

# Does educational inequality predict exercise of users' choice? Survey evidence from domiciliary care services among elderly in Oslo, Norway

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## Abstract

The traditional goal of equality in services remains at the heart of the Scandinavian welfare model; however, in recent decades, policymakers have also placed increased emphasis on user influence over services. *Voice* and *choice* are two channels to achieve this goal. The possibility to give feedback and voicing dissatisfaction to service providers (*voice*) is a well-established channel of service users' influence, however it is increasingly supplemented by user choice schemes (*choice*), where one can choose between different public and private service providers. We use the case of domiciliary care for the elderly to examine how the traditional goal of user equality is associated with the growing emphasis on user influence through voice and choice. The analyses are based on user surveys carried out by the municipality in the city of Oslo, which is arguably the only municipality in Norway where user choice plays a significant role in elderly care. Since the municipality subsidizes the private providers, individual economic resources should have less relevance. However, voicing dissatisfaction and choosing between different providers may anticipate cognitive resources that are not equally distributed among the users. The survey data indicate that there is an association between level of education and propensity to exploit all

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channels of user influence. Expanding user influence by introducing user choice thus confirms the differences between highly educated and less educated.

#### KEYWORDS

domiciliary care, inequality, Scandinavia, user influence, welfare

## 1 | INTRODUCTION

One of the main goals of Scandinavian welfare is for citizens from all walks of life to have access to services of high quality, and that their influence over public services therefore is critical for reaching this goal. This goal is well documented in historical analyses (Rothstein, 1998; Sejersted, 2005, p. 135), and is an explicit ambition for contemporary policymakers (St. Meld. 10 (2012)), p. 7; St. Meld. 34 (2012)), p. 52). Within the scholarly debates, the ability of welfare states to deliver equally to all social groups is regarded as a prerequisite in assessments of whether Scandinavian welfare can retain its universal features (Moberg, 2017; Szebehely & Meagher, 2018).

Due to the universal nature of services and the ambition that all citizens receive services guaranteed by the state, adaption to individual preferences has increasingly become a central complementary goal (Christensen & Pilling, 2019; St. Meld. 10 (2012), p. 50), especially for elderly care (Askheim, Christensen, Fluge, & Guldvik, 2017). One way to achieve this goal, is through increased involvement of service users (hereafter referred to as 'users'; St. Meld. 29 (2012), p. 12). This has traditionally been achieved by moving decision-making power and authority as close to the user as possible, and to grant citizens voice; legal rights that empower them to give feedback and voice dissatisfaction in their relations with public employees (Andersen & Hoff, 2001; Andersen & Rossteutscher, 2007; Hernes, 1988). Some degree of decision-making power has also been given directly to the institutions and in the interactions between staff and users (Helse- og omsorgsdepartementet, 2015, pp. 10–11).

However, over the last couple of decades, this strategy has increasingly been seen as unsatisfactory in providing sufficient user influence of services. One critique is that users should have more influence. Another important critique, however, is that not all users are capable of or have the resources to voice dissatisfaction and that this channel of influence benefits highly educated users with good health and strong networks (Christensen & Pilling, 2019). This has prompted policymakers in Scandinavia to enact new means to increase user influence. One strategy has been to open up to private providers, combined with free user choice of service provider (Meagher & Szebehely, 2013). The typical approach is to maintain tight public regulation and to more or less fully finance services, with the proviso that public and private providers are allowed to compete in a quasi-market (Sivesind & Trætteberg, 2017).

Thus, broadly speaking, today, there are two channels of user influence: (a) influencing existing services through giving feedback and voicing dissatisfaction (voice) and (b) changing service provider (choice). Since the local municipality subsidizes private providers, this context is designed to limit the impact of economic inequality among users and is consequently ideal for a study of the role of nonfinancial individual resources. Exercising voice and choice demand the ability to gather and process information and formulate reasoned preferences (Greve, 2009, p. 549). Such cognitive skills vary between citizens and is a possible source for inequality that it is vital to examine. In this article, we examine the impact of individual nonfinancial resources on both channels of user influence among users of domiciliary care services in Oslo, Norway. More specifically, we study the relationship between users' level of education and their ability to influence domiciliary care services through the two channels of user influence.

## 2 | USER INFLUENCE IN SCANDINAVIAN WELFARE

When citizens are dependent on state-guaranteed services, concerns of empowerment are raised in the context of the ability of citizens to maintain control of their lives when they use services (Blomqvist & Rothstein, 2008). Even when dependent on welfare services, a more demanding, educated, and individualistic population has shaped the 'demand for more autonomy and choice: for the ability to shape one's own life, to be recognised as an independent person rather than a dependent subject' (Newman & Tonkens, 2011, p. 10). The answer to the arguably conflicting goal of social equality and individual emancipation was to render control to the citizen through the expansion of user influence.

