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Development of a Swedish community mental health service market

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ABSTRACT
The aim of this study was to examine changes in an organizational field over time when implementing a freedom of choice model. Main focus was on the range and characteristics of providers and services. Our findings suggest that the expected effects of the reform in terms of variety of providers and services within the organizational field did not materialise due to a lack of market competition. Providers complemented each other rather than competed with each other, and the logics of care, choice, and advocacy challenged each other within the quasi-market. All informants described financial conditions in the market as extremely strained. Strong personal commitment characterized providers entering and exiting the market. A gap was found between policy goals and experiences among stakeholders, and efficiency was found to be the policy goal achieved most often in practice. This raises the questions of how the Swedish community mental health service market will develop in the future and what the implications are for the participants.

KEYWORDS
Mental health; social policy; choice model

Introduction

Transforming the organisation of public welfare services into quasi-markets as a means to increase citizens’ choice is gaining ground in Western countries. Although certain aspects of quasi-market implementation have been studied, several questions remain unanswered. As Gingrich (2011) claims, there is not just one ‘welfare market model’ to relate to, but a range of different models. However, the lessons learned in one case might provide knowledge that is also useful in other contexts. This study addresses the knowledge gap concerning what happens to an organizational field over time when a quasi-market is implemented and seeks to answer the following questions: How is the organizational field changed when a quasi-market is implemented in terms of numbers of providers and the provider characteristics? Who inhabits the reformed organizational field? How does the organizational field develop in relation to the expected development due to policy stipulations?

In 2009, a new piece of Swedish legislation (SFS 2008, 962) enabled municipalities to organise any service they provided as a choice model. Such a model is based on continuous competition between providers so that users’ choices determine whether a business will survive in the market. Competition intends to stimulate service providers to develop their services, and this should provide for greater diversity and efficiency. The Swedish Government Official Report (SOU 2008, 15) summarized the policy goals of the market reforms in five aspirations: 1) to increase individual choice, 2) to increase individual power, 3) to increase the diversity of services, 4) to increase the quality of services, and 5) to increase the efficiency of services.

Psychiatric care is a welfare sector where choice could be considered to be of particular interest. It is an organizational field where individual choice has traditionally been absent (Rogers and
Pilgrim (2005), and implementation of choice in this context would likely be a major change compared to prior practices. This field therefore constitutes the focus of this study. The common and extensively used community mental health service ‘day centre services’, which aim to support persons with psychiatric disabilities in their everyday life through activities and fellowship (Lehtinen et al. 2007), was selected to represent the field. Activities offered at Swedish day centre services represent a wide range, from socially oriented activities such as reading a newspaper or playing games to more structured activities where participants often have specified schedules, individualized plans, and personal objectives, including making handicrafts, gardening, or working in a café (Tjörnstrand, Bejerholm, and Eklund 2011). Participants are often advised to attain day centre services as a complement to their medical care by their contacts in psychiatric health care. As of April 2016, 8 out of 290 Swedish municipalities had implemented choice models within their organisation of day centre services (SKL 2016).

One of these eight municipalities was the capital, Stockholm. Due to the capital’s strategic significance, and due to its large size, it was selected for the study, assumed to offer opportunities to capture detailed knowledge. The use of the city as a case study was deemed to be the most appropriate method to answer the study’s research questions. In the chosen case, the reform

Table 1. Summary of the material used.

<table>
<thead>
<tr>
<th></th>
<th>All providers</th>
<th>Providers entering</th>
<th>Providers exiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>33</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Dropouts</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Material</td>
<td>33 homepages</td>
<td>8 interviews</td>
<td>2 interviews</td>
</tr>
</tbody>
</table>

Table 2. Quasi-market development in terms of the number of providers each year.

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public providers</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>22</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Non-public providers</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>In total</td>
<td>23</td>
<td>26</td>
<td>29</td>
<td>28</td>
<td>30</td>
<td>28</td>
</tr>
</tbody>
</table>

Table 3. A summary of characteristics of the service providers according to their homepage presentations (the total number of providers is in parentheses).

