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Supplemental home care and topping-up: A shift from service universalism towards a new and privatised public service model?

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Abstract

How does a public service model based on service universalism react to the introduction of market principles of topping up? In a recent so-called Free Municipality Scheme (an experimental scheme that allowed for greater operational autonomy locally in an effort to reduce state bureaucracy), a number of Danish municipalities were for the first time ever allowed to compete with for-profit providers of home care in selling supplementary home care services paid entirely by the user. The take-home message from this experience is that the introduction of supplemental home care entails challenges and eventually wider implications for the public service model, on an economic, organisational and cultural level. Supplemental services represent a new and potentially powerful combination of market and state logics that eventually redirects away from the universalist welfare state and towards a new and increasingly privatised public service model – a model where the service level is determined by the user's capacity to purchase and pay for services. The introduction of such services therefore implies a change of the potential of the Nordic welfare state to ensure equal access regardless of class and income.

Introduction

In the Nordic public service model, service universalism is a guiding principle for care policies and service provision. Service universalism ensures that high quality, uniform services are available for all citizens according to need, that services are publicly funded so that they are affordable for all, and that services are flexible, catering for individual needs (Vabø, Christensen, Jacobsen, & Trætteberg, 2013). As a result, take-up of services in the Nordic welfare states are relatively unaffected by class and maintain a relatively high service level. Some would also argue that the public production of services is part of the universalistic dimension which allows for public control over content and quality of care (Anttonen & Sipilä, 2012; Moberg, 2017).

It has been argued that the introduction of market principles by welcoming in for-profit providers of care somewhat challenges the theoretical ideal of the Nordic public service model (Andersson & Kvist, 2015; Sipilä, Anttonen, & Kröger, 2009; Szebehely & Meagher, 2011; Szebehely & Trydegård, 2012). The empirical reality is nevertheless clear: During the 1990s, all Nordic countries introduced legislative changes that made it easier locally to implement choice models and outsource services to private for-profit providers. As a result, the (local) state plays a diminishing role in the actual production and delivery of services (Anttonen & Karsio, 2017). Across the Nordic countries, there is an increased reliance on private for-profit provision in long-term care for older people. For instance, 125 out of 290 Swedish municipalities have introduced user choice in home care, with the result that by 2015, 25% of home care users in Sweden were receiving care from a private for-profit provider (Moberg, 2017).

This trend has also changed the Danish home care provision for older people. Among the Nordic countries, Denmark has been known to be particularly universalistic in long-term care with high coverage of generous, attractive, free of charge and (until the early 2000s) publicly provided home care services (Rauch, 2007). However, two major trends in home care services have changed the Danish care landscape. First, home care services are increasingly targeted at the most needy persons. Furthermore, fewer older people receive such services, from 18% in 2008 to the present 11% of persons 65+[1], and services have increasingly become focused on personal care, resulting in a reduction in practical help (e.g. cleaning), in particular (Rostgaard & Matthiessen, 2019). Secondly, home care services have struggled under the strain of New Public Management steering principles. Documentation, control and cost-

[1] Also due to increases in health conditions and the introduction in 2015 of re-ablement.

efficiency have become key principles in Danish long-term care and, as a result, public care services for older people have become increasingly standardised and tasks are organised by strict time budgets, leaving little flexibility for either the care worker or the user in the daily organisation and negotiation of care tasks (Tufte & Dahl 2016). For the user this standardisation may make services less attractive, and for care workers this may add to a sense of misrecognition (Dahl, 2009).

Perhaps as a countermove, a liberal−conservative government in 2003 introduced greater flexibility through the choice option in a quasi-market construction of home care.[2] This reform made it possible for users of home care to freely select authorised providers (public or private) for the provision of both cleaning and personal home care, while services remained free of charge. The idea behind the reform was mainly ideological: to stimulate marketisation of public services in general, but also to allow for a mix of market mechanisms with a more active and empowering welfare citizenship, where users express their (dis)satisfaction through the exit from or entry into provider organisations (Petersen & Hjelmar, 2014).

With the requirement that municipalities must ensure a choice of provider, Denmark has transitioned from a public to a quasi-market-based home care model, mirroring the development towards marketisation seen elsewhere in the Nordic region. Since the introduction of choice, the proportion of home care users with for-profit services has steadily increased in Denmark, to 36% at present. A mixed care market has thus been realised. However, in reality it is with some differentiation. Users with personal care, and thus those who are most frail, continue to prefer the public provider. Meanwhile, users with cleaning services more often prefer the for-profit provider; 46% of users who receive cleaning services use a for-profit provider, and only 9% of users with personal care choose that option. Given that hours for cleaning services are more limited than hours for personal care, the total market share of the for-profit sector in home care is estimated to be 15% but has been increasing since the introduction of free choice (Rostgaard, 2017).