User influence is a much used concept in research and policymaking, but there is no uniform definition and the term is sometimes used interchangeably with 'user participation' and 'user involvement' (Christensen & Pilling, 2019, p. 45). User influence is sometimes grounded in the social rights of citizens and their ability to voice concern and preferences to the state that guarantees the services (Dent & Majda, 2015; Hirschman, 1970; Marshall, 1950). A later approach is related to the development of New Public Management and the understanding of users as consumers that operate in a 'market' with different providers, where choice is regarded as an intrinsic good as users choose to their preferences and in doing this give market signals to providers (Clarke, Newman, Vidler, et al., 2007; Fotaki, 2011; le Grand, 2007). What is shared in the different perspectives is the aim of understanding the nature and level of influence that users can exercise when they use services. This includes influence over the content of the service and thus ability to adapt it to individual preferences. In this context, user influence is understood through two main components: empowerment within the relations with a provider and user choice between providers (Trætteberg, 2017).

The goal of expanding individual influence over services is a broad trend in European welfare (Newman & Tonkens, 2011). This trend is partly framed as an emancipation of individuals from their dependence on public services and, by extension, public bureaucrats, and in other contexts, it is cast as a duty on behalf of the individual to assume responsibility for quality monitoring and creating functioning quasi-markets (Verhoeven & Tonkens, 2013). Systematic differences in terms of the ability to exploit user influence suggest that introducing new tools for user influence implies increased individual freedom and control for some, with others unable to exploit the potential for freedom and control over services. In turn, this can lead to services being organized mainly in accordance with the preferences of the most resourceful citizens and may be interpreted as a failure of the market in distributing services fairly. One visible example of such a market failure is the tendency of private providers to establish themselves in high-income neighbourhoods, limiting the possibility of choosing alternative service providers in less resourceful neighbourhoods (Gustafsson, Sörlin, & Vlachos, 2016).

In this article, we examine nonfinancial social inequality in user influence. In Scandinavia, public financing—even of private providers of welfare—is a cornerstone of the welfare arrangement (Sivesind, 2017). Economic inequality is thus less relevant than in welfare models where public responsibility for care for the elderly is dependent on the ability to pay for oneself, like in England (Baxter, Heavey, & Birks, 2019). When it comes to changing provider, this is a form of exercising influence that involves switching costs, including non-monetary expenses that a citizen has to endure when changing providers (Burnham, Frels, & Mahajan, 2003). The higher the switching costs, the more difficult it becomes for citizens to exercise choice. Switching costs consist of economic risk, evaluation, learning, and setup costs, and primarily involve the expenditure of time and effort. These switching costs are higher for less educated (Tummers, Jilke, & van de Walle, 2014). Educational attainment may thus be an important determinant for the ability to influence services, as users with higher levels of cognitive resources are likely to fare better in finding relevant information about care and make informed choices (Baxter et al., 2019; Corrigan, 2005; Rogers & Mead, 2004).

We have limited knowledge of whether educational inequalities predict users' abilities to influence services. Thus, in the empirical section, we study the relationship between educational attainment and both mechanisms of user influence: (a) voicing dissatisfaction and (b) changing provider. More importantly, however, we study the

relationship between the two channels and ask whether educational inequalities in user influence increases or decreases when user influence involves both voice and choice.

## 2.1 | Voice and choice: Two channels of user influence

The traditional form of user influence in the Scandinavian context is empowerment within the user-provider relation, that is, the right to voice opinions and dissatisfaction regarding the service. The formulation of citizens' rights in tandem with the expansion of the welfare state meant that individuals were not forced to beg for core services and could demand them with some degree of authority (Sejersted, 2005, p. 135). Earlier studies have suggested that Scandinavian countries have empowered users of public services (Andersen & Rossteutscher, 2007; Hernes, 1988), largely through collective user influence schemes, such as user boards.

More recently, this approach has been supplemented by more individual forms of user involvement, as individual voice has become a more prominent form of user influence—in addition to user choice schemes that have enabled for-profit providers to gain market shares at the expense of the public sector (Sivesind, 2017). Voice can take a number of different forms, for example, requests voiced in regular meetings with care staff and formal letters or other forms of communication with the provider or municipality. Increased emphasis on individual user influence on services has led some critics to argue that elderly care is increasingly based on the belief that the 'elderly shall themselves provide for their nursing and care needs based on the resources they possess' (Christensen & Fluge, 2016, p. 275, our translation). Empirical studies have shown that education is an important factor in explaining variation in users' ability to exploit user involvement schemes in health and social care (Ocloo & Matthews, 2016) and in explaining why individuals take steps to generate change in their everyday lives more generally (Kiesi & Westholm, 2007).

Inspired by Anglo-Saxon countries, Scandinavian welfare states introduced user choice as a second channel of user influence (Pollitt & Bouckaert, 2011). Theoretically, the introduction of user choice in welfare services is central to new public management reforms, with the establishment of quasi-markets that emulate private market dynamics (Friedman & Friedman, 1990; le Grand, 2007). User choice may also exist with only public providers and thus not entail any form of privatization as is seen for example in some school systems. This is, however, not the case in domiciliary care in any of the Scandinavian countries (Meagher & Szebehely, 2013).

