MUNICIPAL CONTROL OF EXTERNAL PROVIDERS WITHIN THE ELDERLY CARE

- An Example of Public Sector Outsourcing

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Abstract

Swedish municipalities are today using more and more non-public alternatives to provide public services for their citizens. One area where this is increasing is the area of elderly care. By utilizing some form of purchaser-provider model or a check system where the end users themselves choose a service provider, municipalities are de facto outsourcing the production of elderly care. A problem associated with this is how to control that the services produced externally live up to the demands set by the municipalities.

In my study I found that the main control mechanism is a contract which is usually combined with additional control mechanisms. These include surveys aimed at the end users, a form of inspection which according to research is not very appropriate for the area of elderly care. A more appropriate control mechanism could be a quality control system which is also recommended by the National Board of Health and Welfare. They are however very passive and at the moment not working to enforce tighter regulation within this area. The provider companies themselves are also working with the issue of quality control and are moving towards some form of quality certification. My study indicated significant differences between the municipalities that used external providers, but some form of standardization is likely to occur within this area.

Key words: Decentralization, elderly care, municipalities, outsourcing, public sector, purchaser-provider model
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1. Introduction

1.1 Background

Due to various reasons, Swedish municipalities are today using more and more non-public alternatives to provide public services for their citizens. The problems associated with this phenomenon are today becoming increasingly clear. Municipalities that have tested the use of private providers for services such as elderly care, have in recent years been plagued by a number of scandals. One of the more infamous, the so called ISS Care scandal in October 1997, occurred in Solna outside of Stockholm. Even though it was blown out of proportion by the media, it still revealed that politicians had poor knowledge of what was happening in their own municipality. All of the politicians that were responsible in this case claimed that they knew nothing of what was going on until they watched it on television (Idenstedt, 1997). The inspecting authorities later found the municipality responsible for causing the unsound conditions at the elderly home in question.

Scandals such as this one have exposed defects in the way control is exercised over the outsourced production of public services. Perhaps the complexity and importance of this control issue was not fully visible until the system was implemented. Or maybe the whole system is still new to the municipal employees and politicians, and the mistakes being made are all part of an initial learning process. Regardless of why mistakes have been made it is safe to say that the issue of how to control private providers is a difficult one.

The complexity of the problem consists of two things. Swedish municipalities have a legal responsibility for guaranteeing that certain services are...
provided to those citizens who are entitled to them. This also includes guaranteeing that those services are of a good standard. What this means is that the municipalities must have some way of insuring that the services produced for the citizens meet these demands. This is especially important when it comes to services that deal with people, such as health care. On the other hand, they want or need to put the production of certain public services in the hands of external producers, mainly private ones. This means handing over a certain amount of autonomy to the external producers if they are to be able to do things differently and hopefully better than the municipal organization. Furthermore, this also means that the responsibility for fulfilling political goals is to a large degree left in the hands of external producers. Producers over which the politicians can exercise very little direct power. This could be compared to the old municipal organization where the employees have to do exactly what the politicians want them to.

To summarize, the problem is basically that there is a need for retaining the control of vital public services at the same time as the detailed control over the final production of these services is put in the hands of external producers. Simply put, municipalities need to both keep control and give it up at the same time. Sounds like a bit of a dilemma, doesn’t it? Some might argue that municipalities never give up their control, but as I see it, by giving up their ability to use direct control, they are unquestionably giving up a certain amount of control. In any case, this demonstrates just how complex and difficult the issue of public outsourcing really is. Solving this control issue will be crucial for many Swedish municipalities if they are to maintain the control initiative for regulating the current welfare system. If the municipalities fail to come to terms with the control issue themselves, other forces may step in to fill the regulation void.
1.2 Problem

Politicians in many Swedish municipalities have in recent years decided to allow market based companies to enter the previously closed markets for public services. The politicians have various motives for doing this but they all have one thing in common; they wish to change something and they are using the private providers as a tool to create this change. However, by bringing in private alternatives they are also changing the way the municipal organization functions and indirectly creating a number of organizational problems that need to be solved. They are at the same time creating a new market, a market for publicly financed services which is often referred to as a quasi-market. This new market, like all markets, needs to have some form of regulation. This could be in the form of self-regulation by the municipalities that are creating the markets. It could also be in the form of regulations imposed by external forces such as the state.

In this thesis I am primarily interested in studying the first form of regulation, i.e. how the municipalities can regulate the markets they are creating. In addition to the question of regulation I also want to look at the broader picture and see what factors could lie behind the increased use of external providers. My main questions are therefore as follows: How can the increased use of external providers be understood? How can municipal control be exercised over external providers in order to ensure that the municipality lives up to its obligations towards its citizens? What does the academic theory say about this type of control problem and what have Swedish municipalities done in reality to deal with it?

In addition to this I want to explore the other forms of regulation which could become a possibility, either as a solution if self-regulation fails or as an addition to self-regulation. The questions I will be asking in this case are the following: What are the other possible forms of regulation for this type
of quasi-market? Is it possible to see any empirical evidence of alternative forms of regulation evolving within the elderly care sector?

The practical relevance of studying this problem should be quite obvious. The practitioners, the municipalities that want to use external providers, need more knowledge about how to deal with the complex issue of control.

From a theoretical standpoint, there have been some studies made within this area such as a British study made by Callis et al (1994). They studied the different means by which quasi-markets have been regulated in the U.K. In Sweden, researchers have been exploring the attempts that have been made to use quasi-markets in various municipalities. Among the more comprehensive ones is a study made by Rombach (1997) of the effects of introducing a quasi-market into one specific municipality. Even the Swedish Association for Local Authorities has recently made a study of several municipalities (Svenska Kommunförbundet, 1999). The Swedish National Board of Health and Welfare has made a study specifically focused on the use of the purchaser-provider model within the area of elderly care (Socialstyrelsen, 1995).

With the exception of the study by Callis et al, most of the studies have focused on the effects the implementation of a quasi-market system have had on the municipal organization as a whole. There have been discussions about the division of responsibility between different parts of the municipal organization, as well as the new role politicians should play in the new system (Rombach, 1997). The importance of control, or regulation as Challis et al refers to it, has in Sweden only been studied to a lesser extent so far. This means that there is a theoretical relevance for making further studies within this particular field and to build on the ideas that have been generated in previous studies.
1.3 Purpose

In short, the purpose of my thesis is twofold; to look at the various ways in which control over external providers is exercised today, and to show how this control may develop in the future. As far as the situation today is concerned, I want to show some concrete examples of what has been done in some Swedish municipalities that use external providers, and in addition to this briefly illustrate that other institutions could have a certain influence over the control issue. With the future aspect I want to show that the way control is exercised over external providers in the future, could depend on both the municipalities themselves as well as the role which other institutions choose to play.

1.4 Limitations

The questions I am asking could be answered by studying various quasi-markets within the municipal field. I have chosen to limit the study to just one specific area namely the care of the elderly. The reason for choosing this area is that it is a service that is concerned with producing services directly aimed at people, and it is the type of service that is generally associated with the need for certain quality standards. Since quality is very important, the need for a sufficient control system is equally important. The importance of a control system for this area also makes it a valid area to study. This also means that the control focus will be limited to control over quality. How control is carried out in regards to cost control is not studied in this thesis.
1.3.1 Definition of elderly care

In my definition of elderly care I include all the forms of care that are aimed at helping the elderly. This includes everything from domiciliary care (home care) to nursing homes and supported living facilities that are offered to the elderly. The reason for including all these areas is that they are usually handled together by the same department within a municipality. It is also not always clear where to draw the line between these areas since several of these services may be included in one contract with a provider. Another reason for including all areas in my study is that it provides me with a broader range of empirical material that will hopefully allow more conclusions to be drawn.

2. Method

I will in this chapter try to describe the various research methods I have used in the writing of this thesis. I will start with a short description of two commonly used research methods; positivism and hermeneutic. After that I will describe my chosen approach and some of the pros and cons that could be associated with it.

2.1 Positivism

Positivism dates back to philosophical discussions in Germany and Austria in the early 20th century (Wallén, 1993). The basic idea behind positivism is that a scientific hypothesis must be verified empirically before it can be considered true. Anything that could not be verified empirically, such as feelings, values, religious and political statements, did not belong within the scientific sphere. Another characteristic of positivism is that explanations should be expressed in causal terms. Within some sciences, such as biology,
there is also a wide use of reductionism. This means that the whole is understood through the study of separate parts. Another characteristic is that the researcher should be objective and not be influenced by non-scientific beliefs.

Another way of describing positivism could be to say that it is deductive. The process begins with abstract theories about the real world (Targama, 1998). These theories are then converted into a hypothesis which can be tested against empirical data gained through experiments or observations. The empirical data will either confirm or dismiss the initial theories. The opposite of a deductive method is an inductive method. This means that the process begins with empirical data of some sort which could be gained in the same way as data collected using a deductive approach, i.e. through experiments or observations. The empirical data is then interpreted and used to form abstract theories. In other words, an inductive researcher will try to build theories and models to explain what he has observed. The use of an inductive approach does not exclude the use of a deductive approach. The theories or theoretic models designed using an inductive method could later be tested using deductive research (see figure 2.1).

Figure 2.1 An inductive vs. a deductive research method.
Positivism is commonly used within such areas as natural science. The strongest critique against positivism is that the human being is seen as an object (Wallén, 1993). The principal of reductionism could lead to the loss of a greater holistic view. Positivism also excludes research about the meaning of feelings, experiences, and cultural phenomena which can not be objectively measured. Hermeneutic and systems theory are seen as the main alternatives to positivism. However, as Wallén (1993) points out, they are not really an alternative since they deal with different types of problems than positivism.