A precondition for the customer-choice reform was the purchaser/provider split, inspired by new public management reforms (Hood, 1991). This implies that the public purchaser (in charge of the referred services) decides which services the user is entitled to, on the basis of the municipal quality standards and individual needs assessments, while the provider (either public or private) delivers the service to the user. The service package is therefore identical across provider types, with the same assessment procedure applied and no user fees involved. In principle, for-profit providers must provide the same basic services within the same budget, but are otherwise free to compete with the public in terms of communication, customer relations, time of delivery, continuity of staff etc.

Most recently, marketisation principles have been extended also to the public provider. A number of public providers of home care in Denmark have participated in a policy trial in order to test the viability of and interest in supplemental services, provided by the public and paid for by the user, in order to top up services granted by the municipality through the regular process of needs assessment (referred services). Before this policy trial, only private providers were allowed to offer the user the option of topping up by purchasing additional services, either in the form of personal care or cleaning. This has so far prevented Danish municipalities from entering the market of supplemental home care services, an otherwise profitable market representing a substantial amount of the total sales of private for-profit providers. For instance, in Sweden, a total of 8% of all home care users utilise the opportunity to top up (Moberg, 2017). Profits on supplemental home care services in the Swedish case

[2] In addition, Danish municipalities can also contract out service provision of nursing homes to private for-profit firms and non-profit organisations.

even appear to be larger than for other services (Storm, Stranz, Szebehely, & Trydegård, 2013; Svensson & Edebalk, 2006).

There are no equivalent figures published in Denmark on to what extent supplemental services comprise the total revenue for for-profit providers. However, as we outline later in the article, the for-profit providers interviewed for this study estimated that supplemental home care constitutes about 5 to 6% of private for-profit providers' total revenue, i.e., similar to the Swedish model. In addition, Danish survey data show that 46% of users with a for-profit home care provider purchase supplemental home care services[3]. This represents 10% of all home care users.

Danish municipalities have long argued that without the possibility to offer supplemental services, they are in a poorer market position compared with for-profit providers. Consequently, six Danish municipalities recently became part of the so-called Free Municipality Scheme 2014−2016, which allowed them – on a 3-year trial basis – to sell supplemental home care services as a top-up to the otherwise free-of-charge and publicly provided home care services. The aim of the Free Municipality Scheme was to allow municipalities to experiment with new and innovative types of service provisions, in a context of less bureaucracy and state regulation (Askim, Hjelmar & Pedersen, 2018).[4] Users in the six municipalities were able to purchase extra practical or personal care services, in addition to the services for which they had already been assessed. Or they could purchase services that were normally not part of the municipal service supply, such as wellness treatments, gardening, snow shovelling, extra meals or assistance with shopping or other errands.

Beyond creating a more equal market position, the municipalities also argued that this would ensure continuity of care and care personnel, thus increasing quality of care. This argument reflects that users of home care services often prefer having the same care worker perform multiple tasks instead of having care workers from different providers coming into their home (Rostgaard, Andersen, Clement, & Rasmussen, 2013; Svensson & Edebalk, 2006). By being able to provide both referred and supplemental services, the public provider could, with the new scheme, ensure that users of public home care have the supplemental and referred services delivered by the same care worker. Thus, a new feature was introduced into an otherwise universal and public social service model: Users with economic means were allowed to top up services in an otherwise publicly tax-funded system.

The main question in this article is whether the scheme implies a change in the principle of service universalism, whereby generous and uniform services are available for all citizens based on need. Such a change could thereby be a threat to the core principles of the Nordic public service model. Is the scheme signalling a re-calibration of the public service model where service levels are increasingly determined by the ability to pay and thereby favouring wealthier users? To investigate this, we consider in the article the potential for the institutional change of the public service model from the analytical perspectives of economic, cultural and organisational dimensions. By drawing on interviews and document data, we use the empirical example of public supplemental services to examine whether market and state logics have combined into a new form of welfare, and discuss how this can affect the overall public service model, such as in Denmark. Lastly, we offer some conclusions regarding the potential implications for the concept of service universalism.