As a channel of user influence, two of the goals of user choice reforms are worth highlighting (le Grand, 2007). First, the competitive element supposedly gives all providers incentives to improve their services, hence improving quality for all.

Second, the ability to select their own provider supposedly empowers users who can choose providers of their own liking and exit those with whom they are not satisfied (Hirschman, 1970). One motivation for introducing user choice in public services is to increase the possibilities for user influence, making it accessible to citizens with fewer resources. Indeed, empirical studies from Norway show that user empowerment is a central motivation for establishing user choice schemes (Deloitte, 2015, p. 14).

The overarching theoretical point is that in such a system, citizens decide the fate of the providers of welfare. In this way, they become empowered to "vote with their feet" in choosing a provider and do not influence public services only through their voice or at the ballot box (Warren, 2011).

## 2.2 | Conditions for user choice

As we saw earlier, the expansion of individual users' influence has been criticized for shifting responsibility for the content of services from the provider to the user, which may benefit social groups that are more likely to articulate and demand preferences. User choice has the potential to expand user influence for all, but for user choice to play

such a role, certain conditions need to be fulfilled, most centrally, the issue of information (le Grand & Bartlett, 1993). Users need to know about their right to choose, how to change provider, and what alternative providers can offer. Empirical studies from Sweden suggest that quality shortfalls in the content and delivery of information inhibit users' ability to make informed choices based on neutral information (Moberg, Blomqvist, & Winblad, 2016, pp. 284–285).

Studies have shown that due to their health situation, many elderly are unable to reap the benefits of choice opportunities and that those most in need of exercising choice are least able to do so (Meinow, Parker, & Thorslund, 2011). Furthermore, even when disregarding the current health situation, users have different levels of prior resources. Higher educated users may be better at arguing for change, exploiting user choice, and generally working the system (Baxter, Glendinning, & Clarke, 2008; Winblad, Isaksson, & Bergman, 2012).

### 3 | CASE DESCRIPTION

Domiciliary care in Oslo is an ideal case in which to examine the relationship between user influence and non-financial individual resources. A key obstacle to user choice is the major transaction costs that inhibit users' choices in many core welfare services. Changing the service provider of kindergartens, schools, or nursing homes for the elderly involves a disruptive change. In practice, the social costs involved often make the change unpalatable. However, in domiciliary care, contact with the provider is often only a few hours a week, and in many cases, users are in contact with multiple care workers, which makes a change from one provider to another less burdensome. This may be why, across countries, domiciliary care is a welfare area in which private providers typically play an important role (Meagher & Szebehely, 2013).

Furthermore, the city of Oslo has expended considerable efforts in making user choice available to all citizens, regardless of individual resources. In Norway, as well as in other Scandinavian countries, domiciliary care is a municipal service, with considerable decision-making power left to local authorities. Oslo, the biggest city and capital of Norway, was an early champion of user choice and probably has the most established regime for user choice. Whereas only 9 % of the municipalities in Norway offer domiciliary care services delivered by private providers (Monkerud, Indset, Stokstad, & Klausen, 2016, p. 149), in Oslo, about 30% of users receive practical home-based help from private providers, while 15% receive health services provided by nurses working in private companies.<sup>1</sup> The private providers are predominantly for-profit and the users of nonprofit providers constitute a very small share of the market in this particular area.

In Oslo, users of domiciliary care services are by default offered a public provider, operated by the municipality. However, users can easily opt out of the public option and choose between a number of private providers, albeit financed by the municipality. Domiciliary care consists of two types of services: nursing, which is provided by professional nurses and considered a health service, and practical assistance, which does not require professional nurses and consists of practical help in the everyday life of users. Whereas nursing is free of charge, the municipality charges users per hour of practical help, depending on the user's income. In all cases, the rates are heavily subsidized, and the municipality charges the same fee irrespective of whether the provider is public or private. To gain access to services, a citizen must apply to the municipality, which will then grant a certain number of hours per week. The citizen can then choose a provider based on readily available information, published on the internet and in written form. Users can change provider by telephone, internet, and mail. Services are mainly offered to the elderly, but there is also a small percentage of under-67-year olds with complex care needs who receive services.

### 4 | DATA AND METHOD

In order to study user influence among users of domiciliary care services, we relied on a user satisfaction survey carried out by the city of Oslo in 2017. The survey included a long list of items measuring satisfaction with different

aspects of the services as well as important background questions. We were also allowed to include some items measuring empowerment and the respondents' highest level of education. A total of 4,757 users participated in the survey, achieving a response rate of 43%. Among the respondents, 27% only received nursing care, 41% only received practical assistance, while 30% received both nursing care and practical assistance. Two percent of the users received "other services." With little information about these other services, we omitted these users from the sample, ending up with a final sample of 4,644 users.

