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Privatisation of residential care for children and youth in Denmark, Finland, Norway, and Sweden

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Abstract

Few studies have investigated the privatisation of residential care for children and youth, and no studies have compared, mapped, and discussed the care markets that have developed in the Nordic countries. Here, we map and discuss the role of providers of residential care for children and youth in Denmark, Finland, Norway, and Sweden. In addition, we explore the driving forces behind the current situation in these countries. Although these countries have significant level of privatisation, they have several differences in terms of the participation of the public sector and how market shares are divided between, for example, for-profit companies and non-profit organisations. These differences are discussed as a result of the historical positions, for example, of non-profit organisations as well as differences in the way the countries adapted New Public Management and procurement regulations.

Keywords
Privatisation, marketisation, residential care, child welfare

Introduction and aim

Out-of-home care (OHC) for children and youth is a far-reaching intervention that targets children that are maltreated by their parents, and adolescents with severe antisocial behaviour problems. In the Nordic countries, just as elsewhere, the organisation of such care is varied and includes both family foster-care and residential care. Over recent decades, the field of residential care for children and youth has been subjected to significant changes. In all the Nordic countries, residential care is now bought and sold in markets. However, the development of these markets and how they function today differ somewhat between the countries. This article sets out to map and discuss the markets for residential care for children and youth in Denmark, Finland, Norway, and Sweden. With a comparative approach, the article provides a picture of the mix of providers of residential care in the Nordic welfare states and highlights factors that have contributed to the somewhat different developments.

The Nordic countries are known for their comprehensive welfare states, and references are often made to a Scandinavian/Nordic welfare model, a model that emphasises universalism, solidarity, and decommodification. The welfare services in the Nordic countries are largely publicly funded and citizens are traditionally granted equal access to the services (Cox, 2004; Esping-Andersen, 1990). However, since the late 1980s, the traditional Nordic welfare model has been under significant pressure to reform (Cox, 2004). In most Western countries, including Nordic countries, reforms aligned with the New Public Management (NPM) movement have impacted the way welfare services have been offered (Hood, 1995; Pollitt & Bouckaert, 2011).

Although the NPM movement has affected all Nordic countries, each country implements NPM and governs its welfare provisions differently. For example, the level of outsourcing of services and the role of different types of providers, for-profit, non-profit and public sector organisations, differ both between countries and welfare sectors (Sivesind, 2017; Stenius & Storbjörk, 2020). As will be shown in this article, the reforms have also affected residential care for children and youth – albeit, also in this case, to different extents.

Compared with other care markets, that of residential care is comparatively small and targets a marginalised group. Due to the residual character of the services in this field, the marketisation has largely gone under the radar, both in public debate and in research. Nevertheless, we know that both Finland and Sweden have seen an increase in outsourcing of residential care and a significant increase in the proportion of for-profit actors (Lundström et al., 2020; Porko et al., 2018). In Norway and particularly Denmark, the development has been somewhat different. To our knowledge, no studies with a comparative perspective have analysed differences between the Nordic countries. The aim of this article is therefore to explore and compare the market shares of different types of providers of residential care for children and youth in Denmark, Finland, Norway, and Sweden and to explore the driving forces that may underlie the (sometimes) diverging paths in the different countries.

Marketisation and control

As indicated above, the tendency towards increased marketisation of the field of residential care must be understood against the background of reforms inspired by the NPM movement. From the beginning of the 1980s (earlier in some countries and later in others), the advantages of market solutions were emphasised by politicians inspired by neo-liberal economists and public choice theory. Fed by growing pressures on public finances, increased marketisation was perceived as a solution to the allegedly inefficient and expensive public sector (Petersen & Hjelmar, 2014). Consequently, new actors were granted access to previous state monopolies in order to introduce competition (Le Grand, 1991).

In the field of residential care for children and youth, the increased marketisation – combined with concerns regarding the welfare of placed children – spurred initiatives and regulations intended to increase the control of the markets. For example, reforms regarding the monitoring of residential care were implemented. Sweden established a centralised inspectorate responsible for licensing and inspecting residential care in 2013 (Pålsson, 2018). In Denmark, Finland, and Norway, similar albeit more regional arrangements were developed (for more information on monitoring and licensing in the Nordic countries, see Pålsson et al., n.d.). When it comes to controlling the behaviour of sellers and buyers of care, all Nordic countries have adopted the EU directive on public procurement (including Norway under the EEA treaty), but how the directives are applied to social services differ between the countries (Segaard & Saglie, 2017).