<table>
<thead>
<tr>
<th>Home page</th>
<th>Building-based</th>
<th>Work-place-based</th>
<th>Building and work-place-based</th>
<th>‘In-house’ related terms</th>
<th>‘Employment’ related terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>25 (26)</td>
<td>1 (26)</td>
<td>0</td>
<td>23 (26)</td>
<td>1 (26)</td>
</tr>
<tr>
<td>2015</td>
<td>21 (28)</td>
<td>1 (28)</td>
<td>6 (28)</td>
<td>24 (28)</td>
<td>12 (28)</td>
</tr>
</tbody>
</table>

Table 4. Policy goals related to the experiences of the informants.

<table>
<thead>
<tr>
<th>Policy goals</th>
<th>Market development according to the informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increased choice</td>
<td>Participants were no longer strictly referred to the district’s own services as before.</td>
</tr>
</tbody>
</table>
| 2. Increased power | ● Participants were no longer strictly referred to the district’s own services as before.  
|                     | ● Decisions at the expense of participants:  
|                     | 1) experiences that former participants were no longer assessed as being in need of the service despite severe mental health problems (Provider 1)  
|                     | 2) young people tended not to get favourable decisions (Provider 2)  
|                     | ● Hierarchical structures decreased professionals’ and participants’ power (Providers 2 and 9) |
| 3. Increased variety of services due to competition | ● Providers complemented rather than competed with each other (Provider 6) |
| 4. Increased quality of services | ● User-led organisations opted not to enter (Provider 3) |
| 5. Increased efficiency | ● [Not covered by the data material]  
|                           | ● Providers experienced a strained economic situation and took financial losses instead of making a profit (Providers 1–9) |
meant that participants could choose between all authorized providers available within the city. Prior to the reform, most participants were referred to the nearest service in their home districts. In the new system, participants had to apply for attendance from a public assessor who was a social worker who assessed each participant’s needs and decided whether day centre service was an appropriate service for the person in question. Upon a positive decision by the assessor, the participant was free to choose among the service providers. Within the new system, economic compensation accompanied each individual, and providers were to deliver services that could be covered by that money.

This study is part of a larger project where expectations prior to and experiences after the launch of the reform among participants, professionals, and policy-makers have been explored in the same municipality (Eklund and Markström 2014; Andersson et al. 2016; Fjellfeldt et al. 2015, 2016). The aim of this study was to examine changes in an organizational field over time when implementing a freedom of choice model. Main focus was on the range and characteristics of providers and services.

Theoretical framework

The theoretical framework behind the data analysis included the concepts of logics and the institutional logics perspective.

The institutional logics perspective is described by Thornton, Ocasio, and Loundsbury (2012):

*The institutional logics perspective is a metatheoretical framework for analyzing the interrelationships among institutions, individuals, and organizations in a social system . . . The principles, practices, and symbols of each institutional order differentially shape how reasoning takes place and how rationality is perceived and experienced. (Thornton, Ocasio, and Loundsbury 2012, p. 3)*

In relation to this description, Meagher et al. (2016) found that institutional changes, such as privatization and corporatization in the context of welfare market implementation, affect the mix of institutional logics that organize a field. These changes involve new constellations of relationships, norms, and justifications for action, and thus the implemented market logic challenges the existing institutional logics. Pache and Santos (2013) used the term ‘hybrid organizations’ to describe how implementation of quasi-markets leads to a special kind of organization in which features from different sectors are combined and competing demands and institutional logics interact.