## 4.1 | Dependent variables

We used two dummy variables to measure user influence: "Voiced dissatisfaction" and "Changed to private provider." About 36% of the users had voiced dissatisfaction (Table 1) in one form or another ("Have you voiced dissatisfaction to an employee or manager with the service you receive?" [Yes/No]). This is a measure of the traditional form of user influence in Nordic welfare states (*voice*), whereby users can give feedback and have influence on services. The second variable measures user *choice* and represents the next level of user influence. The default option of domiciliary care are public providers. Thus, the use of a private provider means that a user has actively changed provider. About 28% of users had opted out and changed to a private provider. Unfortunately, the data set does not include information of how often users have changed provider, or whether they have changed back to a public provider.

## 4.2 | Independent variables

The main independent variable was users' highest level of education. The variable distinguished between basic school/unspecified (reference category), high school, and university/college. The sample was split in almost three equal-sized parts, with one-third having basic school/unspecified as their highest level of education, one-third having finished high school, and one-third having attained higher education university or college qualifications (Table 1).

In order to study whether educational inequalities in user influence increases or reduces when user influence involves both voice and choice, in the final model, we included voicing dissatisfaction and its interaction with education as independent variables.

## 4.3 | Control variables

In studying users of domiciliary care, we can encounter serious challenges of self-selection; for example, exploiting the possibilities of user influence may be correlated with several factors, such as the users' physical health and medical condition as well as the available assistance and resources from friends and family. Thus, in the analyses, we controlled for a range of possible confounders, mainly based on information registered by the municipality: the users' age, gender, type of home service (nursing, practical assistance, both), hours of care per week, and area of residence. Furthermore, we controlled for scores on activities of daily living (ADL), which is a registration of a user's dependence on care services. Based on separate scorings on hearing, vision, and memory, the users were categorized under "independent," "need for supervision," "need for limited assistance," "need for extensive assistance," or "total dependence." Finally, we controlled for a set of self-reported variables related to satisfaction with life and network: whether the users were feeling lonely (negative responses to the item: "When I feel like it, I usually have someone to be with"), their resource network (whether they received additional help from friends or family), and general satisfaction with life (missing values recoded to the mean score).

**TABLE 1** Descriptive statistics

	Obs.	Mean	SD	Min	Max
Voiced dissatisfaction	4,644	0.357	-	0	1
Changed to private provider	4,644	0.278	-	0	1
Highest level of education					
Basic school/unspecified	4,644	0.338	-	0	1
High school	4,644	0.340	-	0	1
University/college	4,644	0.321	-	0	1
Service					
Nursing	4,644	0.279	-	0	1
Practical assistance	4,644	0.416	-	0	1
Nursing and practical assistance	4,644	0.305	-	0	1
Gender (women = 1)	4,644	0.689	-	0	1
Age					
<67 years	4,644	0.158	-	0	1
67–79 years (ref = <67 years)	4,644	0.263	-	0	1
80–90 years (ref = <67 years)	4,644	0.432	-	0	1
90 years + (ref = <67 years)	4,644	0.147	-	0	1
Hours of nursing/practical assistance per week					
0–1/0–5 hr	4,644	0.177	-	0	1
1–3.99/0.5–0.99 hr	4,644	0.495	-	0	1
4–5.99/1–1.99 hr	4,644	0.190	-	0	1
6–9.99/2–4.99 hr	4,644	0.081	-	0	1
10+/5+ hr	4,644	0.058	-	0	1
Feel lonely	4,644	0.188	-	0	1
Resource network (help from friends/family)	4,644	0.066	-	0	1
Life satisfaction	4,644	3.683	1.083	1	5
ADL (hearing)					
No problem/not relevant	4,644	0.650	-	0	1
Supervision	4,644	0.242	-	0	1
Limited assistance	4,644	0.086	-	0	1
Extensive assistance	4,644	0.018	-	0	1
Total dependence	4,644	0.004	-	0	1
ADL (vision)					
No problem/not relevant	4,644	0.523	-	0	1
Supervision	4,644	0.387	-	0	1
Limited assistance	4,644	0.058	-	0	1
Extensive assistance	4,644	0.029	-	0	1
Total dependence	4,644	0.003	-	0	1
ADL (memory)					
No problem/not relevant	4,644	0.631	-	0	1
Supervision	4,644	0.216	-	0	1

(Continues)

**TABLE 1** (Continued)

	Obs.	Mean	SD	Min	Max
Limited assistance	4,644	0.123	-	0	1
Extensive assistance	4,644	0.030	-	0	1
Total dependence	4,644	0.000	-	0	1
Assistance when filling out questionnaire					
No assistance	4,644	0.755	-	0	1
Assistance from next of kin/others	4,644	0.179	-	0	1
Filled out by next of kin/others	4,644	0.049	-	0	1
Assistance from employees	4,644	0.017	-	0	1
Residence					
Outer east	4,644	0.228	-	0	1
North	4,644	0.143	-	0	1
Inner west	4,644	0.120	-	0	1
Inner east	4,644	0.154	-	0	1
East	4,644	0.226	-	0	1
Outer west	4,644	0.129	-	0	1

Unfortunately, the survey contained no information of how (and whether) users retrieved information about the services and their right to change provider. The survey do enable us, however, to control for whether the user received help from friends or family when filling out the questionnaire.