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[3] Special analysis of 2017 data from the Danish Longitudinal Survey on Ageing (DLSA), not published. Analysis of 2017 data from the DLSA shows that 12% of users in the age range of 67−97 years purchased such services (Rostgaard & Matthiessen, 2019).

[4] The municipalities targeted users 65+ who were either receiving home care services or living in a nursing home (Hjelmar & Christiansen, 2016). This article focuses exclusively on home care. The municipalities were Fredensborg Kommune, Fredericia Kommune, Odsherred Kommune, Vejle Kommune, Vesthimmerland Kommune and Viborg Kommune. These municipalities cover approximately 300,000 inhabitants, representing 6% of the Danish population.

Method and data

The analysis is based on empirical data from an analysis of the Free Municipality Scheme conducted during 2014−2016. The analysis was commissioned by the Ministry of the Interior and Economic Affairs. The purpose was to evaluate the results of the introduction of supplemental home care services and to assess whether the six participating municipalities met the requirements stipulated by the ministry. The main requirements were that the purchasing price of supplemental home care services should reflect actual production costs (the average and long-term costs of producing the services) and that quality standards of normal home care services should not be lowered such that users would need to purchase supplemental services to reach the same service level.

Data consist of interviews, registry data and documents from the municipalities, collected in the period February−September 2016 (Hjelmar & Christiansen, 2016). Twenty interviews were conducted; 15 in-depth individual interviews and 5 focus-group interviews. Interviewees included home care users who had purchased supplemental services (6 persons), private for-profit providers of home care (managers of 4 firms), front-line home care workers working with supplementary home help in the municipalities (9 front-line care workers) and public home help managers working in the municipalities (5 managers). Interviews with users, care workers and managers focussed on experiences with producing, purchasing and/or delivering supplementary home care, as well as their reflections on overall consequences. The interviews were structured around the following themes: supply of supplemental services, the demand for supplemental services, overall satisfaction with the scheme, the price level, and whether the supplemental services replaced referred services. All interviews were transcribed and thematically analysed using a semi-deductive approach through ad hoc techniques (Kvale & Brinkmann, 2008; Miles & Huberman, 1994).

We also collected 18 reports and documents produced by the municipalities for the Danish Ministry of Social Affairs and the Interior. These detailed the price calculation of supplemental services and the efforts made to ensure that supplemental services did not replace any referred services. The documents provide an insight into the political and administrative considerations concerning the topping-up scheme, and illustrate implementation challenges in each of the six municipalities.

Lastly, we analysed registry data from all six municipalities. Registry data document the volume of supplemental home care services sold during the trial period and whether the services sold were identical to a service for which users had already been assessed or whether they were other types of services (e.g. wellness treatments).

Topping up with supplemental home care – the Danish case

We analysed the implication of introducing market mechanisms in an otherwise public service model from three analytical dimensions: an economic dimension, an organisational dimension and a broader cultural dimension. Together, these three analytical dimensions highlight the main experiences from the scheme and allow us to discuss more systematically where the challenges are and whether we see the contours of a new public service model.

The economic dimension

Overall, the scheme showed only a limited user demand for purchasing supplemental home care services. Registry data show that municipalities sold about 950 home care services during the 3-year trial period, representing less than 1% of the total budget for home care in the six municipalities. In terms of the share of users, a total of 4% of all users of home care bought supplementary home care in the trial period, corresponding to only about 2% of the target group per year.

Most users bought single services, for example extra cleaning services just before Christmas. Extra cleaning constituted by far the most popular supplemental service, perhaps reflecting the nationwide trend to cut down in the provision of cleaning services and thereby prioritise personal care. Approximately 90% of the supplementary home care sold was extra cleaning. Other supplemental services sold included assistance with shopping (3%), gardening (2%), ironing and repairing of clothes (2%), assistance with moving furniture etc. (1%), care of pets (1%), changing of light bulbs (1%) and assistance with taking an extra bath (1%). In total, practical help represented approximately 99% of the sales, while personal care represented only around 1% of the sales (typically the extra bath).