Overall, the control mechanisms (i.e. rules on procurement, regulations regarding market entry, etc.) may influence the mix of providers. Research has shown that differences in the adoption of EU directives on public procurement have contributed to differences in other parts of the welfare markets in the Nordic countries (Stenius & Storbjörk, 2020; Sivesind, 2017). Procurement and licensing policies and procedures have, at least in Sweden, been shown to favour larger companies over smaller establishments (Pålsson & Shanks, 2020). Such differences may contribute to explaining provider variations in residential care among the Nordic countries. In addition, historical divergences in the residential care markets in the different countries are also likely to be of importance in this respect.

Child welfare in the Nordic countries

Denmark, Finland, Norway, and Sweden have many similarities with regard to how child welfare is organised. In all of these countries, child welfare services are embedded in more or less comprehensive welfare systems, built on e.g. ideas of universalism. Basic needs of all citizens should – ideally – be secured by general welfare systems and the citizens, irrespective of their economic status, should be entitled to e.g. child, unemployment, and sickness benefits, and old age pension. In contrast to the general welfare regimes, the child welfare systems are selective services. Local authorities are responsible for meeting the needs of those that require additional support, and the child welfare services have the ultimate responsibility for investigating children's needs, to offer help and support and to provide protection for children who need it. This includes interventions without consent from children and parents. The work in child welfare is undertaken by professional social workers and guided by national child welfare legislations (Pösö et al., 2014). Only a small proportion of children and youth come into contact with the child welfare services, and of those that do and are subsequently subjected to an intervention, the majority receive some form of in-home treatment. In general, the Nordic model of child welfare has been described as family oriented – i.e. child maltreatment is mainly considered a family dysfunction (Gilbert et al., 2011). In line with a family orientation, the preferred choice of intervention is that of least intrusion, and interventions are as far as possible voluntary and decided in cooperation with the parents. If in-home services have been (or are believed to be) insufficient and a child needs to be placed in care, foster care is normally preferred over residential care (Pösö et al., 2014).

Although the child welfare services in the Nordic countries share many features, there are also noticeable differences between the countries. For example, the proportion of children placed in residential care and family foster care differ between the countries. In Finland, half (50%) of the children in care are placed in either residential care units or so-called professional foster homes. The latter facilities care for around 9% of all placed children and

are by law defined as family foster care but are in practice similar to small residential care units (RCUs) as they may have employees and must be licensed (Finnish Institute for Health and Welfare, 2020). In Norway, only around 9% of the placed children reside in residential care (Statistics Norway, 2021), whereas the proportion in Denmark and Sweden is 33% and 22%, respectively (Lausten & Andreasen, 2019; Swedish National Board of Health and Welfare, 2019). The number of children placed in foster/residential care naturally affects the size of the residential care markets.

Due to differences in statistics, legislations and definitions, it is difficult to compare the proportion of children in residential care in the Nordic countries with that of other countries. The proportion differs greatly, from a few percent in some countries to nearly all in others. However, even in an international perspective, Norway places a small proportion of children in residential care, while Denmark, Finland and Sweden are comparable to some other European countries, such as Italy, Scotland and Spain (Thoburn & Ainsworth, 2015).

Methods

This study was initiated by a Nordic research network regarding privatisation and competitive tendering in the personal social services in the Nordic countries. The authors collected data in their respective countries.

The Danish data are based on a national register of all social services including RCUs for children and youth kept by the Ministry of Social Affairs. The Finnish data on private producers are based on the National Supervisory Authority for Welfare and Health (Valvira) register. Valvira's register includes non-public service units with a license. These data were combined with a list of municipal service providers' units provided by the State Regional Administrative Agencies and state-owned units provided by the Finnish Institute for Health and Welfare. The Norwegian data were collected from Statistics Norway, and the Swedish data are based on the national register of RCUs, which is kept by the Health and Social Care Inspectorate (IVO). The Swedish register covers all units licensed to run RCUs. Publicly owned facilities do not need to apply for a license in Sweden, but they do need to report their units to IVO and are therefore included in the register. All data was collected during 2020. Unlike the rest of the countries, Norway does not keep registers on units but on the number of beds provided by different providers. As the other countries' data on beds is more unreliable than that on units, the share of beds in Norway is compared with the share of units in the other countries. This should not affect the possibility to compare Norway with the other countries; previous research has shown that the proportions of different provider types are similar regardless of whether beds or units are counted (Meagher et al., 2016).