Regarding the control variables, Table 1 shows that the majority of users (69%) were women, that the great bulk of them were elderly, that more than half were aged 80 or above, and that about half received relatively few hours of help per week. Very few users were registered as “totally dependent” on the ADL scores, which makes sense since the most dependent were probably living in nursing homes and not at home. The table also shows that few users received additional help from friends/family but that as many as 22% received assistance from next of kin/others when filling out the questionnaire.

Few of the independent variables were strongly correlated, suggesting that multicollinearity was not a major problem in the analyses (see Table A1). The highest correlation scores were between feeling lonely and life satisfaction ( $r = -0.39$ ), age and ADL (hearing) ( $r = 0.32$ ), and between ADL (hearing) and ADL (vision) ( $r = 0.31$ ). All other correlations were below 0.2.

## 5 | RESULTS

Table 2 summarizes the results from the logistic regression models of the relationship between educational attainment and exploiting the possibilities of user influence: voice dissatisfaction and change to a private provider. Model (i) only controlled for education and type of service, whereas Model (ii) added a long list of control variables (see description of the variables above). In the final Model (iii), we examined whether the two channels of user influence were related, and whether educational inequalities in user influence increased or decreased when considering both channels of influence (voice and choice). The complete tables with all the control variables are included in (Table A2).

The results in Table 2 indicate a strong relationship between educational attainment and user influence. First, users with a university or college degree were much more likely than those with a lower level of education to have voiced dissatisfaction or changed to a private provider. This relationship held when controlling for a host of relevant



**TABLE 2** Individual resources and user influence (logistic regression)

	Voiced dissatisfaction		Changed to private provider		
	(Model i)	(Model ii)	(Model i)	(Model ii)	(Model iii)
High school (ref = basic school)	0.113	0.142†	0.166*	0.122	-0.040
University/college (ref = basic school)	0.335***	0.274***	0.346***	0.308***	0.094
Voiced dissatisfaction					0.063
*High school (ref = basic school)					0.438*
*University/college (ref = basic school)					0.529**
Service (ref = nursing + home ass)					
Nursing	-0.115	0.081	-1.225***	-0.888***	-0.907***
Practical assistance	-0.293***	0.019	0.668***	0.820***	0.832***
Control variables	No	Yes	No	Yes	Yes
Constant	-0.583	-0.601	-1.194	-1.966	2.028
Adjusted r2	0.006	0.059	0.080	0.142	0.148
N	4,644	4,644	4,644	4,644	4,644

Note: Control variables: Gender, age, hours of care per week, feeling lonely, resource network, life satisfaction, ADL scores (hearing, vision, memory), assistance when filling out questionnaire, area of residence.

\*\*\* $p = .001$ ; \*\* $p = .01$ ; \* $p = .05$ , † $p = 0.1$ .

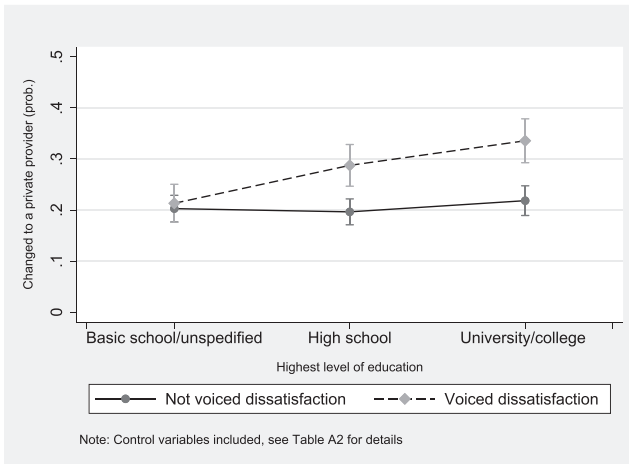
variables, including the users' health and resource networks. As such, the results seemed highly robust, suggesting that nonfinancial individual resources are an important predictor of whether users will exploit the two channels of user influence.

Second, and most importantly, the results suggest that the different mechanisms of user influence increase rather than reduce the impact of individual resources. In Model (iii), the interaction terms between voicing dissatisfaction and level of education strongly predicted the probability of having changed to a private provider. Thus, resourceful users were more likely to exploit the traditional channel of user influence (voice), and by doing this, they were even more likely to change to a private provider (choice).

Regarding differences between nursing and practical assistance, the interaction terms were strongest for those who only received practical assistance, followed by those who received both practical assistance and nursing. The interaction term was not statistically significant among those who *only* received nursing (results not shown). This is partly a reflection of private providers being more widespread among users of practical help compared to those receiving nursing (15 versus 30%). It may also relate to practical help being a more complex service with a (subsidized) fee paid by the user and more non-medical judgements about the content and quality of services. The more a service demanded in terms of articulating needs, paying a fee, and assessing quality, the more important individual resources seemed.

Considering other variables related to individual resources and user influence, the results in Table A2 suggest that having voiced dissatisfaction is negatively related to old age and positively related to having received assistance when filling out the questionnaire. However, controlling for a host of other factors none of these variables are related to having changed to a private provider.

