouchers, which cover a full day of care in public kindergartens or half a day of care at private ones, and parent co-payments. Due to cost differences between private and public kindergartens, parent co-payments for private kindergartens can be seven times that paid for public ones. In Sweden, childcare is subsidised to a far greater degree. There, universality of access is ensured by co-payment ceilings set by municipal authorities based on household income; this means that private providers cannot charge beyond those amounts.

Results-based management

Key finding: The case studies show an emphasis on results-based management of private provision of public services.

Employment services

In the UK, the DWP is the contracting authority for providers of employment services. It has few controls over the providers besides payment for results, as discussed under the financing section. The payment-by-results system is intended to incentivise quality. In Lithuania, a potential service user's eligibility for training is contingent on their securing a future employment contract. A formal assessment of the quality of formal training programmes is conducted. The provision of non-formal training – training not accredited by the Ministry of Education and not providing formal qualifications – has, in essence, been opened up to any willing provider; the only control mechanism is approval of regional social partners. In either case (formal or non-formal training), only those who are guaranteed to be employed for at least six months after the training are eligible. This means they have to sign an agreement with the would-be employer before availing of the training.

The Swedish public employment service applies the LOV Act, allowing job-seekers registered with the public employment service to choose from a list of private providers. These private providers are selected by the public employment service based on competence and experience of the company in job placement.

Elder care

In Sweden, the procurement selection criteria for private providers are set by elected local politicians. In the municipality of Växjö, the criteria are based solely on the quality of the service, with the price having no weight in the equation. The municipality conducts follow-up surveys and evaluations each year to check whether quality requirements and regulations are being respected by the private provider of home-care services. The municipality also conducts a yearly follow-up opinion survey among the customers of both municipal and private home care to ensure that the quality standards of the service provided are being upheld.

In Spain, home-help providers are selected through a procurement process that, following cases of corruption, demands anonymity of the tendering companies. This is supposed to help those involved in choosing the winning bid to ensure that the most suitable provider is selected. In the UK, independent organisations inspect how long-term care providers adhere to quality standards, but local authorities as commissioners are free to set their own quality criteria. This results in varying levels of commitment to quality over cost.

Healthcare

In Lithuania, private providers of healthcare emerged organically; a mechanism for compensating them for treating insured patients was developed at a later stage. For this reason, there is no top-down procurement process. For the private provider interviewed in this case study, the public subsidies for primary and secondary healthcare services covered only 20% of the cost of providing these services. Moreover, these subsidies come with requirements, including audits by local authorities and the National Health Insurance Fund authorities, renewable annual contracts with the National Health Insurance Fund, and a licence from the State Health Care Accreditation Agency, among others.

In the case of the PPP hospital in Spain, a private company in a joint venture constructed a hospital and was in charge of its management. This was one of the first cases in Europe where clinical services have been included in the concession, initially signed in 1999 for a 10-year period. The contract was terminated early and the bidding process reconvened (see the Spain healthcare case study for details).

ECEC

In all three case study countries, vouchers enable users to opt for private providers. In Sweden, a centralised state agency, the Skolinspektion, is in charge of the accreditation of private schools. By contrast, in Lithuania, all private kindergartens and schools operate on a purely private basis – they do not have to get certified as an eligible provider, although they do get partial compensation per child through the state if they meet hygiene and organisational requirements. In Sweden, the Skolinspektion also conducts follow-up and evaluation surveys on a variety of topics including the quality of education, school environment and educational achievement, whereas in Lithuania there is no centralised supervision of private providers.

In the UK, the Department for Education sees a much reduced role for local authorities in shaping the range, accessibility and affordability of private and independent provision and is in favour of unfettered operation of market forces (Department for Education, 2013). The state role is reduced to securing sufficient childcare places for children of working parents, securing free early education places for eligible children aged 2–4 years, and ensuring that information is provided to parents. In the local authority examined in this case study, comparatively high payments were made for early education places, which meant that services were financially viable; this is not the case for other local authority regions in the UK, such as the south-east.