This article focuses on RCUs that have a treatment-orientation and target children placed by child protection units rather than establishments that a) function like housing for minors without extensive treatment needs, or b) target children with disabilities. In accordance with this, the data from Finland, Norway, and Sweden do not include units/beds primarily targeting unaccompanied asylum-seeking minors (often placed in establishments without treatment orientation) nor children with disabilities. However, due to differences in legislation, the data from Denmark include units both for unaccompanied asylum-seeking minors and children with disabilities, as there are no straightforward means to distinguish these facilities from the rest. However, there are no indications that the share of different providers is significantly affected.

The RCUs/beds are categorised into three categories based on ownership:

1. Units/beds owned by for-profit companies, e.g. limited companies, general partnerships, etc.
2. Units/beds owned by the public sector, i.e. by municipalities, either in the form of municipal companies or in the form of ordinary municipal services and by the state.
3. Units/beds owned by private non-profit organisations, e.g. associations and foundations.

The field of residential care has many grey areas, so comparisons between countries are not easily performed. As noted above, legislation and available statistics may differ somewhat between countries. However, although this means that exact numbers should be interpreted with caution, the bigger picture presented here is still valid.

Findings

Proportion of different types of providers in the countries

Finland and Sweden clearly have significant similarities in terms of market shares of different types of providers (Table 1). For-profit companies dominate the market in both countries (around 80% of the units), and the role of non-profit and public organisations are relatively small in both countries. In Finland, the non-profit sector owns a somewhat larger share of the units compared to Sweden (8% and 3%, respectively); in Sweden, the public sector owns a larger share of the units compared to Finland (20% and 10%, respectively). Finland has a larger number of RCUs than Sweden, which likely corresponds to the greater proportion of children being placed in this type of care, and the relatively high proportion of small establishments, i.e. professional family homes. Of the privately produced residential care in Finland, about 37% of the units are such establishments (Porko et al. 2018, 18). Overall, however, the similarities are greater than the differences. As we will see below, there are also significant similarities in terms of how the residential care fields have developed in the two countries.

In this comparison, Denmark appears to be something of an outlier. Around half of the RCUs in Denmark are owned by non-profit organisations (46%), while the role of for-profit companies is relatively marginal compared to the other countries (22%). In addition, the public sector owns a larger share of the market in Denmark (32%). Denmark has a large number of RCUs, which is probably a result of the size of units and that the data also include facilities for asylum-seeking children and children with disabilities. Norway stands out in the respect that comparatively few children are placed in residential care. The level of privatisation in Norway takes a middle position: 35% publicly owned beds, 45% that are owned by for-profit companies, and 20% owned by non-profit organisations.

Table 1. Share of RCUs (%) for children and youth owned by different providers in Denmark, Finland and Sweden, and share of beds owned by different providers in Norway (all *percentages may not total 100% due to rounding*).

	Share of units 2020 (%)			**Share of beds 2019 (%)**
	Denmark N=1090	Finland N= 778	Sweden N=501	Norway N=1702
For-profit companies	22	83	78	45
Non-profit organisations	46	8	3	22
Public sector	32	10	20	34

The development of residential care markets in the different countries

Having established some of the differences and similarities in terms of market shares of different providers in the countries, we will now turn to the development of the markets in the countries and the driving forces behind this development. As one noticeable difference between the countries is the position of non-profit organisations, this will be given specific attention in the descriptions below.