To gain understanding of dynamics in various organizational fields, a number of logics have been identified and conceptualized. In the context of choice in health care, Mol (2008) identified two contrasting logics – the logic of care and the logic of choice. Within the logic of choice, a market vocabulary prevails. For example, customers buy their care in exchange for money. However, Mol (2008) questioned whether the transformation of patients into customers improves the situation for the person concerned, and one issue discussed concerned the personal responsibility associated with the logic of choice. When a person makes a decision that turns out to be wrong one, the failure belongs to that person. Thus the logic of choice adds guilt, which is likely to be considered counter-productive in the health care context. Within the logic of care, however, in a situation of poor outcome of a treatment the provision of comfort would be the natural response. Mol (2008) argued that the logic of care gives space for fragility, which is dismissed within the logic of choice. Further, both Fotaki (2009) and Mol (2008) pointed out that health care and many other public services concern ongoing processes rather than one-off transactions. Fotaki (2009) writes:

*Provision of public services is rarely about acquiring products for pure consumption, but more about providers and users jointly addressing essential social and human needs. (p. 87)*

Provision of public services is rarely about acquiring products for pure consumption, but more about providers and users jointly addressing essential social and human needs. (p. 87)
A final logic identified to be of relevance in relation to quasi-market implementation in community mental health services is the logic of advocacy, which appears in the form of user organizations (Meyer 2010). Social movement service organizations, including some user organizations, often seek to bring about their social change goals through the provision of social services. Provision and advocacy in these organizations is linked with one another that neither can be engaged without the other. Solidarity and collective identification are important concepts related to the logic of advocacy.

To further increase the understanding of institutional logics, the empirical findings were also related to the policy goals associated with the implementation of the freedom of choice model (SOU [Government Official Reports] 2008,15). They were understood as a desire to spread the principles of quasi-market models as implemented in public welfare with the aim to increase citizens’ freedom of choice while also contributing to higher quality of service and facilitating the efficient use of public funds (Le Grand 2007). Furthermore, providing users with choice was intended to induce diversification in services and service providers as well as to reduce inequalities in service provision (Warner et al. 2006).

**Method and material**

A case study (Yin 2014) was set up to to examine changes in an organizational field over time when implementing a freedom of choice model. In order to understand the processes at work in the implementation of the reforms, we needed a method that allowed for several sources of data to be included. Additionally, case studies have been suggested to be appropriate when studying complex phenomena where the researchers lack control over the events or processes (Yin 2014). To answer the research questions, number and characteristics of providers were studied, as well as dynamics within the organizational field. The case was selected to be the geographical area of Stockholm, and the organizational field in focus was day centre services. Data was collected from 2010 to 2015.

We chose to focus on day centre services because these represent a large portion of the community mental health services along with supported housing. As mentioned, a major Swedish municipality was selected that had implemented a choice model concerning day centre services in 2010. The municipality had about 900,000 inhabitants at the time of the study and consisted of fourteen city districts. When the study was conducted, a total of 970 persons were attending day centre services based on a professional assessment of their needs (Stockholms stad 2012).

To study the development of the day centre services in terms of the range and characteristics of the providers and services, we undertook a survey of all day centre services within the market. Within the market, all providers present themselves through a website consisting of text and images. The websites representing a total of thirty-three different providers were collected, and the data were categorized as representing the market’s early stage (2012) and when the market had been running for five years (2015). This time period was estimated to be sufficiently long enough time to conduct a longitudinal study of the reform’s effects. An inductive approach was initially used when collecting information, and all text and all pictures were included. In a second stage data were categorised into codes and themes related to the research questions.

To explore changes in dynamics in the market, we conducted interviews with managers representing service providers that had entered the market. Nine providers had entered the market during the first five years, and all managers were contacted by mail or by phone. Eight of them chose to participate in the study to share their experiences and opinions of the market. Three of the providers had also exited the market during the first five years. We were able to get into contact with two of them, and they both agreed to participate. One informant was interviewed twice because the provider they represented both entered and exited the market during the time period of the data collection. Interviews were conducted face to face and were often held
where the day centre services were located. The time for each interview was between one and two hours, and the interviews were recorded digitally and transcribed verbatim. The participating providers were given numbers 1–9. A number of themes were addressed during the interviews. Open ended questions posed concerned: core characteristics of the provider, experiences associated to entrance to and exit from the market, providers position in relation to other stakeholders, and market economic conditions. During the interviews, informants also emphasized other themes, such as standardized procedures and hierarchical structures.