2.2 Hermeneutic

Hermeneutic has its’ roots in the interpretations of the Bible and other texts (Wallén, 1993). Hermeneutic can in a general sense be described as interpretation of texts, symbols, actions, experiences etc. The person who is making the interpretation has a preconceived understanding in the form of values and beliefs. The interpretation alternates between looking at an individual part and the whole. The interpretation also has to take into consideration the context in which a text was created. Historical texts such as the Bible are usually interpreted by looking at what the intentions of the author could have been and who it was originally aimed at. Interpretation often means looking at explanations that can be found behind that which can be observed in a text, a conversation, or actions. Hermeneutic is qualitative in nature, in comparison to positivism which is quantitative.

2.3 The chosen approach

My empirical research has been done in the form of case studies of four different Swedish municipalities. As a common denominator they are all based on the same questions. The advantage of using case studies is that one can get an understanding of what is happening in reality (Wallén, 1993).
Another advantage is that one can get a deep understanding of a certain process. A disadvantage with using case studies is that it is difficult to draw general conclusions. This could to a certain degree be avoided by doing a comparative study. Such a study could be done by comparing the specific case to an external reference objective, or to other cases in which the conditions could be different. The nature of each case can be very specific and this could affect the conclusions that that one draws from it. This means that the conditions associated with each case must be accounted for in detail. In my thesis I will compare the cases to each other and to an example of outsourcing within the private sector.

I had initially intended to study just one municipality, but my study was quickly augmented to incorporate three additional cases. This was done because I wanted a more extensive empirical base to work with, and to allow a comparison between different cases. The first municipality was selected after discussions with a personal contact I had in that particular municipality. The additional municipalities were selected from a list of municipalities which use private providers for 20 percent or more of their elderly care. The list was compiled and published by the magazine Kommun Aktuellt (Kommun Aktuellt, 1999). All of the chosen municipalities are located in the greater Stockholm area. The selection of municipalities was mainly based on a natural selection process; that is, I contacted a number of the municipalities that were listed by Kommun Aktuellt and the ones that had time to take part in my interviews were selected. This selection process could of course create an unwanted bias of some kind, but since I have managed to include municipalities of different size and with different political majorities I believe that the selection provides a good foundation for making comparisons between the different cases.

My four cases are all based on personal interviews with people in leading positions within the area of elderly care in each municipality. In one of the cases, I interviewed a politician who was the chairman of the political Board
that makes the political decisions regarding elderly care. In the other three cases, I interviewed the administrative managers that had the operative responsibility for purchasing services from external providers. During one of the interviews there were two managers from the same department present to answer my questions. The managers interviewed also supplied me with internal material such as bid specifications, operational plans, and even copies of actual contracts with providers. For reasons of anonymity these sources are not listed in the bibliography. They are however cited as sources in the various cases but only as a “municipal source” and not by their actual names.

The interviews were in the form of deep interviews. I basically used three main questions in each of the four interviews. These questions concerned the use of goals, the use of contracts with external providers, and the use of some form of check system. I gave each respondent the possibility to freely elaborate on my general questions without steering the conversation too much. Depending on what the respondents told me, I then posed new questions until each of my main questions had been explored in detail. The interviews were conducted in September and October 1999, and they each lasted for about one hour.

After having conducted all the interviews, I compiled the data into four different case descriptions which can be found in chapter 5. The four municipalities are presented as anonymous cases. The reason behind this is that my primary purpose is to see how different municipalities have worked with the use of providers - not to show deficiencies in the way some municipalities approach this issue. To avoid any controversy I have decided not to publish the names of the municipalities. My belief is that the names per se are not important, it is the conclusions that can be drawn from the cases that are important.
There were obvious differences between the four cases. I could have excluded some cases and only analyzed those that were similar to each other. However, I chose to include all the cases in my study and use their differences to illustrate the variations that can be found amongst municipalities that use external providers. The problem with having several different cases is that it is difficult to generalize in one direction or the other. On the other hand, it provides a broader picture of the research area and the different cases also provide a contrast to each other. This means that the empirical material can generate new theories, but they have to be tested through further research to provide more general conclusions. An analysis of all the cases is made in chapter 6.

In addition to the four cases, I also contacted people within other institutions such as the Swedish National Board of Health and Welfare to get empirical data about other regulating forces. This data was collected through the use of written questions. The results of this data are discussed in conjunction with the analysis of the four cases.

I would characterize my approach as being mainly hermeneutic. I am not primarily trying to prove a specific hypothesis but rather to explore a phenomenon and describe what I have observed. To a certain extent I am also being positivistic, in the sense that I have a theoretical framework and models that I base my research questions on. An example of this is the theory on control in a decentralized system which I try to test against the reality in the municipalities I study. However, my approach falls short of being positivistic since I do not actually formulate my research questions in the form of a hypothesis. Furthermore, as I stated earlier, the lack of empirical data and the differences between the cases makes it impossible to generalize and therefore it is not possible to prove a specific hypothesis in this case. Due to the relatively free nature of my deep interviews, the empirical data could also yield other interesting information not explicitly stated in a hypothesis. An example of this could be evidence of different
organizational behavior or other information that could fall outside of a specific hypothesis. Subsequently, a positivistic approach is not suitable in my case. Considering that my aim is to explore a certain phenomenon it is better to use the empirical data to describe the phenomenon studied and to try to give it meaning by relating it to a theoretical framework. This means using a hermeneutic approach where the collected data is interpreted and matched against certain preconceptions, instead of matching it against a previously formulated hypothesis. In this case the theoretical framework could be viewed as the preconceived understanding against which the empirical findings are interpreted.

2.4 Notes regarding the translation of Swedish terms

The public sector which is the focus of this thesis is associated with a number of specific Swedish terms which are difficult to translate directly into English. Regarding the names of Swedish institutions, I have used official translations where these have been available. I have also used a special dictionary by the Swedish Association of Local Authorities (Kommunförbundet, 1993), and an ordinary Swedish-English dictionary. In addition I have looked at the translations used in publications by official institutions such as the National Board of Health and Welfare. To clear up any misunderstandings, I included a list of the special terms and their translations as Appendix A.

3. Two perspectives for viewing organizational change

Elderly care is the area in which the use of external providers has increased the most during the 1990’s (Svenska Kommunförbundet, 1999). How can the trend of using external providers within elderly care be understood? Jacobsson (1994) argues that if we want to understand the changes within
the public sector, we need a broad theoretical frame. He points out two different perspectives that are needed in order to understand changes within an organization. I will build on his model in order to shed light on some of the underlying factors behind the use of external providers in municipalities as a whole and within the specific field of elderly care.

The first perspective is a rational way of looking at organizational change. Change is seen as something which is the result of either a conscious decision or an adaptation to environmental changes. The second is an institutional perspective in which the aim is to understand why certain organizational structures develop. The focus in this perspective is on non-rational factors rather than rational ones.

3.1 Change from a rational perspective

The rational way of looking at the use of private providers within the public sector would be to see them as the result of a political will. Politicians deliberately implement a market based model in order to achieve certain political objectives. For the right wing parties, such as the Conservative Party, the objective could be to break up public monopolies and reduce the public sector as a whole (Svenska Kommunförbundet, 1999). By breaking up public monopolies they would achieve the goal of allowing the consumer, the end users, to choose between different providers. This intention has been expressed by politicians in municipalities such as Nacka. Behind this also lies a belief that private companies are more efficient and can do things better than public organizations. This ideology leads to a desire to implement a system which allows the use of private providers.

However, this does not mean that a completely different ideology would not use the same competitive system. Even the left wing parties such as the Social Democrats could have reasons for choosing a market based model. In
In this case, the motive is not primarily to offer alternative choices but rather to achieve better cost efficiency, or to raise quality standards (Svenska Kommunförbundet, 1999).

In the case of cost efficiency, competition is often seen as something that can improve this. Therefore, if the aim is to get better value for the tax money, a market-based model could be seen as the tool to achieve this.

When it comes to increasing quality standards, alternatives are needed to allow benchmarking. If an organization has a monopoly, there is nothing to compare it against. Creating a competitive system could be a way to raise the standards since quality could be used as a means of creating a competitive advantage. Quality motives have been expressed as being an important factor behind the use of private providers in Malmö for instance (Svenska Kommunförbundet, 1999). Here the decision to use private providers could be seen as an attempt to consciously try to create a future state in which the service offered to the citizens would be of a higher quality.

Political decisions could, as previously mentioned, also be seen as the result of environmental pressures. Two big environmental factors as far as elderly care is concerned, could be bad municipal finances and demographic changes.

Financial difficulties have been stated as a primary motive for implementing organizational change in several municipalities (Montin, 1993). In the beginning of the 1990's, many municipalities were faced with a new economic reality following the financial crises in the Swedish society as a whole. Municipalities, for example Linköping and Norrköping (Montin, 1993), needed to make organizational changes in order to cope with a rising budget deficit. Financial difficulty is probably one of the factors that have affected all Swedish municipalities to a certain degree.
Demographic change means that the average life expectancy for Swedes has risen over the past century due to both a high degree of welfare and advances in modern medicine. This has led to an increase in the number of elderly citizens in society as a whole. The group of elderly who are over the age of 80 is expected to increase by 18 percent between the 1996 and 2005. The amount of elderly care needed will increase for the increasingly older population (Svenska Kommunförbundet, 1999). At the same time the amount of taxes that the municipalities have to work with will not increase. This means increased pressure on the existing resources to produce more for the same amount of money. In other words, there is a crucial need to improve the efficiency of publicly financed services. This external factor could put pressure on politicians to introduce a more cost efficient system in order to avoid a huge budget deficit and subsequent budget cuts. This factor is probably more influential in municipalities that are decreasing in population or in those that have a stable population.