Denmark

Private providers have for a long time been important actors in the Danish field of residential care. Until the 1970s, the private RCUs were owned mainly by large non-profit/philanthropic organisations, which together with the public sector provided most of the residential care. Since the 1960 and 1970s, social pedagogy – i.e., professional activities that combine social and educational approaches (Timonen-Kallio & Hämäläinen, 2019) – has thrived in Denmark (Jakobsen, 2014). Facilities based on this approach – i.e., social pedagogical homes (many of which are small-scale non-profit units) – emerged as an alternative to the traditional institutions and still play an important role in the residential care market in Denmark (Bengtsson & Jakobsen, 2009; Egelund & Jakobsen, 2009).

In the Structural Reform of 2007, the autonomy of municipalities in Denmark was enhanced as the responsibility for and financing of the specialised social area was moved from regions to municipalities (Nørrelykke, Zeeberg & Ebsen, 2011). The reform aimed to introduce market-like mechanisms in all policy areas. In addition, the reform included implementing the Social Services Gateway (Tilbudsportalen), a website that stores information regarding all social services. The purpose of Tilbudsportalen is to ensure comparable and transparent information about all social services offered to the municipalities. Municipalities are only allowed to purchase social services listed at Tilbudsportalen.

The changes in child welfare continued with the "Child's reform" in 2011, which aimed to prioritise kinship or foster family placements rather than placements in institutions (Socialstyrelsen, 2011). Consequently, the share of children and young people being placed in residential care has gone from roughly two-thirds in 2011 to one-third in 2020.

In 2014, the supervision of residential care was reformed (Social- og Indenrigsministeriet, 2020). The Social Supervisory Authority, which includes five regional offices, was established to ensure uniform licensing and supervision of all social services. From this point, all RCUs had to be licensed through the supervisory authority to access Tilbudsportalen. There are additional regional framework agreements, but these are used mainly to support specialised institutions for specific needs and for secured institutions.

Non-profit organisations have always had a strong position in Denmark. From the late nineteenth century, philanthropic movements have been involved in child welfare services. Despite many changes on the policy level and the change following the Structural Reform of 2007, the non-profit organisations have kept their strong position in the market.

Finland

Until the 1980s, residential care in Finland was provided by a few large non-profit organisations together with municipalities and the state. At the end of the 1980s, the field started to change as partnerships between non-profit organisations and municipalities weakened and new actors entered the field. In 1988, the share of private producers was only 23%; by 2018, they accounted for about 80%. In the 1980–1990s many foster families changed their status to companies offering services such as professional family homes. In the 2000s, more private companies began offering foster and residential care services. In the 2010s, the pri-

vate service production became more centralised as large companies bought smaller units already operating (Porko et al., 2018). The situation on the market has constantly changed, and in 2020 the largest company owns nearly 40 care units.

Finnish administrative history has seen few sudden and major reforms. Rather, the changes have been gradual. A significant step towards market logics was taken in the 1980s as the old administrative system was deemed too complicated, centralised, and detailed. The reforms that took place between 1984 and 1995 focused on increasing municipal autonomy and deregulation. Municipalities were given freedom to purchase services from private producers. Also, the state subsidies system was reformed in the 1990s with the goal of increasing the incentives for municipalities to arrange services in a more economically efficient way. As Finland experienced an economic depression during the 1990s, the interest in new service-providing arrangements increased (Niemelä, 2008; Niemelä & Saarinen, 2008).

Finland's efforts to join the European Community was also a relevant factor in the development of the residential care market. In 1994, Finland passed its first Procurement Act to justify its fulfilment of obligations related to the European Economic Area. At that time, the government and the Ministry of Finance were strongly motivated to bring market mechanisms to the public sector. Finland's first Procurement Act was deliberately made comprehensive by national decisions. Social and health services were covered by the act entirely regardless of their purchase value (Särkelä, 2016).

The status of non-profit organisations as service producers in social and health significantly changed in the 1990s and 2000s, and the development towards corporations has been significant in child protection (Särkelä, 2016). In the Procurement Act of the 1990s, profit-seeking corporations were placed on the same level as non-profit organisations. According to Särkelä (2016), this was never a proclaimed goal of the decision-makers, but the role of the non-profit associations was not considered in the reforms. Some former non-profit organisations changed to corporations and many left the market altogether (Lindholm, 2016). The growth in numbers of for-profit units is also likely to have been influenced by the fact that professional family homes were mostly established as private limited companies rather than non-profit foundations or associations.