The interaction effect from the full model is illustrated in Figure 1. The figure shows that among the least educated users, the probability of changing to a private provider did not increase if they also voiced dissatisfaction. As the level of education increased, however, the difference between those who voiced dissatisfaction and those who did not increased. Keeping all other variables at the mean level, among users with a high school qualification, the



**FIGURE 1** The interaction effect of education and voicing dissatisfaction on changing to a private provider (predicted probabilities; all other variables set to mean level)

**TABLE 3** Users' perceptions of and experiences with user influence by highest level of education (percent)

	I am included in deciding how the services I receive are carried out			My feedback was handled well <sup>a</sup>			The service improved after I voiced dissatisfaction <sup>a</sup>		
	Basic school	High school	Uni/college	Basic school	High school	Uni/college	Basic school	High school	Uni/college
Totally disagree	3.8	3.0	3.9	3.7	4.6	4.3	7.6	6.9	6.2
Somewhat disagree	7.4	9.5	7.7	6.9	7.3	8.9	8.8	10.0	12.7
Neither agree nor disagree	14.4	16.1	16.4	11.4	14.0	16.6	19.8	21.2	22.5
Somewhat agree	36.3	34.0	36.1	44.0	36.1	35.8	36.0	29.1	30.6
Totally agree	32.3	31.7	31.8	27.4	32.7	30.5	19.1	24.7	21.7
Do not know	5.8	5.7	4.1	6.7	5.4	3.8	8.6	8.1	6.2
n	1,469	1,505	1,450	493	523	583	486	519	581
$\chi^2$		0.114			0.029			0.104	

<sup>a</sup>Question asked only to respondents who had voiced dissatisfaction.

probability of switching to a private provider increased from 20% to 29% if they also had voiced dissatisfaction. For users with a university or college degree, the increase was even higher, from 22 to 34%.

A possible limitation of the results is that the dependent variables only measured user influence among presumably *dissatisfied* users. Satisfied and loyal users might have also influenced services through communication with a service provider. However, this limitation should not be problematic unless the highly educated users generally received worse services than the least educated users. In order to unravel such a possibility, we explored users' perceptions of and experiences with user influence and how the responses varied according to the users' highest level of education. Table 3 displays responses to three survey items measuring user influence: "I am included in deciding how the services I receive are carried out," "My feedback was handled well," and "The service improved after I voiced dissatisfaction."<sup>iii</sup> Only respondents who had voiced dissatisfaction (about 36% of the sample) answered the two latter questions. All three questions were answered using a 1 (Totally disagree) to 5 (Totally agree) scale.

The overall impression from Table 3 is that a majority of the users had positive perceptions of and experiences with user influence. About two of three users agreed (somewhat or totally) that they were included in deciding how the services were carried out. Only a little more than 10% disagreed (somewhat or totally), while the remainder either had no opinion or did not know. Among those who had voiced dissatisfaction with the service, the percentages are almost identical on the response to whether the feedback was handled well. The users were somewhat more critical of the final item, although more than 50% agreed that the service had improved after having voiced dissatisfaction.

Most importantly, however, the users' perceptions of and experiences with user influence were not strongly related to individual resources: the level of satisfaction did not vary significantly based on the users' highest level of education. This held both when we considered the item posed to all respondents and the two items posed only to respondents who had already voiced dissatisfaction. The variation in the second statement ('My feedback was handled well') was statistically significant, but substantial differences were limited: 66% of the most highly educated and 71% of the least highly educated agreed with the statement. Thus, the main findings in this article did not seem to be affected by bias in relation to the dependent variables.

## 6 | DISCUSSION

A majority of users of domiciliary care services in Oslo are satisfied with the possibility of influencing services. This is in line with earlier studies of Scandinavian welfare (Andersen & Rossteutscher, 2007). User influence is a core part of Scandinavian welfare models, and its ideological roots can be traced back to the beginning of the welfare state (Rothstein, 1998). Since the 1970s, user influence has been included in policy documents, arguably gaining importance from the 1990s onward (Askheim et al., 2017).

At the same time, the ideal is that all users, irrespective of individual or other resources, should be able to exploit all the possible channels of user influence. In the traditional public-sector-dominated Scandinavian welfare states, the main channel of user influence was *voice*: the ability to co-determine the content of services and to voice dissatisfaction. By introducing private providers and user *choice*, Scandinavian countries introduced a channel of user influence whereby users can 'vote with their feet.'

The results of this study suggest that the majority of users were satisfied with the possibilities of user influence, regardless of individual resources. In one way, it is a triumph for the model that the least educated were just as satisfied with their ability to obtain change as the most educated.

However, our findings clearly suggest that both voice and choice are related to nonfinancial individual resources. Highly educated users are more likely to voice dissatisfaction *and* to switch to a private provider. More importantly, however, considering voice and choice in relation seems to further increase the importance of educational attainment: Highly educated users are more likely to voice dissatisfaction, and by doing this, they are even more likely to change to a private provider. Unfortunately, our study does not inform us if users became more content with services after changing provider. This is an issue for further research.