The contents of the websites and interviews were analysed by conventional content analysis (Hsieh and Shannon 2005). The material was first read several times get an understanding of the content as a whole. The data were then categorised into codes and themes related to the research questions. To validate the analysis of the data, triangulation was conducted by multiple analyses (Ritchie and Lewis 2003) where the two authors read the interview material in parallel and discussed various possible ways to interpret the data. In table 1 the material used is summarized.

There are limitations of the study. One limit concerns the possibility that we were at the mercy of the informants presenting themselves in a good light, and perhaps the idealistic appearance was just a front. Parallel studies, however, have revealed both a strained market where profits are difficult to make (Andersson et al. 2016) and the importance of close relationships with day centre service personnel from the participants’ perspective (Fjellfeldt et al. 2016), and these previous results suggest that the findings presented in this study can be considered valid. Another limit concerns the selection of only a single case. However, the aim of this study was to gain an understanding of a complex phenomenon, not to compare different cases, and it is hoped that this study will be able to contribute to a future study comparing how different cases have addressed the issues in focus here.

Findings

Emerging number and characteristics of providers

When the quasi-market was set up in 2010, all twenty-three public providers that had previously offered day centre services within the city were included. They did not have to apply to enter the market. On the contrary, they were not allowed to remain outside the market. The next year, 2011, the quasi-market was opened up for non-public providers to enter. Certain criteria had to be met concerning manager and staff qualifications and the service providers’ facilities and economic situation. During the quasi-market’s first five years, two public providers exited the market and nine non-public providers entered the market. One of the non-public providers also exited the market during this time period, and one of the non-public providers expanded during the time period to include two units.

During the interview with Provider 3, it was described how a user-led provider refrained from entering the market once the manager saw the application form:

\textit{No, this is humiliating, the manager thought, to need to be subjected to this examination when you have been doing it and have been trusted for so long (3).}

This meant there was at least one provider that considered entering the market but who abstained from entering due to the market’s requirements.

The change in terms of numbers of providers over the five-year period was in total a loss of two public providers and a gain of eight non-public providers in the market. This meant that participants had in total six additional providers to choose from in the first five years after the quasi-market was set up. However, the biggest difference for the participants was that the market model enabled all participants to choose from any district’s services, whether public or non-public. Participants were no longer strictly referred to their own district’s services as before. Table 2 shows the development of the quasi-market in terms of the number of providers within the market each year.
Services could, according to the providers’ homepages in 2012, be characterized as safe spaces in building-based settings (Bryant et al. 2011) that were to some extent complemented with more exposed places offering services such as employment-oriented settings. In 2015, most of the providers were still considered safe spaces in building-based settings. Services were offered in ‘Day Centre Houses’, where mental health professionals were available at all time. The houses were not accessible to the public, but intended for participants only. However, there was a trend among providers to use a more employment-oriented vocabulary in 2015 compared to when the reform was first implemented. A model gaining ground within the field was ‘Individual Placement and Support’ (Drake, Bond, and Becker 2012), which means the participant is placed in a position within the regular labour market, but gets relevant and individualized support to manage the work. The model advocates a ‘place then train’ approach in contrast to the traditional ‘train then place’ approach. The employment-oriented setting is supported by strong evidence for its effectiveness in randomized control trials. In *table 3* characteristics of services are summarized.

To sum up, not much happened on the market in terms of number of providers during the markets first five years. However, the findings showed a major change regarding providers characteristics: a large number of providers had undertaken an employment-oriented terminology.