Another important driving force for the reduced position of non-profit organisations has been the changing status of the Finnish Slot Machine Association (RAY). This government-supervised and owned non-profit gambling association was essential for the funding of Finnish social and healthcare non-profit organisations, as the association has been considered to be part of Finnish "indirect" public administration through which funds from gambling were allocated to non-profit organisations in the social and healthcare sector (Myllymäki & Tetri, 2001). According to a law passed in 2001, public funds could only be given for activities that did not significantly distort market competition. This led to the association starting to withdraw from the financing of social and health services. As a result, the non-profit sector, which had been a traditional municipal partner, began to weaken (Särkelä, 2016).

Norway

Private non-profit organisations have been active in Norway's child welfare sector for decades. For-profit RCUs first entered the field in the 1980s, initially as collectives for substance users. The 1992 Child Welfare Act omitted the obligation to license RCUs, a condition specified in the 1953 Act. Allowing private for-profit companies into the market was supposed to create healthy competition and greater variation in available places, the same

arguments used for privatisation of other sectors. As a result of the reform, many small and large private initiatives found an opening in the child welfare market. Although they were not licensed, all private RCUs had to be part of a county's plans for institutions in order to be used, but over time this was not considered sufficient. When the state took over responsibility for the institutions from the counties in 2004, licensing of private providers was again made mandatory (Backe-Hansen et al., 2011).

The state taking over responsibility for the provision of residential care was part of the centralisation of specialised child welfare interventions. It created the basis for establishing the Directorate of Children, Young People, and Families (Bufdir) and defined five regions instead of 19 counties as the operative level. Oslo remained outside of this system. During the first few years of its existence, the Directorate and the regions were primarily responsible for operating the RCUs. Now, Bufdir's responsibility has increased as it is also responsible for developing routines, standardised procedures, and overall planning of the institutional sector, including procedures for licensing and monitoring.

Several important trends seem to have driven Norway's development of child welfare over recent decades (Backe-Hansen et al., 2011; Grünfeld et al., 2020; Melby et al., 2020), many of which are similar to those of other countries. In the 1990s there was a more or less ideologically-based drive to invite for-profit actors to provide child welfare services, especially residential care. The desire to reduce expenditure for residential care reduced the number of publicly owned RCUs, which had higher staffing costs than the privately owned RCUs. Coupled with the wish to reduce expenditures, a view of residential care as a "last resort" became predominant, systematically reducing available places since 2004.

The obligation to ensure equal possibilities for competition through public procurement regulations (EEA regulations) was also important in the development of the Norwegian field of residential care. The procurement procedure is seen as a bureaucratic and complicated procedure prioritising larger companies because of the infrastructure needed, so many smaller units have disappeared or been bought by larger companies such as Stendi (formerly Aleris). However, unlike the other countries, Norway has taken measures to increase the rate of non-profit places. Such organisations now have their own negotiations with Bufdir, which allocates a number of guaranteed places to the institutions (see FOR-2016-08-12-974). The negotiations take place approximately every two years, with the option to prolong the contract. In addition, institutions negotiate directly with regions or even some municipalities.

Oslo chose to remain outside the central system; Oslo's 15 boroughs were given full economic responsibility for using institutions. When a placement is required, the boroughs contact the central unit responsible for public institutions (Barne- og familieetaten, BFE) as well as private providers. At the same time, the central unit is responsible for licensing and approving institutions.

Sweden

In Sweden, the field of residential care has gone from being dominated by the public sector in the 1980s to being dominated by for-profit companies in later years. This development has gone through different phases. In the 1980s, political decisions opened the market for new actors and substantial deregulation took place. As in the other countries, the motives included enabling innovation and diversity and coming to terms with inflexibility and ineffectiveness (Lindqvist, 2014). During the first decade, most of the new businesses that entered the market were small and often owned by former foster parents or former employees in the public child welfare sector. By the end of the 1980s, close to half of the total num-

ber of beds were operated by such private owners. Another important driving force was changes in the financing of residential care; in the 1990s, financing of residential care was moved from the state and regional level to the municipalities. Market principles such as outsourcing were promoted (Government Bill 1992/93:43), and when the public procurement act came into force, also in the 1990s, it changed incentives and opportunities for actors to enter the market. During this period, larger companies became increasingly more common, and the small family-like units became less competitive. This development continued into the 2000s (Meagher et al., 2016).