Municipalities in some big city regions such as those around Stockholm, have had an increase in the number of residents in recent years. A good example of this is Case 2 which today has a lower average age of its' citizens compared to neighboring municipalities. In a municipality where the population is stable, it could be expected that the general trend of an increased share of senior citizens would apply. If the municipality is decreasing in population, that is to say young people are leaving the municipality and moving elsewhere, then the relative share of senior citizens will increase more rapidly than the general trend.

In any case, most municipalities are affected by the trend of an aging population. Many municipalities are probably also aware of this and the effect it will have on municipal finances.

In conclusion, the rational way of looking at the municipal changes is to see them as the result of strategic political decisions that are in some cases influenced by environmental factors. An example of an organizational
Theorist who represents this perspective is Mintzberg. He believes that an organizational structure is designed according to how it can best fulfill its task. He points out five basic structures that all organizations can be divided into (Mintzberg, 1993). Organizational change is seen simply as a transition between the various organizational structures as an organization develops.

3.2 Change from an institutional perspective

The institutional perspective aims to explain why certain organizational structures develop. This perspective is concerned with non-rational factors rather than rational. What is forgotten in the rational perspective is that a new organizational model is something that is usually introduced where an old model is already in place. An existing organization will have routines for how things are done based on old ways of working (Levitt & March, 1988 as stated by Jacobsson, 1994). These routines can become rooted in the organization, when the individuals within the organization become better and better at what they do. This can, according to Levitt and March, create a situation where organizations choose to keep their old routines, even though new and superior ways may exist. The routines will in a sense make decisions for the organizations. Such decisions are then neither the result of strategic thinking nor are they caused by environmental factors.

The way in which an organization is affected by change, whether induced by strategic decisions of environmental pressures, will be dependent upon the organization itself. A municipality is a public organization with elected politicians at the top of the hierarchy. In the traditional municipal organization, the politicians are used to giving directives to municipal employees. There is an employment relationship between employer and employee. The employer, here the politicians, can at any time change or give completely new directives for the work that should be done. There is no competition within the organization and very little experience of working within a
competitive environment. All of these characteristics that I just mentioned are affected by a decision to bring in external providers to compete with the municipal producers.

The relationship between politicians and an external party is of a contractual nature. This means that their assignment can only be regulated in the contract and at the time that the contract is being negotiated. In order for this not to be a problem, the politicians must first of all be aware of this difference that occurs when external providers are used. They must also be aware of the importance of making their directives clear in the contract and that these directives should be in the form of goals that give the providers some autonomy. It is difficult for them to change anything retroactively. Whether or not the politicians are aware of this change is something that will affect the outcome of the organizational change. The problem with politicians and their difficulty to adapt to a new role is described by researchers such as Rombach (1997).

Employees are also faced with a new situation if the organization changes towards using private providers. The division of the municipal organization into a purchasing and a providing part, could lead to sub-optimization if there are no real competitors. The employees may still view it as the same organization and not really see any difference. Those who are purchasers may not want to be tough in a negotiation with their former colleagues and therefore accept their bid if they have no other choices. In the case where there is competition, employees may be faced with the same problem as the politicians, i.e. how to formulate goals in a contract. This is especially true if the politicians have not been involved in the process and set certain goals for the employees to use.

The implementation of a market based model such as the purchaser-provider model, can, from an institutional perspective, be viewed as a form of isomorphism. Isomorphism can best be described as a process through which homogenization occurs. DiMaggio and Powell (1991) are two institu-
tionalists who have described three forms of isomorphism. One of these is mimetic isomorphism, that is creating an organizational structure by copying something that exists in another organization. In this case the municipalities are copying the structure used in the private sector and trying to implement it in a public organization. The use of the purchaser-provider model can also be viewed as a trend. In this perspective, organizational change can be seen as nothing more than an attempt to follow a current trend.

Another trend that could be viewed in the same way is decentralization. This has been a trend within Swedish municipalities since the middle of the 1980s (Montin, 1993). It followed a discussion about a lack of efficiency and too much detailed control by politicians, and it led to a delegation of power through the use of goals. Decentralization opened the door for such new ideas as the purchaser-provider model which became popular at the end of the 80s (Montin, 1993).

Decentralization is not the only political reform which has affected municipalities in recent years. One of the biggest political reforms of the 90s as far as municipalities are concerned, has been the Ädel reform. This reform was approved by the Swedish parliament in December 1990. The reform, which came into effect in January 1992, meant that the municipalities received the total responsibility for the care of the elderly (Socialstyrelsen, 1992). This included taking over responsibility for the primary care of elderly who no longer needed to be under the direct care of a doctor. In other words, if a doctor concluded that they were well enough not to need further treatment, they would be the responsibility of the municipality who would then have to pay for their continued stay in a hospital bed. This meant that the county council (Landsting in Swedish), no longer had the responsibility for providing nursing homes for the elderly. Ownership of nursing homes as well as 55000 employees working within the primary care, moved from the county council to the municipalities (Johansson, 1993).
To create an incentive for the municipalities to move patients from the primary care to nursing homes, a new fee of 1800 SEK per day was charged for elderly patients who stayed in a hospital bed after their treatment was finished (Johansson, 1993). This financial incentive made it cheaper for the municipalities to provide a bed in a nursing home than to leave the elderly in the hospitals.

A study by the Swedish Association for Local Authorities names the Ädel reform as one of the reasons for the increased use of private providers within the area of elderly care (Svenska Kommunförbundet, 1999). According to the study, the municipalities did not have the necessary resources to quickly fulfill the task on their own. As a result they could have been given a legitimate reason for adopting the already popular trend of using external providers. This is not something which is explicitly stated in any study, but it is a possible interpretation.

The difference between viewing organizational change as a trend, and viewing change as a rational phenomenon is distinctly clear. If the change is due to a trend, the result could be that the organization adopts a structure that is not very well suited for its’ specific conditions. In the second case, theorists such as Mintzberg argue that organizational structure is based on adapting to contingencies, i.e. the organization adapting to its environment. They are in fact two opposite perspectives for viewing organizational change. In my analysis of four Swedish municipalities, I will adopt an institutional approach because I believe it the best way to try to explain patterns of complex organizational behavior.
4. Decentralization and the purchaser-provider model

The purchaser-provider model is a form of decentralized system. It is also the most commonly used model when it comes to using external providers for the production of public services. In order to understand how the purchaser-provider model differs from a more traditional municipal organization, one must first understand the difference between a centralized and a decentralized system.

4.1 The difference between a centralized and a decentralized system

In a centralized system, control is exercised through the use of detailed operational rules (Engellau, 1982). The people in charge say exactly how things should be done. When a central system is decentralized it does not mean that control is simply given up or handed down to a lower level. It just means that the method of control changes. The detailed control of the centralized system is replaced by goals that state what should be done but not how this should be done. In short this means increasing the autonomy of the operational level by giving it the possibility to decide how the goals should be fulfilled (compare figure 4.1 and 4.2). The use of goals makes it necessary for the controlling level, or the strategic level as organizational theorists such as Mintzberg call it, to go out and check that the goals have been fulfilled. In other words there is a need for a control system that monitors the output (Engellau, 1982).
Figure 4.1 Control in a centralized system: In the centralized system the controlling level exercises control through detailed operational rules that state how things should be done. The operational level then carries out the directives exactly as they have been given without the possibility of doing things differently. (Source: Engellau, 1982)

Figure 4.2 Control in a decentralized system: In the decentralized system the controlling level sets goals that the operational level should fulfill. Control is exercised through a control system which checks to see that the actual outcome corresponds to the goals. (Source: Engellau, 1982)
To relate this general discussion about decentralization to the more specific situation in the municipalities that I wish to study, it can be said that municipalities that use external providers are a form of decentralized organization. The operational level is in this case the providers that have been contracted by the municipalities. The municipalities still wish to retain control over the services that are offered to their citizens so they will have to resort to an alternative control system based on goals and evaluations.

4.2 The purchaser-provider model

The purchaser-provider model has been used by some municipalities for the production of technical services since the early 1980s (Montin, 1993). However, when it comes to the more soft services such as health care, the model is a relatively new phenomenon for which there is no standard definition (Blomquist, 1994). This has meant that it has been given a different meaning in different municipalities. Some have seen it as an accounting system while others have seen it as a paradigm shift. There are examples of the model being used solely as an internal model as well as a model for taking in external providers.

One of the reasons for the different use of the model has been the different purposes for which it was introduced, according to a study done by Blomquist (1994). In one of the municipalities that she studied, the model was characterized as a management accounting system. When the model was first described to the employees of the municipality, it was done using illustrations of a balance sheet, a profit-loss statement, and cash flows. In another municipality, the model was used to fulfill ideological goals. The new political majority wanted to replace the old "outdated socialist model" with something new that could open up for competition and alternative choices.
Montin (1993) argues that there are three pillars on which the purchaser-provider model rests. The separation of politics and production, the creation of business-like conditions and competition, and the creation of a new role for politicians. Montin has found that the first two of these are discussed in most municipal documents concerning the use of a purchaser-provider model. The third pillar is often seen as an effect of the first two. For me it seems like the only real common denominator for all the various versions of the model is the division of the organization into a purchasing and a providing part, i.e. that which Montin refers to as a separation of politics and production. The creation of business-like conditions and competition is dependent on whether or not external providers are used and, as I stated earlier, this is not always the case. The third pillar is dependent on the role the politicians choose to take in the new system, and whether or not the politicians as well as the municipal employees understand this new role.