The expectation – and motivation – of the municipalities prior to the scheme was that the demand for supplementary home care would be considerably higher.[5] A key reason why the demand for supplementary home care turned out to be so low was that there was not a competitive pricing level compared with general market prices. The cost of supplementary home care typically varied between EUR 50−85 per hour, thus exceeding the price for purchasing private household services (EUR 30−50 per hour). Prices varied within the municipalities, depending on whether the service was carried out on a weekday or on the weekend and whether the services were carried out by skilled or unskilled labour. Typically, one hour of extra cleaning on a weekday within normal hours and carried out by unskilled labour would cost around EUR 50 per hour. In the interviews, the general view among home care users was that this was too costly, but as the following statement shows, some users were willing to pay for quality of care and care work:

> *I could have bought much cheaper help, but I wanted professional help, and I wanted to have staff with decent working conditions. That's why I chose the municipality instead of a private alternative, even though the price was higher.* (Home care user, Vejle Municipality)

Why did the municipalities set the price so high? The main reason seems to be that they were under external pressure not to distort and undercut the market. Despite the ambition to experiment with the market mechanism in the public sector, The Danish Ministry of Social Affairs and the Interior was not willing to introduce equal market conditions between the for-profit and public providers, in order to offer some protection for the private for-profit providers and their market share. An example is that the Ministry required municipalities to submit comprehensive documentation for the procedures used when calculating prices and it maintained control over the approval of calculations and cost-setting. As a result, municipalities applied a precautionary principle through all the steps of the price calculation, which thus resulted in quite high costs compared with the private market (Hjelmar & Christiansen, 2016). In comparison, private providers operating in the home care market have not been similarly constrained. They have generally been allowed to lower costs for supplemental services if they found this beneficial in the negotiation for a service contract with the municipality.

Hence, private for-profit providers have had no reason to fear price competition, which is perhaps why we, in the interviews, generally found that they did not object to letting municipalities offer supplementary home care. The private for-profit providers have often argued in terms of fairness in giving the municipalities the same opportunities – as illustrated by the following statement:

> *We were very positive. We felt that they should also have this opportunity. We didn't mind and do not see it as a problem at all. It doesn't affect our company in a negative*

[5] As shown in the introduction, 46% of users with a for-profit home care provider purchased supplemental home care services.

> *way. We basically thought: Congratulations!* (Private for-profit provider, Vesthimmerland Municipality).

The private for-profit providers typically stressed that their businesses were solid and well-tuned to accommodate the needs and wishes of users, including the provision of supplementary home care. They were not worried that their market position would be negatively affected by the new option made available to the municipalities. As it turned out, the volume of sales in the municipalities was so small that, on a running basis, for-profit providers hardly noticed a change in the market.

Our interviews with private for-profit providers indicate that supplementary home care constitutes about 5−6% of their total revenue (similar to the Swedish levels mentioned in the Introduction). This level is substantially higher than the sales level of supplementary home care in municipalities which turned out to be less than 1%.

The organisational dimension

While the economic dimension constitutes a problem for the municipalities in finding a natural cost level in the market, there are also a number of organisational implications. First, our study shows that there are organisational obstacles in relation to the implementation of supplemental services. The interviews with managers in the municipalities showed a lack of experience within the organisation with the sale of such services. Also, there was no apparent incentive in the organisation for supporting the selling of supplemental services. Thus, for the scheme to be a success, there was a need for generating considerable organisational resources and a clear managerial focus to implement the scheme in an effective manner. However, such organisational resources and focus were not actually applied, and as a result, the scheme quietly co-existed alongside the main activities. The potential of the scheme – along with the real demand of public supplemental services – was therefore not fully investigated.

Nevertheless, the local managers felt demotivated when it turned out early in the experiment that the supplemental services were not an immediate success in terms of sales. At the same time, considerable administrative resources were needed to initiate the sale of supplemental services. As a result, the increased budget costs soon attracted the attention of managers, especially among those who sold only few services:

> *The administrative work needed to manage this is considerable. You need to formulate a contract to be signed by users, you need to continuously document the sale of supplemental services, and you need to send out invoices, etc. These administrative costs have to be seen in comparison with how much – or how little – we sell. Seen in this perspective and considering the continuing demands to make our organisation more effective, it makes little sense for us to offer supplemental services.* (Manager, Viborg Municipality)

Second, our study also showed that there are organisational benefits associated with the introduction of supplemental services. Most importantly, the documents from the municipalities and the interviews revealed that supplementary home care fit nicely into the carers' work schedule and, in this sense, provided an opportunity for municipalities to offer care workers full-time contracts and thus be more cost-effective in their use of resources. Often, supplementary home care services could fill up gaps in the work schedule. In the mornings and evenings, most care workers are very busy providing personal care, while they are less busy in the so-called 'grey hours' in the afternoon. Apart from this increased usage of full-time contracts, the employment contracts did not change as a result of the introduction of supplemental services.