Large for-profit providers that had been in operation in other parts of the welfare system (e.g., elderly care) now turned their eyes to residential care for children and youth – "[a] well-funded lightly regulated service with profitable business opportunities'" (a.a. p. 14). Since the beginning of the new millennium, the most noteworthy change in the Swedish field of residential care has perhaps been the expansion of such large for-profit providers (care corporations) (Lundström et al., 2020).

When the field of residential care in Sweden was opened up to new providers, the policymakers' intention was not to hand the market over to private providers; neither did they foresee this development. Rather, the policymakers intended that private businesses would complement, not replace, public providers (Meagher et al., 2016). Nevertheless, that was what happened. For the municipalities, this development meant that in many cases it become easier and cheaper to purchase services than to provide them in-house, especially when demands for specialised treatment became more common. Moreover, smaller municipalities may find it difficult to accommodate the needs of varied treatment approaches.

One striking difference between the countries is the position of non-profit organisations, especially when Sweden is compared to Denmark. In the 1930s, non-profits had a strong position in Swedish residential care, and their diminishing role must be understood with respect to modernisation connected to the emergence and development of the welfare state beginning in the 1940s. Small non-profit units that could not live up to standards went out of business. Therefore, when the field was opened up in the 1980s, non-profits had a weak position and "the rules of the game" were constructed to benefit private companies rather than non-profit organisations. For example, the legislation on procurement tends to favour price rather than the added value that non-profits (at least in theory) might add (e.g. catering for minority groups and being driven by other incentives than for-profit companies) (Lundström & Wijkström, 2012).

Discussion

In this article, we set out to compare the market shares of different providers of residential care for children and youth in Denmark, Finland, Norway, and Sweden and to explore the driving forces that may underlie the diverging paths in these countries. The comparison has outlined similarities as well as differences between the countries.

As a background to the understanding of the residential care field, it is of relevance to consider some features of the countries' OHC arrangements. In all Nordic countries, foster care is the preferred choice of placement. However, there are considerable differences in the proportion of children placed in the different placement forms, which naturally affect the size of the residential care market. In this sense, it appears that Norway is on one end of the spectrum (with its comparatively small share of children placed in residential care) and Finland is on the other.

Clearly, the reforms in line with the NPM movement – i.e., increased outsourcing of welfare services – have been a driving force in the forming of residential care markets in all the countries. However, our findings show that there are substantial differences between the countries in terms of level of privatisation and share of different types of providers. In Finland and Sweden, the for-profit sector has been growing since the 1980s and today dominates the field. Although Norway also opened up the residential care market to for-profit providers in the 1980s, Norway's public and non-profit sectors have retained a reasonably strong hold. In Denmark, as the growth of for-profit companies has been slower, for-profit providers still have a marginal role and non-profit providers maintain their strong position.

In Finland, Norway, and Sweden, the major driving forces for privatisation were the deregulations during the 1980s and 1990s, which opened the field to private providers. These regulations were meant to encourage innovation in treatment approaches and cost-effectiveness through competition. The goal was not to hand the services over to the for-profit sector, although this was the result, particularly in Finland and Sweden. Parallel to deregulation, Sweden and Finland decentralised the financing of services (i.e. from the state to the local level). Denmark did not go through the same changes in the 1980s and 1990s, as private actors were an important part of the Danish market already at this stage, although largely in the form of non-profit actors. As for decentralisation in terms of financing (from a regional to municipal level), this took place in 2007 in Denmark. In Norway, the development took a different direction when funding of residential care was centralised in 2004.