Outcomes, access and quality

Key finding: Access, in some cases, but not always, becomes a trade-off for quality of services.

There is tension between the European welfare model of universal public services and the capacity of governments to ensure equitable access for all, be it through solely public provision or with different mixes of public and private delivery. To a greater or lesser extent, in all case study countries, the private sector has been engaged to ensure sufficient provision of certain services. With the exception of ECEC in Sweden and employment services in Lithuania, Sweden and the UK, private provision across countries and sectors is associated with some degree of co-payment. In the UK, which has a longer tradition of marketisation of public services, co-payments now make up around 40% of all elder care costs. In Spain, elder care clients have to rely increasingly on private provision of services and, by extension, on the market; the same is the case in Lithuania for both ECEC and healthcare. In Spain, the introduction of larger co-payments for elder care caused some users to give up using services. In Lithuania, private providers are almost without exception more expensive than public ones, but users are either forced to turn to private provision where public provision has insufficient capacity to meet needs, for example in ECEC, or because of longer waiting times in public providers, for example in healthcare.

Some services, for example employment training and job placement, are universal and free of charge across the board, perhaps due to their nature and their importance to the functioning of the economies concerned. Regarding services that are not universally free, at least some sectors across all the case study countries show evidence of the state cross-subsidisation for those with the highest level of need. For example, in the UK, ECEC is partly subsidised for working parents, with additional funding available to low-income parents.

A key issue in access is that while increased private provision may help in meeting newly emerging needs by means of avoiding even longer waiting lists, access to the providers themselves is not necessarily equitable. Private providers of ECEC in Lithuania and Sweden enrol more children of well-off families than low-income families. While in Lithuania this can be explained by the need for significantly higher co-payments, in Sweden it is more a result of more affluent parents choosing private education for their children. Most of the case studies have also illustrated that co-payment rates vary considerably from provider to provider, meaning public services are failing to be equitable. Some regions or even neighbourhoods may be more affected than others.

In terms of access for disadvantaged groups, in some case study sectors, such as ECEC in Lithuania, interviewees suggested that public providers were better able to support clients with additional needs. In the case of employment services in Sweden and the UK, the public sector was better placed to support those with addiction problems (Sweden) or a background of offending behaviour and mental illness (UK).

There is also evidence of access being reduced by higher costs associated with the service in question – for example, users of the PPP hospital in Spain complained about the high cost of parking. Another aspect of access is working time. In the healthcare sector in Lithuania, there is evidence that privately operated MRI diagnostic centres that operate under service agreements within public hospitals work outside of hospital working hours. This allows them to make maximum use of their equipment, ensuring profitability; it also increases access for patients, including public patients.

Private providers are not always expected to fill gaps in the provision of public services. Access can be viewed not only in terms of service users' access to the service but also in terms of service providers' access to service users. For example, in Lithuania, the right of private providers to receive compensation from the state for providing services to state-insured patients in healthcare was put to question before the Constitutional Court by the then health minister in 2013. While the court ruled in favour of private providers having the right to fair competition for services and users, the general

predisposition against private provision in this sector makes the environment in which private providers operate insecure. This, in turn, could adversely affect their role in filling gaps in public services.

Quality, efficiency and effectiveness

Key finding: Although private sector participation is intended to increase quality, few examples of quality measurement exist, even at sector level.

Quality

Higher quality of services is one of the arguments used in favour of a greater role for the private sector in the provision of public services. Indeed, in some case study sectors, arguments can be made in favour of private providers contributing to a higher quality of services.