Supplemental home care services are often various kinds of practical assistance (typically cleaning) that can be carried out during the afternoon where schedules are less demanding, as the following statement illustrates:

> *Supplementary home care services are valuable for us, as they help us to retain our care workers by offering them a sufficient number of weekly hours so that they can earn a full-time salary. In the afternoon, there is less personal care and more time to provide practical help, and supplementary home care services help to fill out the afternoons.* (Manager, Fredensborg Municipality)

Third, in order not to mix up referred and supplemental services, the front-line care worker, and not the person in charge of the referred services (the purchaser), would typically be in charge of the actual selling of services to the user. Only in a few cases did the purchaser have a limited role in selling services (by presenting information to the user about supplemental services during the assessment of need):

> *Referred services are separated from supplemental home care services organisationally. Supplemental home care services are taken care of solely by the staff providing the services. In this way, supplemental services provided by the provider do not affect the referred services. We still provide the basic and referred services, as we always have.* (Manager, Vesthimmerland Municipality)

The statement also illustrates that the introduction of supplementary home care has emphasised and expanded the role of the front-line care worker rather than that of the purchaser in charge of the referred services. Care workers are now responsible for not only providing, but also selling services.

The cultural dimension

Lastly, the cultural dimension of the scheme concerns the stakeholders' underlying expectations about the role of supplemental services in the care sector, partly as a way to maintain sustainability, but also as a potential threat to the public service model.

As mentioned in the Introduction, practical help (e.g. cleaning) has been significantly reduced in the last ten years in Denmark. In the interviews, public managers emphasised that this has reached a critical stage, not least as they are facing a new populace of seniors who are expected to demand more personalised services. Supplemental services may therefore become increasingly attractive in a situation of shrinking resources, ageing societies and a more demanding welfare clientele.

> *We are facing a new generation that will require new and better services than today. And if the basic service level does not reflect this in the coming years, then there will be an increased demand for supplemental services.* (Manager, Vesthimmerland Municipality)

Nevertheless, an overall concern was also visible – that supplemental services would replace referred services in the long term and thus lead to the erosion of the public service model. This was very evident in the documents submitted by the municipalities to the Danish Ministry of Social Affairs and Interior as part of the free municipality scheme approval process. The concern over the falling public service level was also expressed by several care workers and managers in the interviews:

> *I could easily imagine that in time, cleaning services will end up not being free of charge. Our welfare model is moving in that direction. And what will happen then...?* (Care assessor, Vesthimmerland Municipality)

At the same time, there was a broad acknowledgement among managers, care assessors and care workers in the interviews that supplementary home care represents a valuable policy instrument for the future, as a means for maintaining sustainability and meeting changing demands. According to public managers and care staff, having supplemental services also in the public home care enables municipalities to meet users' demands, even when facing continued cut-backs. From the interviews, it is clear that both care workers and management were conscious about accommodating user demands rather than rejecting them or having to refer users to a private for-profit provider of services instead. The following statements illustrate how the sale of supplemental services may help care workers overcome the frustration of not being able to deliver services according to demands:

> *Before the scheme, many of our users asked us: Can you help me with this and that? Can we get something extra? Then we had to say: I'm afraid we cannot do that. And then we might lose the user to a private competitor. When the opportunity to sell supplemental services arose, I thought it was fantastic! Now we can take charge of the situation and say: Well, you know what – we can also help you with that!* (Care worker, Vejle Municipality)

> *If users ask us whether we can help them with something extra, I think it's very satisfying for us to be able to say: Of, course, we can help you. We can give you the option to purchase extra time!* (Care worker, Vesthimmerland Municipality)

In the interviews with users, they generally expressed satisfaction with being able to purchase supplemental services from a provider that they already know. This made them and their families feel more safe and ensured them a continuity in the care provision: *It is the same care worker who does the extra cleaning. She knows where things are, and she knows how I want it done. We get along well.* (User, Vesthimmerland Municipality)

Discussion

Supplemental services as a potential new welfare strategy – but implications for inequality

How do the experiences in Denmark reflect other Nordic countries where the provision of home care is also situated within the public service model? In the Nordic public service model, there is generally little experience of supplemental services. Within long-term care, Sweden has so-far seen the most use of topping up (Svensson & Edebalk, 2006; Szebehely & Meagher, 2011; Szebehely & Trydegård, 2012). In Sweden – as in Denmark – only private for-profit providers are permitted to offer supplementary home care services. Public providers have so far been allowed to offer supplemental services (and charge for them) only if this would prevent accidents from happening, for example changing light bulbs so that frail older people would not have to climb a ladder (Erlandsson, Storm, Stranz, Szebehely, & Trydegård, 2013). This is a very limited type of service, and in many cases, municipalities offer this service for free anyway. In Norway and Finland, public providers are not allowed to offer supplementary home care services (Deloitte, 2013; Karsio & Anttonen, 2013).