The definition of the purchaser-provider model in a study by the National Board of Health and Welfare (Socialstyrelsen, 1995) seems to focus on the common denominator I mentioned above. "With the purchaser-provider model it is meant that there are separate units for the purchasing and production within the municipality".

If we compare the purchaser-provider model to the general model of a decentralized system that I described above, it is clear that the model requires the politicians to take on a new role. They need to set goals and monitor that these goals are fulfilled rather than trying to control in detail how things are done. This means focusing on what should be purchased instead of how the purchaser should produce the service. This is especially important if external providers are used because the control over these can only be exercised through the goals set up in a contractual agreement. In theory, failure to assume this new role will result in the loss of control for the politicians.
4.3 Alternatives to the purchaser-provider model

The purchaser-provider model is not the only way to achieve a competitive and decentralized system. An alternative that is also used by Swedish municipalities is the check system, or quasi voucher system as it is referred to by Challis et al (1994). This means giving the subsidy directly to the end user and thereby allowing them to choose who they want to buy the service from. The service provider could be either a municipal or a private company. How control is exercised in this situation will be discussed in the next chapter.

Another alternative for municipalities that do not have an organization that is divided into a purchasing and a provider function is to just contract certain services. This could be done in a municipality which does not want a general market based system but which may still want to buy a degree of service as a complement to their own production. The purchaser-provider system or the check system is not a prerequisite for using external providers, but if the intention is to subject all services to competition it is a must to have a system such as one of these.

4.4 The regulation of quasi-markets

A British study made by Challis et al (1994) refers to quasi-markets as managed markets. They define regulation as "the control of standards of quality either through control of new entrants to the market (registration) or through inspection and monitoring mechanisms". This type of control is referred to as service control. They found that the form that regulation takes is contingent on the balance of power between purchaser and provider. Purchasers can be either diffuse or concentrated, and the providers can similarly be diffuse or concentrated (see figure 4.3).
Challis et al have found that the reliance on regulatory mechanisms diminishes as we move from box B to box D. In box A where diffuse purchasers are dealing with diffuse providers, this is a normal competitive market, regulation by an institution (in my case the municipality) could be in the form of registration. That is, providers who wish to enter the market must be approved by the regulating institution according to some preset standards. This would be the case when the check system is used - there would be many purchasers and many providers to buy services from.

In box B the diffuse purchasers are dealing with concentrated providers. This is a typical monopoly situation. In this situation regulation is also used to prevent an abuse of power by the providers. This could be the case if parents have to deal with a school that has a geographical monopoly.

In situation C where the purchasers are concentrated and the providers are diffuse, there could be a mix of regulation and contracts. This could be the case when there is one purchasing municipality that has to deal with several
providers. Contracts can be used, but it could be expensive to negotiate and monitor many different contracts and in this case regulation could be used as a means of lowering transaction costs.

In situation D both the purchasers and the providers are concentrated. In this case contracts are the predominating instruments of control according to Challis et al, since transaction costs fall as the number of contracts diminishes.

5. The use of providers in four Swedish municipalities

The empirical research consists of four separate case studies all of which were conducted in the form of personal interviews with people within the various municipalities. Each case is described here in similar terms and the specific conditions pertaining to each case are described as detailed as possible. For reasons of anonymity, the municipalities are not named, instead they are simply referred to as Case 1, 2, 3 and 4. These names are used in the text to substitute the real names of the municipalities in question. In Case 1 the municipality is simply called Case 1 and so forth. A complete analysis and comparison of the cases is conducted in chapter 6.

5.1 Case 1

5.1.1 The municipal organization

In the municipality of Case 1 the responsibility for providing health care and services for the elderly is the job of the Department of Health and Welfare who act on an assignment given to them by the politicians. In this case, the Board of Health and Welfare in Case 1. The Department of Health and Welfare consists of about 60 employees who have the role of exercising
authority and acting as the purchaser of services. They also have the task of
performing the assessments of needs that determine whether a person is
entitled to care and how much they are entitled to.

The production of health care services supplied by the municipality itself is
managed by the Board of Productions - a separate part of the municipal
organization. The Board of Productions is responsible for the production of
all services which are produced within the municipality. This includes
services such as schools and daycare.

Besides the Board of Productions, services are also bought from private
companies. This is done either by the use of contracts in a purchaser-
provider model, or by directly allocating funds to the end user and allowing
them to purchase the services themselves from the provider of their choice -
the check system. The latter is currently only done within the area of
domiciliary care.

5.1.2 The use of goals

In Case 1 just as in every municipality, there are political goals. The goals in
this case are set up by the politicians at the Board of Health and Welfare in
Case 1. These goals are fairly broad and not very useful as measures. One
such goal is that everyone who has a need should have it fulfilled following
an assessment of needs. Another goal is that every service offered by the
municipality should be subjected to competition. The Department of Health
and Welfare has the responsibility of fulfilling the political goals.
5.1.3 Contracts with providers

There are three similar areas within which contracts are used. These are nursing homes, homes for the elderly, and supported living.

When it comes to nursing homes and homes for the elderly, the municipality both builds and owns these themselves. They then decide who gets to run the homes by allowing both their own Board of Productions and private companies to bid for contracts to provide the management of the homes. This is done using the purchaser-provider model where the Department of Health and Welfare acts as the purchaser.

Today there are two nursing homes, one of which is privately operated. The other one is presently operated by the Board of Productions following the withdrawal of the private entrepreneur who originally won the contract for this nursing home. There were special financial circumstances behind this and the private entrepreneur had to pay a penalty to the municipality to be released from the contract. The current situation is seen only as a temporary one and the municipality intends to accept bids for a new contract as soon as the old contract expires. The current situation means that 75 percent or 115 of the total 155 beds at the two nursing homes are privately managed. The ratio of privately managed beds at the various homes for the elderly is somewhat lower, 57 percent or 84 out of 146 beds. Another related area is the supported living service, that is people who share common facilities and get necessary help. Out of the total of 54 rooms, 70 percent are managed by private companies or purchased from another municipality.
5.1.4 Control mechanisms for contracted providers

Control is exercised in two ways: through the contract itself and through an annual quality control. The bids that are made for the various contracts are first checked to see if they are reasonable. This means evaluating whether or not the bid will provide the bidding company with a sufficient profit to be able to sustain its operations. If the bid is too low, it is feared that the bidding company will not be able to reach the quality standards set in the contract or that it may get into financial difficulties. The purchasers in Case 1 have learned through experience that it is important to look at the solidity of a company. This is because it should be able to withstand any financial difficulties that could arise. Apart from these basic criteria, the bids are of course evaluated according to the specific demands, such as quality specifications, set up by the municipality. Of the bids that meet all the demands, the one with the lowest price is chosen according to the law of public procurement (abbreviated LOU in Swedish). The complete requirements for the bids are regulated by a so called bid specification which all bidding companies can obtain from the Department of Health and Welfare. An example of some of these requirements is that the bids have to contain a plan for how the bidder will organize the care.

After a contract has been awarded to a provider it is up to the Department of Health and Welfare to make sure that it is carried out according to the requirements. This means that an annual control is carried out based on a previously set up plan containing certain variables. As in all municipalities, the National Board of Health and Welfare can also make inspections based on the Health Care Law.

Another control mechanism for the services in special living facilities such as elderly homes and nursing homes, is the medically responsible nurse (MAS in Swedish). The MAS is responsible for ensuring that the regulations that are stated in article 24 of the Swedish Health Care Law are followed.
This includes making sure that there are routines for contacting a doctor or other medical personal if a patient should need this. It also includes checking that decisions to delegate responsibility do not interfere with the wellbeing of the patients, and that the municipal board responsible should be informed if patients have been mistreated or if there has been a serious risk of this occurring. The MAS is a control mechanism that all municipalities must have whether they use private providers or not, so in this sense it is not a control mechanism that is specific for controlling external providers.

5.1.5 The check system

The system of directly allocating funds to the end user is used in Case 1 within the area of domiciliary care - this means giving the elderly basic help in their own home. A handling officer at the Department of Health and Welfare first makes an assessment of needs if someone applies for domiciliary care. This assessment leads to a decision as to whether or not the applicant is entitled to domiciliary care and if so how many hours of help he or she is entitled to. The applicant is then granted a check with which to buy services. The applicant never actually receives any money, instead they inform the municipality of which provider they want to use and the municipality then pays for their services.

5.1.6 Control mechanisms for the check system

Control in this system is primarily a matter of registration or certification. The companies that wish to offer domiciliary care to the citizens of the municipality must first be approved by the Board of Health and Welfare in Case 1. The certification process is fairly simple and is based on two factors - the financial status of the company and the competence of its employees. At the moment, there are ten private providers of domiciliary care that have
been certified. These companies provide one third of all domiciliary care in Case 1.

The municipality does not undertake any quality controls of the service provided by the certified companies. Instead it is presumed that dissatisfied customers will switch service provider if the quality is not satisfactory. Another reason for not having a more rigorous control system is that domiciliary care is not a very complex service in comparison to health care services. In some cases domiciliary care could mean nothing more than some basic cleaning help or a meal service. However, even though there is no formal system for quality control of the service providers, the Board of Health and Welfare can revoke the certification of a company that does not live up to the standards that are expected of a certified provider. In order for this to happen, someone would first have to make a complaint about a service provider and the Board would then make some sort of inquiry. So far this has not happened.