- In sectors with more private providers, more people could get services from public providers, as is the case with employment services in Sweden and ECEC in Lithuania.
- It may mean that more time is spent with users. The privatised employment services in Sweden were found to use more labour-intensive technology and more personalised services. They also succeeded in better motivating job-seekers to search more intensively by, among other factors, spending more time with them. In the case of long-term care in Spain, by contrast, users complained of the worsening of their care because the visits by home-help assistants sometimes lasted only a few minutes, meaning they were forced to pay for additional staff time themselves.
- It can lead to greater user satisfaction. Anecdotal evidence in some of the case study sectors suggests higher user satisfaction with private provision. In Sweden, unemployed job-seekers enrolled in job search activities with private providers said that they were more satisfied with their caseworker and the service received. Home-care user satisfaction surveys conducted by the National Board of Health and Welfare in Sweden show a larger share of older people using private providers reporting that 'compared to users of in-house home-care services, they can to a larger extent influence the time when the home-care service is delivered and also that the private provider takes into account their opinion and request for help' (Socialstyrelsen, 2014). Interestingly, users of home-care services overall in Sweden do not show a preference for private providers. The main concern and potential drawback of private elder care expressed by interviewees was the fear of a lack of continuity in the provision of services.
- There can be greater innovation and variety in services. Competition for service users has led private providers to offer state-of-the-art services to private-paying clients or to better compete with public ones. For example, in tertiary healthcare in Spain, the private Ribera Hospital experienced an increase of 37.3% in the number of births versus 2.4% growth in other hospitals over the same period. This was as a result of the hospital offering epidural anaesthesia with the aim of attracting clients, which was deliberately restricted in some public hospitals. In Lithuania, the private secondary healthcare provider who was interviewed offered innovative preventive services such as non-invasive pre-natal DNA testing. In addition, ECEC providers offered a range of activities during regular day-care hours that were treated as extracurricular and paid services in public kindergartens.

One common trade-off, across case study countries and sectors, is that between increased access and a reduction in quality of services. In both Spain and the UK, where the private sector was looked upon to cut costs of public services, this was achieved by cutting jobs and resulted in worsening working conditions for staff. In the UK, this particularly affected part-time, low-paid women workers. Although working conditions are not a central question for this research, they ultimately affect the quality of services being provided. In the UK, the low hourly rate paid by local authorities to private providers and the flexible contracting arrangements of the providers themselves have created something of a cost-cutting spiral – low investment in training and a high turnover of care staff carries clear implications for both the continuity and quality of care. The increasing shortage of staff among both state and private sector providers of elder

care (driven in part by low hourly rates of pay) raises questions about the ability of the market to provide safe, reliable and high-quality care. Providers that wish to offer good rates of pay, guaranteed-hours contracts and staff training may find themselves squeezed out of the market by larger firms that can afford to undercut on price by cross-subsidisation and paying staff just the national minimum wage. Part of the solution could be to monitor their activity and insist on certain levels of quality.

Efficiency and effectiveness

Cost-efficiency, one of the main arguments in favour of a greater role for the private sector, is impossible to gauge in any of the four case study countries, although some separate studies were cited and opinions voiced in both directions. Hidden costs are commonly cited as an issue in calculating the cost of service from public versus private providers. These costs include the administrative burden of engaging the private sector, be it through procurement processes or buyer–purchaser schemes, and supervising and monitoring the quality of and access to services. It has to be acknowledged, however, that monitoring should be done for both public and private services.

However, as with quality and access, arguments on this issue can go both ways. To provide some examples that support the idea that private sector provision means cost savings, in the UK cost savings of around 20% are assumed possible with each contract placed with the private sector (Whitfield, 2012). In Spain, various analyses of efficiency of concessions versus direct management of public hospitals show varying results. Arena and Alberto (2013) concluded that the 'average full departmental health expenditure (primary and specialty care) … in 2012 is lower than its expenditure on direct public management by 11.7%' (p. 12). The case study concession holder estimated that if such differences were possible to calculate, concessions would represent savings of 25%. However, several studies hold that there is no empirical evidence for this. For example, Acerete et al (2011) state that 'the available figures lead us to the conclusion that the second contract [in the Alzira case] is not as good a deal for Valencia's Department of Health as the current official narrative claims' (p. 25). Furthermore, in Sweden, caseworkers in private employment services were found to spend more time with clients, which was seen as a gain in quality; however, this did not translate into higher overall chances of finding a job, suggesting that there are no large efficiency gains to be made from outsourcing job placement activities to private providers.