**Strong personal commitment**

Informants from the entering providers all described how the service providers originated from a strong personal commitment to providing their services. Personal commitments were expressed in many different ways, but none of the informants expressed any other reason than this for running their business:

*The firm was established after my son developed a psychosis. I discovered that resources were completely absent in the community to support young adults to get back to work or studies.* (7)

The reason for Provider 5 to exit the market was that a key person resigned, and the skills required to be a provider in the market were thus lost. The person’s motivation to resign was a disagreement with the leadership of the organisation. The disagreement was explained in terms of what was of most importance; the professionals’ ambitions to work with individualized support, as opposed to the company’s expectations of economic efficiency:

*When pursuing mental health services, you should do it properly with high quality in my view. The Board was only seeking profit, while I saw the person.* (5)

This example showed how the personal commitment of the informant prevailed over other interests.

**Losses instead of profit**

In order to survive in the market, all of the providers needed funding in addition to their incomes from the compensations because the compensation accompanying each participant was too low to cover the costs of the services. Providers dealt with this problem in different ways depending on their overall financial situation. Some of the providers provided services to additional groups in order to enable the business to continue running.

*“We have expanded our services. We are a company that suddenly must survive. We cannot address just one client group”.* (1)

Others covered the loss themselves:

*Before, the material [when doing pottery] was included as well. And now they don’t compensate it. So, we have to solve it. Right now, we give away materials. We lose a lot of money anyway.* (3)
Some providers received external funding to manage financially:

_We managed to find a financier who wants to support us._ (7)

Provider 2 had been running for twenty years and had established a solid economy. Because they made a profit based on other incomes, they did not yet have to make a profit on the mental health services:

_I can say that we took large losses the first month. I saw the decline in October, then we dropped by x thousand each month._ (2)

In addition to the losses, the Individual Placement and Support (IPS) model used by provider 2 to support participants, had a contradictory logic compared to the logic of assessment within the quasi-market. The logic of the IPS-model was initial extensive support, which gradually was scaled down. The logic of assessment within the system was to start small and then scale up the support, and this resulted in a situation where provider 2 was not paid for the amount of services it rendered.

Provider 9 was a public provider that exited from the market due to financial issues. Prior to the new system, rents were detached from other costs and were covered by the district budget. After implementation of the reforms, however, rents for premises were to be covered by the compensation within the system. For this provider, that was an impossible economic equation. The district officially called the decommissioning a ‘relocation’, and the district planned to purchase support services from other districts instead of running the services itself. In theory, this meant that the district still fulfilled its duty towards its citizens, although through other districts’ mental health service providers:

_There are official documents related to this closure where it has not even been called a closure, it’s been called a relocation … well, you do not close anything because the support continues; you buy it from other districts, but it is just a play on words, because the day centre has really been closed, staff have been dismissed, and the participants have had to get their support in other districts. I think it is a world of difference to say that the mental health services are not closed down, since the support continues, but it’s the provider as such that has closed down._ (9)

The informant also stated that it had been obvious from the very beginning that the compensation system associated with the market could not possibly cover the costs of providing services. Because of this, concerns were raised about the future of community mental health services in the municipality:

_If the situation continues as it is today, all providers will close down. They have to, because ultimately it’s impossible. And now these new conditions; they got less compensation this year. It was a total pouring of cold water; they get a one percent cut._ (9)

Accordingly, all informants described the financial conditions in the market as extremely strained.

**Competition within the quasi-market**

The number of providers within the market was relatively stable, and only a small number was added during the first five years of the implementation. Not much happened regarding an increased variety of services (SOU [Government Official Reports] 2008, 15) in terms of activities offered due to the small increase in market competition. When talking about competition in the market, the informants described how it did not work as intended. A situation of complementing each other rather than competing with each other was described. Provider 6 said:

_What is so very exciting in a system like this is that you want to bring in competition, but in practice another logic prevails. You want the best for the participant, so you don’t mess with other providers in order to succeed._ (6)
Provider 6 thought they were needed on the market because no one else met the specific needs of their participants. They did not consider themselves as competitors with other providers, but rather as enablers to a group of people who otherwise would not get any support at all based on their dual disabilities of hearing impairment and mental health issues. Provider 7 also thought that their business addressed a certain group, but they emphasized the need for other providers as well.