There are notable differences with respect to the role of non-profits in the countries. Both Denmark and Norway have a strong representation of non-profit providers. A reasonable assumption for this is that history matters or, put differently, that path dependence is of significance. Both countries have a strong and long-lasting tradition of using non-profits, either rooted in social pedagogy or in traditional philanthropy, and these types of organisations still play a significant role. In comparative studies focusing on other welfare areas (child and elderly care), similar tendencies have been noted, and the differences in the role of providers have been suggested as partly rooted in the developments after World War II (Sivesind, 2017). At this time, Sweden prioritised public provision of welfare services, whereas Denmark was more open for alternative (non-profit) arrangements. By the 1980s, Sweden had developed a large public sector which became a target for critique focusing on ineffectiveness and bureaucratization. In the privatisation process that followed, many for-profit companies entered the welfare markets. Unlike in Denmark, where the non-profit sector already was considered a viable alternative to the public sector, the non-profit sector in Sweden did not have a foothold and was not able to withstand the competition from for-profit organisations, nor to muster much political support. Norway also opened up to for-profit providers in the 1980s but experienced less need to cut costs by outsourcing, and there were also strong protests against privatisation by e.g. Norwegian unions (a.a.). As noted, Norway is the only Nordic country that has attempted to strengthen the position of non-profits by giving them priority in the procurement processes. In Finland, the diminishing private non-profit producers paved the way into the market for private producers.

One of the most important changes in the residential care market during the 2010s has been the establishment of large companies in the field of residential care. Multinational companies with businesses in other care areas in Finland, Norway and Sweden – e.g. Humana, Ambea, and Aleris – have gained a foothold in the field of residential care mainly by acquiring smaller units. Many of these corporations originate from Sweden, probably

partly as a result of the country's favourable conditions for (large) for-profit companies. For example, large corporations seem to have benefited in the procurement processes (Pålsson & Shanks, 2020), which may be one reason for their growth in both Finland and Sweden, countries that apply rigorous procurement regulations on residential care services. As noted above, Norway has for this very reason taken measures to prioritise non-profits in procurement processes. How Denmark's "Tilbudsportalen" affects the market share of large companies is unknown, although corporations have so far been less successful in Denmark.

As noted, the markets in Finland, Norway, and Sweden were established as a result of state decisions during the 1980s and 1990s. During the 2000s, more or less strong attempts to re-regulate the market can be observed in all Nordic countries, for example, in the form of the establishments of inspectorates that are responsible for licensing and inspecting residential care. The most obvious example, however, is Norway, which through Bufdir steers the market through the use of rules on establishment and which has set up targets for the share of non-profits. On the other end of the spectrum, we find Sweden and Finland with their relatively low-level requirements for entering the market and with their loyalty to the EU Public Procurement Directive.

Future research, limitations, and grey areas

To our knowledge, this article is the first attempt to map the Nordic markets of residential care for children and youth, an underexplored research field. We know that trends in the UK are similar to trends in Finland and Sweden (Jones, 2015), but overall there is little knowledge about international trends in child welfare. This stands in contrast to the knowledge about the impact of NPM on other welfare areas, which have been explored to a greater extent. One reason for the scarce knowledge regarding child welfare and particularly residential care is the residual character of such services. Interest in residential care seems to have reached the general debate and the political sphere only when scandals regarding the delivery of these services are publicized (e.g. occurrence of substance use, violence and suicide in the facilities).

As we see it, the organisation of child protection is important not only for children and families who need the services but also for social workers who provide it. Today, the market of residential care in the Nordic countries is fragmented, so it is difficult for stakeholders to get an overview. It is also a market in which the mechanism of "consumer choice" is limited, as is the user's possibility to change provider should they be unsatisfied with the care. Furthermore, there is an almost total lack of knowledge about the quality and effects of care given by different providers. Thus, we do not know what an optimal mix of providers is or even if the type of provider is related to the type of treatment provided or, most importantly, to quality of care. More research on the users' – in this case, the children's – possibilities to make their voices heard in these organisations, and on these markets, is needed.

While writing this article, it became obvious that there is a lack of commonly understood concepts and ways of reporting basic facts in this area. For example, the difference between for-profits and non-profits is not always clear-cut. However, and most importantly, there are grey areas when it comes to defining residential care, both in relation to (professional) foster care and in counting beds and units. Additionally, residential care assigned through child welfare services target somewhat different groups of children in the Nordic countries.

Despite conceptual and methodological difficulties, this crude analysis of residential care in the Nordic countries adds knowledge to the existing body of research on marketisa-

tion of welfare services. Most importantly, however, this analysis points to the importance of comparative research about an area involving far-reaching societal interventions in the family sphere.

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