Even though the check system is today only used in a simple service such as domiciliary care, there are discussions in Case 1 about also using it for the other services. In such a system the assessment of needs would decide not only if an applicant is eligible for care but also how much care they are entitled to, i.e. how big the check should be. A person with an extensive need for care would get more money to pay for necessary care. Certification would be used to replace the contracts that are used today. The controlling role for outside authorities such as the National Board of Health and Welfare would still remain the same because the same laws regarding health care would still apply. The role of the inspecting MAS would also be unchanged.
5.2 Case 2

5.2.1 The municipal organization

In Case 2 the municipality is divided into six different districts, of which each have an identical organization. The districts are responsible for all the services that are directly related to the citizens, such as elementary schools, daycare and health care. Other services such as high school education and city planning are managed centrally. This organization is very decentralized and each district has its own Board of Elderly and Handicap Care. Within each board there is a corresponding department that implements the decisions of the board. The districts manage the municipal operations and make the necessary assessments of needs for people seeking care. The only services which are purchased from external providers are nursing homes. This is done using the purchaser-provider model.

5.2.2 The use of goals

At a central level there is the Board of Care and Integration which sets the strategic, political goals within the area of health care. A central office called the Development Office has a work group that sets the operational goals for all the health care in the different districts. The work group consists of representatives from each district and is headed by a so called development leader from the Development Office. The goals set up by the work group are then used as operational goals for the work in each district.

5.2.3 Contracts with providers
As previously mentioned, contracts are the only form used to take in external providers and this is only done for nursing homes. This has to do with the Ädel reform which gave the municipality the responsibility to take care of patients that do not need to be under the care of a doctor. This created a sudden need for nursing homes that the municipality did not have. This was solved by purchasing the service from private providers. Today the municipality only owns and operates one nursing home with 25 beds. The rest, 188 beds, are purchased from either private companies or other municipalities. This means that the municipality itself provides less than 12 percent of all nursing home beds.

5.2.4 Control mechanisms

Control is exercised in several ways. First of all the contract specifies how the care should be organized. The exact details are listed in the bid specification supplied by the Development Office, upon which all bids are based. The bid specification that is used in Case 2 was primarily developed by looking at how other municipalities had formulated their bid specifications. They also discussed internally what was important to include in the bid specification.

After a contract has been awarded, the handling officers that make each individual assessment of needs will visit the nursing home in question before placing applicants there. This assures that the handling officers have continuous contact with those who provide the services that they are purchasing. As in Case 1, there is also the MAS who is responsible for ensuring that the Health Care Law is followed.

An additional control tool that is being developed is a survey that will ask each customer about the service they are getting. This survey will be anonymous. The Development Office is currently looking at an additional
control system that is in use in the municipality of Stockholm. This system uses special “elderly care inspectors” who perform continuous quality inspections of all the homes for the elderly and nursing homes that the municipality utilizes.

5.3 Case 3

5.3.1 The municipal organization

The care for the elderly is in Case 3 separated from other social services. On the political side there is the Board of Health Care which sets the political agenda. The operational work is carried out by the Department of Health Care which not only carries out the assessments of needs but also produces the services that are offered to the care seekers. This means that there is no division between the purchaser and the producer. This does not mean that there are no privately operated health care services in Case 3. Private providers are used selectively, in other words, the administrators at the Department of Health Care choose whether or not they want to take in bids for a certain service. That service is then contracted to a provider. There are no plans for introducing any kind of check system.

The purchaser-provider system was previously used as an internal system within the municipal organization. It was canceled after a period of time because it only led to a sub-optimization within the organization. The purchasers were not as good at negotiating as those who provided the services. This in turn drove up the price of the services and caused deficits in one part of the organization, while another part of the same organization showed a surplus. The system also led to a low degree of cooperation between managers within the same department who were responsible for separate budgets. No real evaluation of the system was ever made.
5.3.2 The use of goals

The political Board of Health Care sets a number of political goals for municipal health care. In some cases these goals are very broad. An example of this is a goal that states that the well-being of the elderly should be guaranteed. Some of the political goals are more concrete such as one that states that a new home for the elderly should be built in northern Case 3. These goals are then translated by the Department of Health Care into a number of operational goals that are used to guide the work. One example is that the political goal of building a new home for the elderly is translated into a time plan which states that the work of building the new home should start in the year 2000 and be finished in 2002 (municipal source).

5.3.3 Contracts with providers

Contracts are the only means by which Case 3 takes in private providers to perform services for the care seekers. There is currently only one such private contract and it is for the management of a facility which provides domiciliary care and supported living. This contract was negotiated at the end of 1996. A nursing home was previously also managed by a private company, but after the contract period of five years was concluded, it went back to being managed by the municipality.

The development of the bid specification in Case 3 was achieved entirely by using a standardized bid specification which was published in a book by the Swedish Association of Local Authorities. This standardized form was then adapted to fit Case 3’s needs. It also includes a number of municipal guidelines that have been decided by the Board of Health Care in Case 3. These are very general guidelines that apply to all health care in Case 3 and they are in no way specific to the particular contract in question.
5.3.4 Control mechanisms

The standardized bid specification states that the municipality has the right to conduct annual quality controls within all elderly care whether it is municipal or private (municipal source). Surveys to the care seekers and their relatives is listed as one instrument of control. According to the bid specification, the surveys must show that the demands that are placed upon the provider are fulfilled. This is only stated in general terms and it says nothing about any specific quality levels that the providers should reach. Furthermore, it says that the assessment officers and the medically responsible nurse (MAS in Swedish) should not make any serious remarks against the service of the provider.

Apart from the formal demands that the provider must live up to according to the contract, there is one more control mechanism. This is the medically responsible nurse (MAS) which I mentioned above. However, as I mentioned in the Case 1 case, the MAS is not anything that is specific for municipalities which use private providers. Therefore it could be said that Case 3 has no special control mechanisms for external providers apart from the annual follow up, which is also nothing unique for the private providers because an annual follow up is made of the municipal production as well.

5.4 Case 4

5.4.1 The municipal organization

The Board of Health and Welfare in Case 4 is the political institution responsible for the care of the elderly and handicapped. They set the political goals that are to be carried out by the Department for Health and Welfare. The municipality of Case 4 uses a purchaser-provider model and contracts all services within the area of care. This has been done since 1994.
and was originally initiated for ideological reasons. Today approximately 50 percent of all care is carried out by private providers. The check system is currently not used by Case 4 and there are, at the moment, no plans to introduce it within the area of elderly care.

5.4.2 The use of goals

As mentioned above, goals are set by the political Board of Health and Welfare. These goals are stated in a document called an Elderly Care Plan. This plan contains both a vision and goals. All of the five goals are concrete goals that can be followed up. Three of these are measurable and they are as follows:

- At least 95 % of the care seekers should have received the help they have been promised at the last assessment of their needs.
- At least 95 % of the care seekers should have confidence in the staff.
- At least 90 % of the care seekers should be satisfied with the help they are receiving.

Apart from these general goals, there are specific goals for each service area. For example, within the area of housing for the elderly, it is stated that it needs to be more flexible and allow people to stay in their own homes if this can be achieved at "reasonable costs" for the municipality.

5.4.3 Contracts with providers

As previously mentioned, contracts are today the only means by which Case 4 utilizes private providers. Contracts are based on the bids that are made by various providers. The bids are as usual based on a bid specification that is drawn up by the Department of Health and Welfare in close cooperation with the politicians at the Board of Health and Welfare. According to the
person in charge of contracting services, the politicians need to be involved in the process. "The politicians really have to tell us what it is they want to buy if the process is to be successful. They also need to understand that they should focus on the what and not the how", she said. By this she meant that politicians are in general used to dictating how everything should be done. "If this is done, there is no purpose in contracting services because no one will want to bid for something if they can’t influence their own work", she added.

The head of the Department of Health and Welfare compared the situation to another Swedish municipality for which she had also worked and said that there was a big difference between the two working methods. She said it was not easy to get the politicians to change and to understand the new way of working, but they had tried to educate them and get them involved in the whole process. Another thing that they thought had made a difference in Case 4’s case was that the person in charge of contracting has previous experience of this from working within the county council.

The bids that are made are evaluated using a comprehensive evaluation form. This form checks to see how well each bid lives up to the goals that are supposed to be met by the providers. The check consists of two parts, the evaluation of the written bid, and an oral hearing. The variables that are evaluated include five different categories ranging from health care and social issues to administrative issues such as routines for handling information and complaints. Each category contains a list of variables that each bid is matched against. Each bid is then given a grade according to how well they fulfill the criteria of each category. Some of the grades are given weights to mark that they are more important. Finally the bids are summed up. The price is included in the bid but the other factors are generally more important than the price itself. It has actually never happened that they have accepted the lowest bid. However, the price is important if there are several
bids that are given an equal evaluation based on their content. In that case, the bid with the lowest price would be awarded the contract.

When it comes to housing services, the municipality only contracts the management of these services. This means that they either own or rent the facilities themselves and rent them out to the care seekers who wish to live there. The tenants are required to provide their own furniture and other inventories in their own rooms, the common spaces are furnished by the municipality. The care providers then provide everything that has to do with the care of these tenants, i.e. service personnel, medications etc. The reason that the municipality provides the facilities themselves is that they want to be able to use the same facilities even if they switch provider in the future.

The contracts themselves are of a more general type. This means that it is more of a frame that sets prices and standards but not necessarily the amount of care that is bought for each care seeker. This is because the care seekers may have changed needs as time goes by, and that means that it is impossible to specify beforehand exactly how much care they are buying.