Something that appeared in the interview data from the two providers who had exited the market was an experience of the importance of relationships between participants and the personnel of the service provider. Provider 5 talked about how the participants could choose a new provider based on where their former supervisor had a new employment. In this case, the personnel could be seen as the crucial competitive factor because they were the reason for choosing a specific provider.

**Consequences of standardized procedures and hierarchical structures**

Prior to the reform, participants could contact providers themselves, but when the market reform was implemented, a gatekeeper function was also implemented. Each participant had to be assessed by a public social worker who was given the mandate to determine if the individual’s needs warranted day centre services. Only when having been given a positive decision could the participant choose among the services. This meant that the distance between participants and providers at the initial stage had increased. Provider 1, which had previously been a public provider, commented on the change:

> Previously you could take your own initiative if you wanted to start here. It was so much fun, actually. But now it’s changed; they [participants] are not the ones who are the customers anymore, it’s the municipality. Everyone must have a decision. (1)

Another issue that was addressed in the interviews was a difference between providers’ and social work assessors’ judgements. The provider previously mentioned, Provider 1, had also experienced that former participants were no longer assessed as being in need of the service when the gatekeeper function was established:

> There were persons that we thought were crystal clear to get support. Going in and out and not being able to sit still and all that; that’s the side effects of their medication. If you are psychotic, then you walk around doing things. But then you get no decision. Because they never kept quiet and worked. (1)

This statement indicated that the reform meant that persons with severe mental illnesses were excluded from the services after being assessed. Unfortunately, this study was not able to determine whether these persons got some other kind of support adjusted to their needs. Provider 2 had experienced that positive decisions were not taken when needed with regard to new participants:

> During my first years, I met a hundred young people who wanted to start, but they did not get any decision. They said, help me, I want to get out, help me break my isolation. I have such a social phobia, I cannot go to the Employment Service, I’m too scared… but then they got no decision. (2)

Provider 7 had held members’ meetings before deciding to enter the market. Entering the market was seen as the only way to keep the business going financially, and this forced the provider to agree to the participant assessment procedure associated with the market. However, this provider dealt with the required assessment in a different way. A person could start immediately and was then supported and helped by personnel during the rigorous assessment process. This again exemplified the ‘person first’ discourse, and this provider would rather face financial uncertainty than endanger the person.

Providers 2 and 9 described how standardized procedures of hierarchical structures were implemented within the new model. One experience concerned the assessors’ difficult situation
when being trapped between the participants’ needs and directives coming from department heads in the municipality:

It’s hard for us, so it’s probably even harder for social workers to contradict their bosses and sit and argue. They understand. I think there is a lot of goodwill among each individual social worker, but they should also be authorized to grant as much support as needed. (2)

Another aspect concerned experiences expressed by the public provider regarding the city district managers’ new role in the hierarchical structure. The informant felt that the new model affected power relations and limited the power of both the providers and participants:

It is much more difficult to protest because everything is already set up. I cannot say that my boss and my boss’s boss are persons who just ride roughshod over someone. What happens is a small tilting. Administering something that one might actually dislike, but you do it anyway, we know the world history of that, so I think it’s terrible. (9)

This quotation suggests how the administrative structure could make persons who were otherwise perceived as humane make inhumane decisions. The informant carried great concern about contemporary developments within the field of community mental health services.

**Discussion**

**Changes in the organizational field**

Not much happened in terms of the number of providers during the market’s first five years. Among new providers specialization was reached to some extent. Among the large group of providers though, there were few new innovations, and providers to a large extent offered services in the same way as before. However, offering services according to the ISP-model was an exception, occurring at several providers. The lack of expected consequences in terms of variety of services from the implementation of a market model based on continuous competition where service providers develop their services and profile themselves (SOU [Government Official Reports] 2008,15) can be understood in light of the findings showing that there was no continuous competition taking place within the day centre services. Instead, providers complemented each other rather than competed with each other.