Introducing new tools for empowering users confirms social inequalities in the ability to take control over services. The findings herein should be of interest to policymakers in terms of the nuances and possible tradeoffs they face when pursuing the route of expanding user influence through new channels and new service areas. Although this study is limited to domiciliary care for the elderly in Oslo, we believe that the relations between educational attainment and the ability to exploit user influence is also likely to feature in other contexts and in other service areas. Differences in conditions result in, for example, better information practices, and a more random geographical distribution of private providers may make user choice schemes more egalitarian than in our case; however, the fundamental link between educational attainment and the ability to exploit the possibilities of user influence are probably difficult to eliminate. As mentioned earlier, domiciliary care is a welfare service characterized by comparably small social costs when it comes to changing service provider. Thus, it is not unlikely to imagine that similar

mechanisms is at play in service areas where users have a deeper relation with the provider, such as nursing homes, schools, and kindergartens.

Regarding the ongoing debate on whether user choice schemes propel a consumerist development of public services, our results contribute with some nuances. A fundamental critic against user choice is that users are seen as responsible for the quality of the service they receive, as they can easily exit the service they do not enjoy (Rostgaard, 2011). In many cases this makes users disempowered, as 'difficulties in navigating the care system [leave] people feeling overwhelmed' (Baxter et al., 2019, p. 11). Our findings suggest, however, that by keeping a high quality public default option, users' need for continuity (Rostgaard, 2011) is covered as they can seek changes to services without fundamental disruptions. The continued dominance of the public provider may reduce the concern of transferring risks to groups without sufficient social capital (Stevens, Glendinning, Jacobs, et al., 2011, p. 272) and thus lessen the risk of exacerbating social inequalities. At the same time, unsatisfied users have a safety valve as they can exit the default option. The differences related to educational attainment suggest that availability of and ability to process information is a crucial factor in the functioning of user influence. Unfortunately, we do not have data on the information provided by the municipality and the providers and how the users perceive this information. Even if improved information access can reduce social inequalities, some studies suggest that this problem is hard to overcome (Baxter et al., 2019, p. 3).

In addition to being associated with a consumerist development, user choice in public services is also related to the citizenship role of the users. Indeed, studies have shown that the performance of governments in providing services is instrumental in obtaining legitimacy in government (Gustavsen, Røiseland, & Pierre, 2014; Rothstein, 2009). As increased use of market mechanisms and the use of non-public providers increase the distance from input to output in the democratic process, what happens in the meeting between user and provider gains importance as part of the democratic process (Warren, 2011). Our findings thus indicate that user choice schemes in elderly care may have implications for the democratic legitimacy of government. These implications pull in opposite directions as the overall satisfaction with the ability to influence possibly strengthens legitimacy among all users (Berg & Dahl, 2019). Simultaneously, the considerable differences based on educational attainment suggest that this exacerbates an inferior notion of control among individuals at the bottom of the ladder (Burchardt, Evans, & Holder, 2015, p. 62).

Furthermore, the results inform at least two ongoing scholarly debates about current developments in Scandinavian welfare.

First, Norway, together with other European countries, is part of a trend in which governments seek to give the elderly greater control of their own care and to include family, voluntary, and personal resources in covering the needs of the elderly (Christensen & Pilling, 2018, pp. 13–14). Using user influence to shift some of the responsibility for the burden of care from the government to the individual citizen has also been identified in various European care systems (Trætteberg, 2018; Verhoeven & Tonkens, 2013). Therefore, the increasing social cleavages involved in being in control of one's own life while also dependent on public services cannot be examined in isolation, but as an ingredient in a potential shift in European welfare.

Second, some of the core arguments for user choice are that provider competition propels providers to improve their services, as users have consumer power and can exit providers offering unsatisfactory services, and that giving user choice rights within public service provision increases equality, as all citizens gain access to user choice (le Grand, 2007). Our study shows how individual resources are related to consumer power and that the importance of individual resources may even increase if users are offered more channels of influence. If equality in services is a core value, there are two potential implications of this finding that merit further examination with more comprehensive data. First, quasi-markets in domiciliary care services are likely to function sub-optimally because there are important differences in the willingness and ability of citizens to act as informed, conscious users. Second, introducing more channels of user influence is likely to increase rather than reduce the importance of non-financial resources in user influence. Providers will have to adapt to the preferences of users with more non-financial resources such as ability to gather and process information and formulate reasoned preferences, while users with less resources will be less demanding and thus less likely to experience adaptation to their preferences. Ultimately, this may inhibit the

realization of the fundamental goal in Scandinavian welfare that equal quality and influence shall be granted all citizens unrelated to social background (Sivesind, Trætteberg, & Saglie, 2017).

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## CONFLICT OF INTEREST

No conflict of interest reported by the authors.