Once the contracts have been agreed and the operations are underway, they are followed up every other month. The person in charge of contracting meets with the managers of each contracted facility to talk about how things are going. Every year the contracts are renegotiated and prices are adjusted according to a preset model. They can also change things in the contract that are unclear, and increase or decrease the volume of service that is purchased.
5.4.4 Control mechanisms

Besides the formal contract and the follow up talks that are made to see that providers stick to the contract, there are a number of control mechanisms. First of all the municipality’s head nurse, or medically responsible nurse as she is called (the Swedish abbreviation is MAS), makes regular inspections to see that the Health Care Law is being followed. This regulates such things as how patient journals should be kept.

Another control tool that is new and still being developed is a survey for those who are living in any of the special housing facilities, i.e. homes for the elderly, nursing homes etc. The survey, which consists of around 20 questions, is supposed to measure how the care takers feel about the quality of the services they receive. There is also a special survey for the relatives with questions regarding how their needs are fulfilled. This means such things as how they are treated by the staff. Another survey is aimed at asking the staff how they feel about their work situation, and yet another survey is for the managers.

A different kind of control tool that is used is a system to handle complaints. The purpose of this system is that anyone should be able to make a complaint to any authority figure they come in contact with. This could be the medically responsible nurse, an assessment officer or anyone else at the Department of Health and Welfare. The complaints that are made are then registered and categorized in a central register. This then provides knowledge about things that need to be changed or improved.
6. Control today and in the future

In this chapter I will compare the four municipalities and try to sum up the ways in which control is exercised today. This includes looking at the alternative regulating forces such as the state and the professions and studying what they are doing today and what their role may be in the future.

6.1 Similarities and differences between the municipalities

When I made the different case studies that are presented in chapter 5, I found that there were both similarities and differences. One similarity between all four municipalities is that contracts are the primary tool of regulation (see figure 6.1). The only exception is Case 1 which uses contracts for the services that the municipality purchases directly, and certification to control the providers that sell services directly to the end users. The use of contracts corresponds well with the theories by Challis et al that state that contracts will be used if both the purchasers and the providers are concentrated (Challis et al, 1994). This is clearly the case where there is one municipality dealing with a few providers.
In the cases I studied there were also some good examples of how municipalities could to a certain degree control that the goals they set in the contracts were really met by the providers. Case 4 was perhaps the best example. They conducted regular talks with the providers to monitor their progress and they had a system for asking the end users about their experiences. Asking the end users may not be an appropriate control mechanism but this will be discussed further on. There were also some good examples of politicians who had learned to adapt to the new system. In Case 1, the politicians were clearly involved in the purchasing process and they also certified providers. In Case 4, I was told that they had explicitly tried to educate the politicians and get them involved in the process as much as possible.

When it comes to using contracts, Challis et al suggest that there are certain deficiencies associated with this form of regulation. "Contracts are concerned with achieving value for money, making explicit the kinds of standards which must be met, and promoting an efficient and business-like approach to services provision. They are not, necessarily, a suitable way of...

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Table 6.1 Control mechanisms in the studied municipalities which use external providers.
upholding the public interest, insofar as they leave it to individual purchasers to define desirable standards." They mean that if the aim is to also ensure a check on purchasers, the contracts need to be accompanied by another form of regulation such as inspection. This could mean that some common standards are set by someone other than the purchaser.

In the municipalities that I studied, the contracts were either based on political goals or a standard bid specification. If the politicians are seen as the purchasers then it could not be said that there is much of a check on the purchasers since they themselves define the standards for what is purchased. However, if we define the purchasers as being the municipal employees that handle the process of contracting external providers, then there is a degree of inspection in the form of the goals that the politicians set. The goals can be seen as standards that the purchasers have to follow. I argue that the first way of looking at it is the more realistic one, because the politicians are the real purchasers whether they are involved in the process or not. This would mean that there is a need for some additional means of regulation other than the contract and it should be carried out by someone other than the purchaser.

There are of course laws such as the Health Care Law that set certain guidelines, but these guidelines are usually very vague. They do not specify explicitly what the minimum standard is, they only state that the standard of care should be good or that the care seekers' needs should be met. Apart from the laws, there is the medically responsible nurse, the MAS, in each municipality who is responsible for inspecting that the Health Care Law is being followed. The National Board of Health and Welfare can also carry out inspections to ensure that the law is followed. However, since the law is primarily concerned with regulating medical practices such as how patient journals are kept, it still leaves the purchasers ample room to choose the level of standard that should be offered.
What this means is that even if the municipalities have full control over the external providers there could still be a control problem. In this case the problem is that the municipalities may set the standards too low as long as they comply with the vague criteria set by the law. For instance, a municipality which is facing financial problems may be tempted to set the standards lower in order to save some money. To avoid this, there could be a need for tighter external regulation concerning minimum standards in the area of elderly care. I will come back to this issue further on.

The certification used by Case 1 for the check system also fits well with the same theories by Challis et al. Certification is used if there are diffuse purchasers and diffuse providers and this is the case if the individual citizens can purchase services from a number of different providers.

In conclusion, it is my belief that the municipalities can today maintain a certain degree of control over external providers by utilizing a number of control mechanisms. First of all the contracts are an important regulating tool. The politicians need to be involved in the process since they are the real purchasers. They need to formulate what it is they want to offer their citizens. In other words they should state what they are buying instead of trying to tell the providers how they should produce the services. Formulating this could of course be a problematic issue since it is difficult to specify exactly what the needs of the municipalities’ elderly will be.

Secondly, the municipality needs to have control mechanisms that ensure that the contracts are followed, i.e. that the services produced match the demands of the municipalities. In my view this is just as important as the contract itself because without ways of ensuring that the contract is actually followed, it does not matter how good the intentions of the politicians are. I would like to compare this to the legal system where laws which are not enforced, gradually lose their effect. I do not claim that all providers are dishonest people who will not honor a contract unless someone is constantly
watching over them, but they could be tempted to cut corners if they know that nobody will ever notice. The most common control mechanism for municipalities is some form of follow up. However, the efficiency of this control tool depends on what is included in the follow up. If it is primarily used as a budget follow up, then it could be argued that it is not much of a control tool since it does not take into account the quality of the services produced. This means that in order for it be a productive tool it needs to check that the services produced by the provider live up to the demands set out in the original contract. What this ultimately implies is that the contract can not be sufficiently controlled unless there are routines for such things as continuous quality control. Can an annual quality control really be carried out if the providers lack a formalized system for quality documentation? The alternative to a formalized quality control system would be surveys aimed at the end users. This seems to be the control tool which municipalities are primarily relying on for measuring quality today.

The idea behind the survey is that the output, i.e. the services produced, can be checked against previously set goals by asking the end users. However, a study by Möller (1997) has shown that this does not work very well when it comes to the area of elderly care. The elderly care seekers’ dependency upon their care givers makes them less inclined to complain or criticize. There is a widespread fear of confronting the helping staff. According to the study, many of the elderly do not even know how to proceed if they want to make a complaint, and even if they did they would not want to use this possibility. The possibility of showing discontent by switching provider also seems to make no difference, a move is the last thing the old and sick want to have to undertake. What about surveys that are also aimed at the relatives of the elderly or the staff themselves? The relatives may be more willing to criticize than the elderly themselves if they see that something is wrong. On the other hand, they lack the necessary insight to give an accurate view of the quality of the services. When it comes to asking the staff themselves there is the question of loyalty towards the employer. There is a new law,
the Lex Sarah, which was introduced following the scandal in Solna. This law forces the employees to report any unsound conditions to the inspection authorities. However, this law can not force the employees to criticize the daily routines in their workplace. In short, the only ones who could really give an accurate picture of the quality are the elderly themselves but they are not inclined to do this.

What this would indicate is that a control system within elderly care that relies upon the care takers, or surveys of the relatives and staff for that matter, is not very useful. This means that it could be questioned how efficient the additional control tools in Case 2 and Case 4 really are since they are to a large degree based on asking the end users. What alternatives are there to asking the end users about the quality of the services? Well, the only real alternative is to demand a quality control system with routines for documenting quality issues. This would allow the municipality to make inspections at any given time to see if the services live up to their demands. An ambitious evaluation of a contract bid is one thing, but if the actual services are not checked there could be no way of knowing whether the bid was just a number of fancy formulations or not. A quality control system could also be coupled to an independent inspection by an external institution such as the state. The National Board of Health and Welfare have developed a set of recommendations for how a quality control system specifically aimed at elderly care can be designed. I will discuss this in detail further on.

In regards to the control issue, outsourcing within the public sector correlates well with private sector outsourcing. The problems are also similar even if they have completely different customers than elderly care and a completely different product. A private Swedish company that uses outsourcing is Hennes & Mauritz (H&M). They design and sell clothes but they do not produce anything themselves. This is instead outsourced to various companies around the globe using contracts as the primary control
mechanism. They also use inspectors that make inspections of the contracted producers to see that they live up to their obligations (www.hm.com).

The problems that can arise from a lack of control are similar to the problems that municipalities may have to face, namely quality problems. In the case of H&M it could mean that the customers are left with defective merchandise which at worst could damage H&M’s reputation. For a municipality that is outsourcing the production of a service, quality problems could have far greater implications. This is especially true when the service in question is health care because quality deficiencies could relate directly to people’s health. This means that the control issue associated with outsourcing is more important for a municipality that contracts elderly care, than it is for a multinational company that contracts the production of various goods. Nevertheless, the control mechanisms available seem to be the same in both cases, i.e. a contract and some form of inspection, even though the means of inspection may not be same. H&M could easily ask their customers how satisfied they are, but the elderly are, as I mentioned earlier, not prone to complaining.