**Institutional logics**

When studying the development of the day centre services, several institutional logics (Thornton, Ocasio, and Loundsbury 2012) were found to be present at once and to be challenging each other. In several informants’ reasoning, a ‘person first’ discourse was identified, and this can be understood as located within the logic of care (Mol 2008). The logic of choice was also present. Provider 9 experienced how a new reasoning and rationality among decision makers replaced the former institutional logic. Previously, the local city district was obligated to provide day centre services to inhabitants with psychiatric disabilities. In the new institutional logic, the market opened up for participants to partake in the services of providers in any of the city’s districts, and the reasoning and rationality was that the city district still fulfilled its duty towards its citizens although through other districts’ mental health service providers. The closure of Provider 9 was called a relocation, even though the activities in the physical building were all closed down and the personnel were all dismissed. Thus there was a discrepancy between the informant who reasoned that ‘the provider was closed down’ and the municipality’s decision makers who reasoned that ‘services were relocated’. The consequence for participants, regardless of which line of reasoning, was that nearby premises and well known and trusted professionals were taken away. This finding sheds light on the risk highlighted by Taylor-Gooby (2008) that the transition to quasi-markets and
individual incentive systems risk damaging the norms that sanction support for vulnerable groups.

Another example of how a logic of choice challenged and overcame the logic of care (Mol 2008) was the hierarchical structure introduced into the system that created a distance between providers and participants. This can be seen as a given consequence of the purchaser and provider model that implies that participants and professionals are somehow counterparts. Fotaki (2009) advocates another approach where the essential event is not acquiring products for pure consumption, but a common process to jointly address social and human needs. This common process was not encouraged by the bureaucratic procedures of the implemented reform that increased the distance between participants and professionals. One example of such a procedure was the newly implemented gatekeeper function that meant that participants could no longer contact providers themselves in order to establish a relationship, but had to go through a government official.

The interview with the representative from Provider 7 provided an example of a typical ‘hybrid organization’ (Pache and Santos 2013) in which features from different sectors were combined and competing demands and institutional logics interacted. The members of the organisation thought that entering the market was the only way to ensure the survival of their day centre services; however, the members allowed their own advocacy logic (Meyer 2010) to continue by encouraging the participants to start prior to an assessment decision, even though they knew a decision was required to get compensation for services delivered. The logic of advocacy meant that this provider would rather face financial uncertainty than endanger the health of their participants. The example also shows how the logic of care (Mol 2008) was present, which gives space to fragility, and how such fragility is dismissed within the logic of choice.

The findings of this study are in line with research focusing on the British health care and welfare-to-work sector (Heins and Bennett 2016) where most providers within the implemented quasi-market were from the start third-sector organisations. Third-sector organisations were supposed to simultaneously address the shortcomings of both the market and government. Theoretically, the providers should be the ‘best of both worlds’ by combining the efficiency, quality, and innovativeness typically ascribed to the private sector with a social responsibility that is typically ascribed to the public sector. The authors of that study (Heins and Bennett 2016) found that there is a need for a nuanced understanding of emerging welfare markets, and this was also shown in the present study. Third-sector organisations did not seem to benefit much from the new market opportunities, but they had no other option than to enter the market if they wanted to continue their work as social enterprises within the field.

The informants related to day centre services as ongoing processes rather than one-off transactions, and this indicated that the logic of care (Mol 2008) was still the guiding principle in practice. This was illustrated by the importance of the relationships between the participants and personnel as experienced by providers who entered as well as those who exited the market. This finding is in line with an earlier study where choice was studied from the participants’ perspectives (Fjellfeldt et al. 2016) where participants emphasised the importance of specific employees. Relationships were highly valued from the participants’ perspective, and this seemed to be an important part of the service from the providers’ perspective as well. A lack of concern in policy documents about the importance of care relationships was found in this case as well as in other cases (Lewis and West 2014). The lack could be understood as the logic of choice prevailing over the logic of care on a policy level.