Regarding effectiveness in terms of achieving better results, in UK employment services, some improvement can be seen in the aggregate number of successful job outcomes, but it is true only for groups closer to the labour market (the results-based payment system means more focus on work-ready clients). The flipside of this argument, however, is that in the UK there is a general misalignment of incentives in the payment-by-results system, as workers are pushed to take on any available job, as opposed to building up the skills necessary to secure a desirable job they could sustain. In Lithuania, there is no evidence either to verify whether the improved employment outcomes were sustained over time.

Employment practices are also connected with effectiveness. In healthcare services in Lithuania, for example, private centres hire more of their doctors on a part-time basis, paying them only for their active hours of work, whereas public providers act as primary employers. Many doctors work in both public and private establishments, having in some cases as many as six employers. The issue of private providers paying only for the 'active' hours of their high-cost staff is also apparent in tertiary healthcare in Spain, where there are reports that insufficient numbers of staff are on call at a given time.

Working time is also related to effectiveness. Hours of service tend to be longer among private providers, some of which provide their services over the weekend. For example, the MRI clinics that operate under service agreements within public hospitals in Lithuania remain open on Saturdays and Sundays when all other planned services in these institutions are not being provided. This allows the private providers to maximise their use of the equipment, thus ensuring profitability. But it also increases access for patients, including public patients.

Conclusions and policy pointers 7

Private providers respond to market opportunities. As the case studies illustrate, these can range from those with the potential to produce a small profit – like healthcare and ECEC services in Lithuania – to very large profit-earning possibilities made possible by large service contracts with municipal authorities in Spain, Sweden and the UK. The potential profits to be gained from the provision of public services determine the very nature of the providers that emerge to meet demand. In Spain, Sweden and the UK, private providers have evolved into large, consolidated and international or venture-capital backed companies as a response to procurement processes that target large providers and require economies of scale for feasibility. In Lithuania's healthcare sector, private providers are typically small general practices and family doctor clinics, perhaps because many of them were established before the introduction of tax-financed services.

The implications of this are:

- the profit incentive and quality of services are not always aligned;
- degrees of separation between the contracting authorities, providers and ultimately service users can increase;
- with the possibility of shifts of ownership and accordingly business models, the risk increases that the well-being of the public becomes a trade-off for the profit incentive.

In this study, non-profit and for-profit providers have been put into one category – private providers. In reality, the two types are essentially different from each other and do not necessarily work hand-in-hand in the provision of public services. In ECEC in the UK, for example, non-profit providers run most sessional care – pre-school care limited to a maximum of 3.5 hours per day – whereas private providers dominate in full day care. This means that the two types do not coexist in the provision of the same service. In Spain, non-profit providers used to dominate in home-help services. However, they have been displaced by large for-profit companies due to very high-value procurement contracts that make it impossible for small firms to compete. They have also been displaced by selection criteria that attribute the highest weight on price, deeming experience in the field unimportant. Given these differences, private for-profit companies and social economy or third-sector entities should be distinguished from each other in any analysis of their role in the provision of tax-financed services.