Therefore, Denmark represents a rather unique case among the Nordic countries. The Danish scheme has interesting implications, not only for Denmark but also for the Nordic public service model and other public service models based on the principles of the universal welfare state.

We see the introduction of topping-up as potentially marking a profound change in the approach to welfare in the public service model. It illustrates the dilemma of a tax-based welfare state based on the financing of public welfare by relatively heavy taxation. Publicly financed and publicly provided services have to be both sufficiently affordable and attractive to be preferred by all users. Research has long established that if middle- and high-income

groups become discontented with the quality of the public services provided and therefore opt out, they will be less willing to support tax-spending on the public system (Brook, Hall, & Preston, 2000; Szebehely & Trydegård, 2012).

For policy makers in Nordic countries, there are three options – which are not mutually exclusive – if the (expensive) public services are to remain attractive for all income groups. They can: 1) increase taxes (or user-fees) to ensure a high quality of welfare; 2) cut down on public services and thereby reduce taxes while trying to ensure quality standards; or 3) introduce individual solutions, such as topping-up, and accept increasing inequality in access to services (Bergh, 2008).

The third option of offering supplemental services is potentially a powerful way to deal with restricted public budgets and rising user needs. Increasingly, service users of all ages demand and expect services that fit their individual needs, and the public sector's existing budget framework can only accommodate these needs with difficulty. Supplementary home care can provide a solution to this, but it is obviously a policy option with implications for inequality as it benefits mainly users with financial means.[6] Additional analysis of which home care users purchase supplemental services clearly illustrates this. In 2012, 3.6 times as many for-profit supplemental home care services were purchased in Denmark by older people with a high income level (more than EUR 40,000 per year) compared with older people with a medium or low income[7].

Hesitant political support but some organisational benefits

It is also a new welfare strategy that requires recalibration of the local welfare organisations as well as the central political level. As shown in the article, opening the supplemental services market to the public provider was not an immediate success when measured by number of sales.

A major explanation for the lack of sales seems to be the high cost which, again, was a result of a somewhat hesitant attitude from the Ministry to position the public and for-profit providers equally in the market. Cost-setting restrictions resulted in prices that were not competitive. This is despite the government having stressed that the public sector should be allowed to compete with private companies only if the competition took place on fair, transparent and equal terms (Danish Ministry of Finance, 2016), but this principle seems to apply mainly to protect the for-profit providers.

On the other hand, the Free Municipality Scheme illustrates that despite a considerable amount of administrative work associated with the introduction of supplemental services, there are also substantial organisational benefits. As shown in the results section, supplemental services have given the public providers better opportunities to organise the working day more effectively by reducing gaps during the afternoon. This has allowed them to meet both the demand for full-time work from the care workers and the need for continuity of care and care personnel for older people.

The interviews also indicate that there is support for implementing supplemental services on a larger scale. From the perspective of care workers, supplemental services enable them to better meet the needs of the users. They expressed no immediate concern as to whether the introduction of supplemental services might result in poorer working conditions, although we know from other studies that for-profit care workers experience significantly poorer working conditions than publically employed care workers do (Rostgaard & Matthiessen, 2017). This is expressed in a number of ways. For-profit care workers more

[6] Another solution is the introduction of tax deductions for household and care services, which was done in Sweden in 2007 (Szebehely & Trydegård, 2012). In Denmark, this solution has only recently been introduced – and on a limited scale. As with the supplemental services, this solution benefits mainly the wealthier users.
[7] Special analysis based on data from the Danish Longitudinal Survey on Ageing (DLSA), not published.

often work alone in work situations that require more than one person, and they have less time to consult with colleagues. They also meet less often with middle-managers and lack their support, and more often they must carry out physically strenuous work and miss out on their lunch break. Overall, they are more often physically and mentally overburdened and, to a higher degree than their colleagues in the public sector, desire to find work somewhere else (Rostgaard & Matthiessen, 2017). It is by no means certain that the working conditions in the private sector will be mirrored in the public sector as a result of introducing supplemental services. However, it is noticeable that the care worker is now the one who can/must offer supplemental services when users find that their needs are not being met, positioning the care worker as a trouble-shooter between shrinking budgets and rising user demands.