The municipalities have one advantage over the multinational companies though. All the providers they use are located in the immediate vicinity and not on the other side of the globe. This means that they have a good chance of actually meeting with the contractors on a regular basis. This means that any eventual problems can be resolved quickly and inspections can be carried out on a regular basis.

The case that I think best illustrates that municipalities can maintain a certain degree of control over external providers is Case 4. They seem to have a holistic approach to the use of external providers. They fully understand the importance that the contract has as a control tool, and they have managed to involve the politicians in the contracting process. In addition they have a battery of control mechanisms that are intended to ensure that the providers
live up to their end of the agreement, even though some of the control mechanisms may not be very appropriate. I am referring to the use of surveys and a complaint handling system which could be questioned based on the fact that the elderly are not willing to criticize (Möller, 1997). This means that the surveys they use may not give an accurate picture of reality. If the intention is to maintain a high standard of quality they would probably be better off relying on a more formalized quality control system or inspections that are not based on asking the end users.

The case that least illustrates municipal control is Case 3 where the use of external providers is more an exception than a rule. The contracts are based on a standardized bid specification and the involvement of the politicians when it comes to designing this bid specification seems to be minimal. No special control mechanisms are used beyond the regular follow ups which are used within the entire municipal organization, and the controls made by the MAS which, as I mentioned earlier, is nothing that is specifically tied to the use of private providers. Case 3 could indicate that municipalities which lack a holistic approach towards the use of external providers, also lack the type of control system that is required when external providers are used. They seem to be relying on the same control system for external providers as they do for the internal, municipal providers. Unfortunately, my research is not comprehensive enough to draw any general conclusions to support this hypothesis.

One thing that all the municipalities using external providers have in common is that they are subjecting the production of public services to competition. By doing this they are also creating a market for publicly financed services. Challis et al (1994) refers to these new quasi-markets as managed markets. Judging from the variations seen in the municipalities I studied, this new quasi-market could be viewed as consisting of early adopters which are still in a learning phase. In this phase, successful
DiMaggio and Powell (1991) refer to this process as mimetic behavior, and they describe it as a way for organizations to deal with uncertainty. "The advantages of mimetic behavior are considerable; when an organization faces a problem with ambiguous causes or unclear solutions, problematic search may yield a viable solution with little expense." The complexity of the control issue that municipalities have to face when using external providers will most certainly create a situation of uncertainty as to how control can best be obtained. There is also a great deal of uncertainty due to the fact that the phenomenon of using external providers is still relatively new for municipalities.

In my study, I found several cases of this mimetic behavior. In Case 2 they studied how the control mechanisms functioned in other municipalities. Their bid specification was modeled after bid specifications in other municipalities, and they were considering introducing some of the control tools used in the neighboring municipality of Stockholm. In Case 4, the person in charge of contracting had previously worked with this for another public organization. This could be seen as an example of employee transfer which DiMaggio and Powell describe as a more indirect way by which imitation can come about. Even Case 3 used imitation. They modeled their contracts after a standard form which was developed by the Swedish Association of Local Authorities, a type of interest group for Swedish municipalities.

DiMaggio and Powell submit that organizations within an organizational field will over time come to resemble each other through a process of homogenization. "Organizations may try to change constantly; but after a certain point in the structuring of an organizational field, the aggregate effect of individual change is to lessen the extent of diversity within the field."
Organizations in a structured field respond to an environment that consists of other organizations responding to an environment of organizations’ responses.” (DiMaggio and Powell, 1991) What this means is that early adopters within a field may differ from each other, but as the field they are working in becomes more structured they will also become more similar to each other. Mimetic behavior, which I described above, is one way by which homogenization is achieved. There are other influential factors which I will describe further on.

Even though municipalities are not a new organizational field, the municipalities that use external providers to produce municipal services can be seen as a new field within the field of municipalities. The municipalities that are today present within this field are, as I mentioned earlier, the early adopters. They are copying from each other but significant differences can still be seen as a result of individual innovations which have not yet been spread to others.

My focus up until now has mainly been on the new organizational characteristics which are being developed by the early adopters within the field of municipalities that use external providers. It has to a large degree been an internal focus insofar as I have only discussed what the municipalities themselves are doing to effect their own situation. However, as I have already hinted several times, there are external factors that could affect the process of structuring this new organizational field, and provide additional regulation. These external forces could be just as influential as the municipalities themselves when it comes to solving the control issue. DiMaggio and Powell point out two external forces, the state and the professions. I will build on this in order to illustrate the external influence that exists today and how it could shape the way municipalities work in the future in regards to external providers.
6.2 The influence of the state

I previously described how Challis et al (1994) found that it could be necessary to have additional regulation to put a check on the purchasers. The obvious regulating force in this case would be the state since it has a role of looking out for the interests of its citizens, especially when it comes to services which are publicly financed. The state is also the only institution which has legislative power and can coercively influence the behavior of others. The state could, if they wanted to, act to impose additional regulation through the use of new laws and increased inspections by state institutions such as the National Board of Health and Welfare.

The reasons behind this could be, as I stated earlier, that purchasers could set their own standards which may not necessarily take into consideration what is best for the end users, i.e. the care seekers. This could lead to quality problems and even quality differences between municipalities. In Sweden where equality for all citizens is an important issue, the state could see it as their duty to reduce injustices by increasing the regulation. One public area where this is already a reality is the area of education. The municipalities are responsible for managing the public schools with a certain amount of autonomy. In addition, publicly financed private schools can compete by trying to be different in some way. In order to make sure that all students are taught certain basic skills, the state has imposed a national curriculum that all schools must follow. This sets the minimum standards.

If the state was to act in a similar way in regards to the area of elderly care, it could set certain minimum standards that all municipalities must follow. At the same time it would act as a force that structures the organizational field. By setting certain standards, the state would be forcing municipalities to purchase similar services. This could for instance lead to more and more standardized contracts. State standards could also demand special control mechanisms such as a formal system for quality control. If this were to occur
it could lead to the municipalities adopting similar methods of inspections. Ultimately the influence exercised by the state could lead to homogenization amongst the municipalities that choose to use external providers. This form of homogenization could be classified as coercive to use a term from DiMaggio and Powell (1991). In other words, the homogenization within the organizational field is the result of external pressures such as new laws or regulations.

What is the state doing in reality in regards to regulating the area of elderly care? To answer this question I contacted the National Board of Health and Welfare which is the inspecting authority on a central level, and the County Administrative Board in Stockholm which is the inspecting authority on the regional level.

Concerning the issue of setting common standards for providers, the National Board of Health and Welfare told me that there were previously special recommendations for dealing with private providers. These included such things as recommendations for the formulation of contracts. Today however, there are recommendations that treat private providers in the same way as their municipal counterparts. These recommendations which are stated in recommendation SOSFS 1998:8 (S), are recommendations for what a quality system should contain (Socialstyrelsen, 1998). In the recommendations it is stated that municipalities “should” have a policy for dealing with the quality of the services. They should also see to it that there is a quality control system in operational areas that allows continuous control, follow up, development, and documentation of the quality. The municipality should also make it clear who is responsible for the task of quality control. Furthermore, it is stated that the quality control system should be a support for the management to help them fulfill their goals. It is explicitly stated that municipalities should insure that these recommendations are also used by external providers in the cases where these are used.
The recommendations about what to include in a quality control system and the routines that are necessary, are quite detailed. If these recommendations were to be enforced by either the National Board of Health and Welfare, or the County Administrative Board, they would effectively set minimum quality standards not only for all private providers but for all providers of elderly care alike. Since quality seems to be the most important issue within elderly care, creating regulations that call for a common quality control system could be the way to go if the state wants to impose a standardization. However, at the moment they are just recommendations and the municipalities are not legally bound to follow them. This means that they serve as excellent advice for municipalities that wish to follow them, but as far as setting common standards they are not very useful. According to the National Board of Health and Welfare, there are currently no plans to introduce any kind of detailed regulation within the area of elderly care.

The County Administrative Board in Stockholm discuss the issue of quality in a report from 1999 (www.ab.lst.se). They ask the question of whether or not the quality is good when it comes to living facilities for the elderly. Their conclusion is that it depends on who is asked. A person who gets their expectations fulfilled would say that the quality is good. This means that whether or not the quality is perceived as satisfactory is dependent on the initial expectations. A person with low expectations could be satisfied with the quality even if a professional might deem it unsatisfactory. The County Administrative Board themselves do not seem to have their own definition for what good or satisfactory quality is. They seem satisfied with just concluding that it is a problematic issue. Neither do they have any ideas of their own for how to deal with it.

Regarding national differences between municipalities as a result of the purchasers setting their own standards, this is already a reality according to a 1996 study by the National Board of Health and Welfare (Socialstyrelsen, 1996). The study concludes that differences exist between different
municipalities regardless of how the services are produced. The differences are seen as the result of different values and cultures, rather than being dependent on whether or not private providers are used.

6.3 The influence of the professions

Professionalization is another force that can bring about homogenization within an organizational field and in this case influence the way in which municipalities exercise control over external providers. DiMaggio and Powell (1991) define professionalization as "the collective struggle of members of an occupation to define the conditions and methods of their work, to control the production of the producers". The members could of course be the professionals who work within the companies that produce the services. As I interpret it, they could also be the companies themselves that in a sense make up a professional group that works for someone, in this case the municipalities that contract their services.

6.3.1 The provider's employees

In the first case, professionalization could be influenced by the existence of labor unions. The employees that work with the direct production of services for the elderly may work for different organizations, but they all have similar jobs. This could lead to demands from the unions that their members should also have similar working conditions. In the case of elderly care, it could mean that they demand a minimum staff for a certain number of care seekers. This in turn could lead to more standardized services.