A mixed picture also emerges, across case study countries and sectors, regarding whether or not private provision delivers on the motives behind greater private sector involvement: efficiency gains, more choice and improved quality. This is confirmed by other EU research studies. As the PIQUE project revealed (cited in Flecker and Hermann, 2009), privatisation had varied effects on quality. It was also found that 'positive effects and better performance as compared to other countries were mostly the result of superior regulation rather than of competition or private corporate initiative' (Flecker and Hermann, 2009, p. 98). Any valid assessment of whether private providers may or may not be better suited than public providers to providing public social services should consider the counterfactual, instead of comparing private provision of public services with how the public sector used to be. How would the public sector have fared with these services without resorting to the private sector? An alternative solution is public sector reform. Even though it was not the subject of study in this research, experiences with insourcing or other solutions to increasing access, quality or effectiveness of services within the public sector itself may also be informative as to the merits or lack thereof of private sector provision.

Outcomes of private provision of public services

Access

There is evidence showing both increased and more limited access as a result of a greater private sector role in delivery. The question of access is linked to financing – in cases where there is equitable financing for public and private providers, as is the case in Sweden, access for service users remains unchanged or improved because of greater variety and expanded capacity of available services. However, where the state is forced to reduce the financing of a particular service, as was the case with elder care in Spain, the entry of the private sector means reduced access for service users as a result of the increased cost of the service. In Lithuania, where the capacity of public providers is insufficient to meet demand, the entry of private providers increased access to public services by means of extended supply. However, access to private providers themselves is contingent on economic means as they require higher co-payments. A key issue for access is the capacity of the state to prevent and mitigate risks associated with contract failure with large providers of public services.

Quality

Quality was also an equally contested issue among sectors and providers. None of the case studies showed a clear preference for private sector provision on the part of the service users, except for Spain, where the main conclusion is that quality was not improved as a result of a greater role for the private sector. There is a greater case to be made for improving user choice, which in itself is a quality control mechanism, by ensuring competition between private and public providers. One issue is that the business opportunities created by opening up competition to private providers and the procurement processes involved, which make it difficult for small companies to compete in some countries, most notably in Spain, have attracted companies without experience in the sectors concerned. This is bound to have a negative impact on the quality of services.

Effectiveness and cost-efficiency

In all the case studies, there have been attempts to measure whether the private sector is, in the end, a cost-saving or more effective mechanism, or just another way of delivering services. No clear conclusions have emerged, although there are claims (most often by the private providers themselves) that a greater private sector role represents savings, with some suggesting savings of 25%. However, there is no clear-cut methodology to calculate the respective savings of private versus public provision because of the complexity and, in many cases, the novelty of the mechanisms involved. Moreover, given that public services in all sectors and countries are constantly undergoing change, often related to changing administrations, there is no stable baseline against which to compare new changes at a given point in time. Some authors find that the cost-saving calculations are overly optimistic given the numerous hidden costs of engaging the private sector, including administrative, monitoring and follow-up needs, and in the event of large contract failures, the need for state-funded solutions.

Role of the state as regulator

The role of the state as a regulator becomes increasingly important as private provision grows, as failure by the private sector to provide the public services it is contracted to deliver would involve such a high level of risk. Key factors include the choice of suitable providers as well as the need for transparency in the procurement and certification processes and the ownership structures of the providers.

Some authorities have responded to these risks by restricting access to funding to public providers only, as was the case of healthcare in Lithuania. Alternatively, the UK case study cites successful examples of insourcing or remunicipalisation in some local authorities, which helped to both minimise the risks associated with contract failure and poor performance, while also lowering running costs through better staff management and reduced turnover. This brought greater benefit to the service user. The risk of reduced access to services in Sweden's ECEC and home care was

addressed by a system of income-related fees for the service recipients set by the municipalities, where private providers are not allowed to charge additional fees.

In the eyes of the public, the private provision of tax-financed social services is a contested topic, at least to some extent, in the case study sectors. In Spain, for example, a 2008 survey showed the public's strong preference for both public funding and public provision of education, health and social services (87%, 86% and 70% respectively). Indeed, private providers are in some cases looked upon to provide public services without the backing of public funds, which makes it seem as if private provision is responsible for the marketisation of services. However, as the Swedish case study illustrates, when backed by public funding and with some regulatory mechanisms such as price ceilings in place, private provision can be at least as good as the public offering and does not result in reduced access for service users. Given the highly politicised nature of the question of the private sector taking on more and new tax-financed services, countries should pay due attention to public consultation on questions relating to public service provision via private providers.