Therefore, future work contracts should protect care workers by ensuring that their work is regulated and that their jobs are not dependant on the sale of supplemental services (Tufte & Dahl, 2016). Managers in general also seem positive towards the possibility of expanding the catalogue of services, and thus providing more personalised services.

Our study thus shows that care workers have gained a new role as salespersons of care. Theoretically, this should cause no problems as the purchaser−provider split is in place and the assessment for referred services and the sale of supplemental services need not be mixed together as a result of care workers' new role. However, the care worker as front-line provider remains the person in charge of reporting back to the purchaser if the older person is in need of additional referred services due to increased frailty or poor health. For example, there could be a need for an additional number of visits or for extending the service level to include other tasks. This places the care worker in a new role and he/she has to carefully balance his/her decision of when to report back the need for additional referred services and when to simply offer the older person the option to top up with supplemental services. This illustrates how the introduction of supplemental services may also affect the perception of need − is need simply an expression of the users' preference for extra services or is it a (real) need for services which the state should provide?

A rookie in the market place: Will I stay or will I go?

As our results show, the sales result in the municipalities was poor, perhaps due to inexperience with operating on market terms. In a service model like the Danish one, the public sector is deeply rooted in universal welfare principles and is not attuned to selling and charging for extra services.

Our results show, however, that the introduction of supplemental services marks an important step in an ongoing development. Public providers increasingly see themselves in competition with for-profit providers, and supplemental services are viewed by public management as a means of competing for existing and new customers. This development has been ongoing since the introduction of the customer choice of home care provider in 2003, as public providers have become increasingly attentive to users' needs and desires, expressed, for instance, in regular satisfaction surveys (Rostgaard, 2017).

The introduction of supplemental services in the public sector resembles the consumer-oriented approach in the private sector, as the focus has shifted from fulfilling the basic needs of the most needy on the basis of common and politically accepted standards, to the supply of personalised services, especially to those users with the economic means to top up services (Andersson & Kvist, 2015).

In essence, this represents a change of discourse. The focus is not only on 'the citizen', it is also on the 'the consumer'. In this new discourse, the role of the citizen (associated with basic rights available to all (operating through public institutions) is mixed with the role of the consumer (associated with self-interest that operates on market principles) (Brennan, Cass, Himmelweit, & Szebehely, 2012). Here, topping-up is a central part of marketisation efforts.

It creates relationships between buyers and sellers, and it uses the market mechanism to allocate care (Brennan et al., 2012; Vabø et al., 2013).

The quasi-market-based home care model in Denmark (and other Nordic countries) is not a full market-based model – as indicated by 'quasi' (Andersson & Kvist, 2015; Doyle & Timonen, 2008). A full market-based model would involve suppliers operating freely in a competitive market where price and quality vary according to consumer preferences. This is not the case in the Nordic home care model. Prices, as well as minimum quality standards, are fixed, and competition is actually very limited since consumers seldom exercise their right to exit/enter different plans and change their provider (because of the importance of continuity of care, etc.).

The option for older people to top up using their own financial resources changes this, at least in principle. Topping-up introduces personalised de facto service levels, price variety (even though government restrictions apply), more competition among providers and a more effective choice among consumers. At the same time, topping-up operates outside the sphere of referred services. Topping-up is a form of parallel care system (market) in which social legislation and basic social needs have less importance, while personal economic resources and personal needs means more.[8] Topping-up implies that those with more resources will be able to purchase higher quality care, and this will, on an aggregate level, lead to increasing inequality in the service provision, a point of criticism usually associated with markets (Andersson & Kvist, 2015; Brennan et al., 2012).

As we have argued, introducing topping up can be viewed as a way to spur marketisation further and, in essence, could be a departure from the principles of the universal welfare state. It can also, however, be viewed as a strategy of resilience and rescue of the current welfare model, where 'attractive private-sector options may mute opposition to the curtailment of public provision' (Pierson, 1996, p. 23). Topping up services, in this view, is a way to expand the service of the public sector and prevent older people from turning to the private market instead of using public home care services[9]. Following this argument, topping-up is not merely about marketisation. The provision of supplemental services in the public sector is not only concerned with basic market principles (consumer orientation and profit-seeking through competition), nor do supplemental services simply follow the logic of state provision to meet citizens' basic rights.