**Experiences of informants in relation to policy goals**

When relating the experiences of informants involved in the implementation process to the policy goals of the implemented reforms, as illustrated in table 4, the experiences and goals seemed to
differ concerning two issues and to be consistent in another two issues out of the four issues that were covered in the interview material.

Regarding increased 1. choice and 5. efficiency, there was a consistency between experiences and goals. The most consistency was found regarding the experiences and goals of increased efficiency. Concerning increased 2. power and 3. variety of services, however, experiences and goals diverged.

The goals that seemed to be reached the most were those benefiting the organization, or quasi-market financiers, which in this case were the city districts. Goals in favour of participants were not achieved to the same extent. Research on quasi-markets in the UK (Greener and Powell 2008) showed that three quasi-markets were characterized as having three different goals – in housing the goal was responsibility, in education the goal was diversity, and in healthcare the goal was responsiveness. Regarding day centre services in Sweden, efficiency seemed to be the goal for implementing the quasi-market model based on the consistency found between several different goals expressed in policy documents and the informants’ experiences of the implementation process. This result might be explained by findings presented in the extensive study of the experience of individual consumer choice over a fifteen-year period of time across nine fields of British public services (PERRI 6 2003). That study concluded by saying:

Designing policies to support individual choice presents governments with both technical challenges and with conflicts of values … they must choose between the available goals, and be willing to accept that all the good things do not go together. (p. 264–265)

In the case presented in the current study, one goal appeared to prevail while others were not met to the same degree.

A look ahead

Most of the non-public providers who entered the market within the time frame of this study could be considered as originating from non-profit third-sector social enterprises. Nevertheless, several providers had been recast into for-profit businesses when entering the quasi-market. This could reflect Heins and Bennett (2016) findings showing that organisations had to transform themselves due to the market conditions. In their study, only those who to a large extent mimicked the behaviour of for-profit businesses remained competitive. At the same time, third-sector organisations had no other option than to enter the market if they wanted to continue their work as social enterprises within the field. In this study, several providers described how entering the market was their only option; however, most of them had not yet mimicked any typical for-profit business behaviour.

Conclusions

Our understanding of the impacts of the implementation of a quasi-market within the Swedish community mental health services was that contradictive logics appeared on the institutional field. Accordingly, the market did not behave in the way it was expected to. The ‘players’ did not follow the ‘rules of the game’, and this situation can be understood by the presence of competing logics. Initially, the market was not an empty space where only ‘new’ providers entered, but instead consisted of a number of public-run providers that had been running for several years in another organizational setting where another logic was present. Presumably, this previous logic continued to prevail in the new setting. Providers who entered the market after the implementation of the quasi-market model carried yet another logic where the ‘person first’ discourse prevailed. An additional explanation for the absence of competition as a result of the logic of choice implemented in the system could be that the financial premises within the market were so strained that
a competitive mechanism did not appear. There was simply no profit to be had. Perhaps the strained financial premises also reflected the societal status of the field in focus.

The findings in this study indicated that all entering providers had a strained economy in relation to their involvement in the mental health market and that some providers exited the market due to negative experiences with the compensation system. The market studied here could be seen as accompanied with too little money for for-profit businesses to enter, and presumably too little money for the idealistic corporations and organisations to survive, and this leads to several questions. How will the market further emerge and develop? What market conditions are needed in order for service providers to survive in the market? What happens when providers run out of money? How does this affect the participants? We have followed the market during its first five years, but this study does not leave us with a full view of the situation or long-term knowledge of the field in question. On the contrary, the field studied here appears to be a field in transition that needs to be followed further to answer the new questions raised. Our findings indicate that implementations of quasi-markets are complex and demanding processes that do not necessarily develop in intended directions, and this calls for more global research on the widespread phenomenon of quasi-market implementation within public welfare services in different geographical and socioeconomic contexts.

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