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## APPENDIX

TABLE A1 Pairwise correlations

	Voiced dis-satisfaction	Changed to private provider	Education	Gender (women = 1)	Age	Hours of nursing/practical assistance per week	Feel lonely	Resource network (help from friends/family)	Life satisfaction	ADL (hearing)	ADL (vision)	ADL (memory)
Voiced dis-sats	1											
Chng. priv provd	0.073***	1										
Education	0.061***	0.045**	1									
Gender (W = 1)	-0.026	0.152	-0.117***	1								
Age	-0.127***	0.063***	-0.116***	0.178***	1							
Hours per week	0.179***	0.106***	0.030*	0.022	0.054***	1						
Feel lonely	0.106***	0.027	0.012	0.016	-0.006	0.131***	1					
Resource netw.	0.032*	-0.026	0.057***	0.019	0.015	0.025	0.031*	1				
Life satisfaction	-0.103***	-0.020	0.016	0.013	0.094***	-0.078***	-0.387***	0.033*	1			
ADL (hearing)	-0.028	0.051***	-0.073***	0.016	0.317***	0.108***	0.036*	-0.011	0.001	1		
ADL (vision)	0.055***	0.064***	-0.010	0.036*	0.190***	0.145***	0.072***	0.018	-0.024	0.313***	1	
ADL (memory)	0.042**	-0.098***	-0.011	-0.080***	0.067***	0.251***	0.063***	0.010	-0.040**	0.189***	0.159***	1

\*\*\* $p < 0.001$ ; \*\* $p < 0.01$ ; \* $p < 0.05$ , † $p < 0.1$ .



**TABLE A2** Full regression models

	Voiced dissatisfaction		Changed to private provider		
	(Model i)	(Model ii)	(Model i)	(Model ii)	(Model iii)
High school (ref = basic school)	0.113	0.142†	0.166*	0.122	-0.040
University/college (ref = basic school)	0.335***	0.274***	0.346***	0.308***	0.094
Voiced dissatisfaction					0.063
*High school (ref = basic school)					0.438*
*University/college (ref = basic school)					0.529**
Service (ref = nursing + home ass)					
Nursing	-0.115	0.081	-1.225***	-0.888***	-0.907***
Practical assistance	-0.293***	0.019	0.668***	0.820***	0.832***
Women (ref = men)		0.011		0.538***	0.539***
67-79 years (ref = <67 years)		-0.097		-0.162	-0.149
80-90 years (ref = <67 years)		-0.581***		-0.035	0.036
90 years + (ref = <67 years)		-0.799***		0.079	0.166
Hours of nursing care/practical assistance per week (ref = 0.5 hrs.) <sup>a</sup>					
1-3.99/0.5-0.99 hr		0.322***		0.622***	0.604***
4-5.99/1-1.99 hr		0.667***		0.992***	0.945***
6-9.99/2-4.99 hr		0.972***		0.988***	0.916***
10+/5+ hr		1.320***		1.143***	1.022***
Feel lonely		0.287***		0.078	0.049
Social network (help from friends/family)		0.250*		-0.315*	-0.349*
Life satisfaction		-0.099**		-0.062†	-0.054
ADL (hearing) (ref = no problem/not relevant)					
Supervision		-0.013		0.091	0.094
Limited assistance		-0.164		0.164	0.172
Extensive assistance		-0.134		0.093	0.126
Total dependence		-0.021		1.271*	1.294*
ADL (vision)					
Supervision		0.136†		0.180*	0.170*
Limited assistance		0.270†		0.684***	0.667***
Extensive assistance		0.470*		0.251	0.200
Total dependence		0.768		-0.780	-0.893
ADL (memory)					
Supervision		0.021		-0.016	-0.020
Limited assistance		-0.244*		-0.293*	-0.265†
Extensive assistance		-0.176		-0.656*	-0.676*
Total dependence		-			
Assistance when filling out questionnaire (ref = no assistance)					

(Continues)

**TABLE A2** (Continued)

	Voiced dissatisfaction		Changed to private provider		
	(Model i)	(Model ii)	(Model i)	(Model ii)	(Model iii)
Assistance from next of kin/others		0.354***		-0.210†	-0.223*
Filled out by next of kin/others		0.673***		-0.124	-0.171
Assistance from employees		0.254		-0.523†	-0.543†
Residence (ref = outer east)					
North		-0.301**		-0.748***	-0.732***
Inner west		0.018		0.061	0.065
Inner east		-0.041		-0.991***	-1.004***
East		-0.095		-0.191†	-0.187†
Outer west		-0.136		0.380**	0.396***
Constant	-0.583	-0.601	-1.194	-1.966	-2.028
Adjusted r2	0.006	0.059	0.080	0.142	0.148
n	4,644	4,644	4,644	4,644	4,644

<sup>i</sup>The share of users choosing a private alternative varies considerably between the 15 city districts in Oslo, from eight to more than 50% of users, according to numbers gathered by the municipality.

<sup>ii</sup>The original question was worded as follows: 'Jeg er med å bestemme hvordan tjenestene jeg får skal utføres', 'Min tilbakemelding ble tatt i mot på en god måte' og 'Jeg har opplevd at tjenesten er blitt bedre etter at jeg meldte det fra'.

\*\*\* $p < 0.001$ ; \*\* $p < 0.01$ ; \* $p < 0.05$ , † $p < 0.1$ .