It nevertheless re-organises what Razavi and others have argued are the four 'logics' in long-term care, which can be summarised in a 'care diamond'. These four logics are the logic of the market, the logic of the state, the logic of non-profit associations, and the logic of family care (Burau, Theobald, & Blank, 2007; Razavi, 2007). The argument is that different logics of care prevail in different care models and different countries. We would argue that supplemental services in a universalistic state represent a new and potentially powerful combination of market logics and state logics.

The new privatised public service model emerging in Denmark relies on a delicate balance between state-provider logics and market logics (Brennan et al., 2012). In this model, public priority is given to marketisation and greater individual choice, while, also giving priority to a legal framework that ensures that public financed care still meets the basic needs

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[8] There are only a few restrictions regarding the types of supplemental services municipalities can offer. Thus, in the Free Commune Experiment 2014−2016, there were examples of services such as nail polishing, snow shovelling and foot therapy being offered.[9] Interestingly, the political debate in Denmark has revealed that some right-wing/liberal political parties support supplementary services on the grounds that it extends consumer choices, while some left-wing political parties are in favour of supplementary services because it extends the possibilities in the public sector.

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of older people. This type of mixed-care production (or welfare-mix) where public and private provision of care are combined in innovative forms is not new (Anttonen & Häikiö, 2011). What is new is that supplemental services represent a type of service that, in essence, changes the role of the public provider: The public sector no longer solely provides social care financed by the state. When supplemental services are introduced, the public sector, like the private sector, offers state-financed referred services and supplemental and tailor-made services financed by the user (Henriksson & Wrede, 2008).

This is a critical juncture in the recent politics of Nordic social care. In a recent article, Szebehely and Meagher (2017) state that an already weakened universalism has become weaker in Nordic long-term care. They argue that this is due to increases in for-profit provision of publicly funded care services (free choice reforms), family care (re-familialisation), as well as of user-financed services (supplemental services). Most clearly, this has occurred in Sweden and Finland, while it is to a lesser extent so in Denmark and Norway. Our results indicate that service universalism might be more threatened by the introduction of supplemental services in Denmark than believed so far.

Supplemental services might help to meet the growing demands for tailor-made services from older people and help secure the position of the public provider in the care market. So far, supplemental services in the public sector are fairly strongly regulated by public regulations (price-setting in particular), as illustrated in this article. Supplemental services, however, will anchor market logics in the public sector and have implications for the way need is assessed. Providers of public home care services have new options in relation to fulfilling individual user needs (as in the private sector), and these options (supplemental services) are completely detached from the authority in charge of the referred services (the purchaser). However, as the care worker is the one to both sell supplemental services and report changes in the need for referred service, there is a mixture of incentives. As a result, market logics have acquired a whole new playing field in public care.

Concluding remarks

There are indications that supplemental home care will become part of the Danish public service model. First, this study has shown that for-profit provision is increasingly popular among users of home care and a large proportion of the older people receiving practical help purchase supplemental services. With the ongoing reductions in service levels and the general targeting of services, there may likely be a potential market for supplemental services, in particular for older people who are receiving practical help only. Practical help has been significantly reduced in the last ten years in Denmark, and this has created a new demand for topping up. Secondly, the Danish government has recently approved a new Free Municipality Scheme operating during 2017−2020, which gives 11 municipalities in Denmark the opportunity to experiment further with supplementary home care. This indicates that the Danish government has maintained an interest in investigating the potential of supplementary home care in the public sector. The new scheme will cover a population six times larger than the first scheme did. The services offered will be more limited in order to benefit from large-scale production, but there will be no changes to price-setting.

We argue that the Nordic home care model and service universalism are being challenged by the introduction of supplemental services. Topping-up, together with an increased focus on consumer choice, is a combination which is in conflict with the fundamental principles of service universalism. The combination creates an incentive for older people with economic means to refrain from the standard public service offered and instead demand a more tailor-made service package. Older people with a lower income cannot to the same extent afford to purchase extra services and, as a result, do not receive the same level of service (Puthenparambil, Kröger, & Van Aerschot, 2017). In the long term, this can

lead to a dualisation of care and a departure from the service universalism that has characterised the Nordic welfare model for decades.

Universalism is the 'trademark' of Nordic welfare states, notably in the social services (Meagher & Szebehely, 2017). The new and privatised public service model evolving in Denmark (and other Nordic countries) is challenging this and represents a new guiding principle for the development of the welfare state in the Nordic countries. Service universalism is not only being challenged by private, for-profit providers moving into service provision, it is also – and increasingly – being challenged by reforms within the public sector that alter the ethos of public care by introducing market principles as a new parallel way of allocating care.

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