While employment and career issues are not the focus of this analysis, it should be noted that without considering these issues, for example whether public and private providers invest equally in training or other important elements of career development, it is not possible to gauge with any accuracy the long-term relative advantages of one over the other. To give an example, it may be that private providers rely on staff trained by the public or the third sectors, meaning that their business models may not be sustained over time. Moreover, as is most evident in healthcare, where the private sector is not the primary employer of its medical staff, it is possible that the system requires public providers to be the primary employers in order to be financially feasible, as illustrated by the case study on healthcare in Lithuania.

Policy pointers

Coherence and continuity

- Consider existing non-profit sector solutions to specific service needs and seek avenues to collaborate with and protect providers in this sector so as to harness the experience they have built up over the years. As the case studies illustrate, organisations in the non-profit sector cannot compete for large procurement contracts against consolidated private for-profit firms that benefit from economies of scale.
- Learn from insourcing or remunicipalisation exercises, as expanding the role of the private sector is not the only means of improving the quality of services.

Monitoring and evaluation

- Apply uniform performance indicators for quality of services regardless of the nature of the provider delivering them.
- Develop mechanisms for systematic monitoring, evaluation and oversight of service provision of all providers of public services at the level of the contracting authority. Ensure that the results of these mechanisms feed into public-service-related policy and practice.
- Improve the technical capacity of governments to establish mechanisms and conditions for fruitful collaboration with the private sector through sharing the findings of systematic evaluations and state-of-the-art research on public services and how they are managed. As the Spanish and UK examples of procurement for public services illustrated, private providers become involved in service delivery through increasingly complex organisational arrangements, which can mean that the actual providers are not the same as the original contractors. It is also important to ensure that governments and public servants have the administrative capacity to implement policy decisions.

- Develop a methodology for calculating all the costs included when service provision is contracted to private sector organisations. This should explicitly include the administrative cost to public sector commissioners and contract managers and any cost penalties incurred for variations to agreed services or products or early termination of underperforming contracts.

Risk aversion

- Minimise the risk of service contract failure by studying the conditions under which this has occurred in the past, identifying lessons learned. Ensure that those handling such contracts have the administrative capacity to do so.
- Given the high societal cost of interruptions to public service delivery, ensure appropriate contingency planning so as to avoid discontinuity of public service provision in the event of a failure of contracted providers.
- Ensure transparency in financing and ownership of public service contractors, which may be backed by private equity and exposed to high levels of financial risk, so as to avoid the detrimental effects of ownership change on the end users of the service. For example, by reducing the volume of services contracted by single specific procurement contracts, contracting authorities would reduce the opportunity for large businesses to dominate and allow other actors to compete.

Future case studies on the experiences of service users regarding private provision of public services could benefit from representative public opinion polls to measure satisfaction with services; with the exception of Sweden, this was not measured in the case study countries. In addition, as the study revealed differences between the conditions under which non-profit and for-profit companies provide public services, future studies could analyse how they fare in comparison to one another and the success factors involved.

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This report explores the growing role of the private sector in the provision of public services in the EU. The research is based on sector-specific case studies carried out in Lithuania, Spain, Sweden and the UK. It focuses specifically on social services of general interest (SSGIs) in the areas of healthcare, early childhood education and care (ECEC), employment services and long-term care. The findings show that in the two countries with long-established welfare systems (Sweden and the UK), the key factor driving governments to expand the role of the private sector has been the expectation of gains in quality and efficiency. In the countries with less-extensive welfare services (Lithuania and Spain), budgetary constraints have been the key driver. The report finds that greater private sector involvement in the provision of public services often leads to less equitable access and that quality-related outcomes can be mixed.

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