I contacted SKTF, the Swedish labor union which organizes employees within the health care sector, to see what they are doing in regards to this issue. They told me that they are not against the use of private providers as long as quality is maintained. However, they have not set up any demands of
their own regarding such issues as quality or minimum staff. In fact they seem to play a very passive role today, an even more passive role than that of the state.

6.3.2 The provider companies

If we interpret professionalization to also mean the professional companies that produce the services for municipalities, we may find other arguments for standardization. Some of the providers, such as the Danish company ISS Care, are multinational and have contracts in several countries within the European Union. For them it could be natural to strive for similar services in all of the countries they operate in. This would make their administration much easier and it would standardize the contracts that they write with each of the purchasers. One way that they could bring about this form of standardization is to influence the EU to create regulations that set international standards within this area.

Even if they do not get international standards to work by, they could still create their own national standards by offering similar services in all the municipalities they operate in. This could lead to the homogenization of services, especially if other service providers copy their standards.

Another way in which the producers could achieve standardization is quality certification. Quality certifications such as the ISO 9000 are used within other industries to create standardized norms of quality. There are certainly motives for the producers to play a more active role when it comes to defining standards for the service they produce. One motive could be to avoid any more scandals that could damage their reputation in the marketplace as well as in the eyes of the general public. Another motive could, as I mentioned earlier, be to create a more efficient administration and reduce the transaction costs of each contract.
To get a picture of what is happening on the provider side, I contacted the Swedish head office of ISS Care Services in Stockholm. Using written questions, I asked what they are doing in regards to setting their own standards using such tools as quality certification, and if they were in any way working for an international standardization of services for the elderly.

In regards to setting standards, ISS Care Services has recently developed a so called contract manual in which they have defined minimum standards for the care they provide. In the manual, they clearly define the conditions that must be met in order for them to fulfill their assignment. Their standards are also stated in their bid for a specific contract.

They also do their own follow ups to check that the services they are producing are satisfactory. This is done using surveys that are carried out by the Swedish survey company Sifo. The surveys are aimed at the care seekers and their relatives, as well as the ISS employees. Once again, it must be pointed out that this type of control mechanism is questionable when it comes to monitoring elderly care (Möller, 1997).

When it comes to using certification, they mention a couple of possible certification standards that are suitable for the types of services they offer. These are QUL and USK (Utmarkelsen Svensk Kvalitet). As of today, there is no decision to use a formal certification within ISS Care Services. However, they do have special operative manuals that the managers of their various operations can use. These manuals are designed in a way that makes it possible to use them as a foundation for a formal certification in the future. In other words, they work according to certification principles but they have not yet introduced a formal certification system.

The last question I asked ISS Care Services was if they are working towards an international standardization of their services. The answer was no, but they do exchange experiences and competencies with the ISS companies in
other countries and they use each other for benchmarking. The only area where ISS is pushing for EU standardization is the market for cleaning services. Within this area they wish to create common quality norms and systems for measuring quality. Concerning care services, ISS is presently not working for an EU standard.

To summarize, the providers seem to be the only external force which has the potential to influence the regulation of elderly care. The control mechanism that the municipalities have not yet adapted, a formalized quality control system, could instead become a standard introduced by the providers themselves.

7. Conclusions

In my thesis I have looked at several questions. First of all I tried to describe some different perspectives for viewing the changes that are occurring in the public sector, especially the trend of using external providers. I found that the changes could be viewed from either a rational perspective, where the changes are the result of conscious decisions to change the organizational structure to better meet the demands placed upon it, or an institutional perspective which views the development of a certain organizational structure as a means of dealing with uncertainty.

The main focus of the thesis was to look at how municipal control could be exercised over external providers in order to insure that the municipality lives up to its obligations towards its citizens. The theory provided me with two primary models; the purchaser-provider model and the check system. I then made an empirical study in four Swedish municipalities to see if they were using these models and to see which control mechanisms they had.
All four of the municipalities studied used some form of purchaser-provider model to contract the services of an external provider. The primary control mechanism was the contract. The additional control mechanisms ranged from the ordinary annual follow up to a combination of several instruments of control. These included the use of surveys aimed at both the end users and the provider employees, regular discussions with the contractors, and inspections by the assessment officers. In all there were many examples of control mechanisms that could be used to give the municipalities a degree of control over external providers. However, no municipality used a more formalized quality control system. This leads me to question how well they can actually control that the services produced really live up to the municipal demands, since studies have shown that it is not very useful to rely on the complaints of the end users when it comes to elderly care.

Only one municipality used a check system. The form of control was in this case only a certification process through which the service providers were approved by the municipality. Regulation was left in the hands of the free market in which the customers were supposed to switch providers if they were dissatisfied. As studies have shown, the elderly are not prone to switching providers, so it could be questioned how well this form of regulation works.

Although the differences between the municipalities were many, there was some evidence of beginning homogenization. Some municipalities exhibited clear signs of mimetic behavior, copying successful methods from other municipalities. If this process continues it could lead to a standardization of the control mechanisms which are used to gain control over external providers. This would mean that municipalities that take an active approach towards implementing suitable control mechanisms for the control of external providers, could if they wish copy successful concepts from other municipalities. As my research has shown, there are a number of control mechanisms in use today, and by utilizing some or all of these it is possible
for a municipality to gain a certain degree of control over external providers. My research also illustrated that some municipalities use control mechanisms that are less suitable as far as elderly care is concerned. Furthermore, all municipalities do not show the same interest when it comes to implementing a control system that is suited for external providers. If only some municipalities manage to deal sufficiently with the issue of controlling external providers, this could leave a regulation void that has to be filled by some other external force.

Even if all municipalities that use external providers manage to implement an advanced control system, there could still be some control deficiencies. One such deficiency is that the purchasers are relatively free to set their own standards, i.e. they buy a service with a standard that they themselves demand. This could lead to standards that are very low in some municipalities. One way around this could be if the state imposes a national minimum standard that all municipalities must follow.

Another deficiency is that none of the municipalities had a system for dealing with quality control. This could be solved if the state forces municipalities to introduce quality control routines in its own operations as well as demanding that external providers do the same. The National Board of Health and Welfare already have recommendations regarding the use of a quality control system for municipalities to monitor quality standards, but the recommendations are not in any way legally binding. Nevertheless, these recommendations could very well be used as a foundation for new legislation in this area. However, at the present time they do not have any plans to impose any minimum standards or any other form of detailed regulation, but the state could if they wanted to be an active regulating force. The knowledge of how a sufficient quality control system should be designed already exists in the form of the recommendations I already mentioned. All that is really needed is to turn the recommendations into legislation. Unfortunately, it does not look like the state will do anything of
this nature in the near future. The reason why I think this is unfortunate is that they seem to have a good knowledge of the kind of quality control system which is needed, and they are the only institution which could effectively force municipalities to adopt such a system.

If the state does not fill an eventual regulation void, who will? Well, one possibility is the professions in the form of both the professionals that work within the provider companies, and the provider companies themselves. The labor unions could make demands regarding a minimum amount of staff in order to give their members a better working situation. Presently they are not making any such demands, nor do they have any plans to do so. They are instead playing more of a passive role insofar as they seem to be waiting to see what happens. In other words, an alternative form of regulation will most likely not be the result of pressures by the unions.

That leaves just one last possible force, namely the providers themselves. Signs within that area indicate that they are taking an active approach towards solving such problems as quality deficiencies. Large provider companies such as ISS Care Services have adopted routines for quality control that could very well serve as a basis for future quality certification. In the case of ISS Care Services, the only thing that is missing is the decision to implement a formal quality certification. The quality control system and routines for the daily work are already in place. I view the providers as the force that is most actively pushing for the use of better quality control systems. A formal quality certification could both create a more common standard of the services produced, as well as filling any regulatory void left by some municipalities. Unfortunately my study only included one provider and this makes it difficult to draw any deeper conclusions about what is happening on the provider side.
9.1 Suggestions for further research

As is the case with all research, I did not have the possibility to go deeply into all of the areas I examined. At the end of my thesis writing it also became clear to me that were many related aspects that could have been developed further. One such aspect that could be interesting to have a further look at is the difference in control systems between municipalities which have a holistic approach towards using external providers, and those which only occasionally use external providers. My research indicated that there could be a significant difference between these.

Another interesting aspect could be to look deeper into what the providers are doing in regards to quality certification. Are other companies besides ISS Care Services also working towards quality certification? A related question that I did not have time to elaborate on is which difficulties could be associated with trying to measure the quality of elderly care. Are there any experiences of this type of quality control system within the elderly care in other countries? Are there any examples of quality control systems within other areas of the service industry? If so could the lessons learned from these types of quality control systems be applied to the area of elderly care?

Finally a question that I did not get into at all is what could happen if a public monopoly is replaced by a private one. If the services of all companies become standardized how does this relate to the wishes of the politicians to provide the users with alternative choices? Is this type of political goal even realistic given that standardization is likely to occur in the long run? These are just some of the aspects that could be studied further. I am sure that there are other aspects of my research that could benefit from further study.
8. Bibliography

8.1 Publications


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8.2 Internet


8.3 Lectures

Appendix A: Translation of specific Swedish terms

Anbudsunderlag - Bid specification
Gruppoende - Supported living
Hemtjänst - Domiciliary care
Kundvalsmodell - Check system
Lagen om offentlig upphandling (LOU) - Law of public procurement
Landstinget - County council
Länsstyrelsen - County Administrative Board
Produktionsstyrelse - Board of Productions
Sjukhem - Nursing home
Socialförvaltning - Department of Health and Welfare
Socialnämnd - Board of Health and Welfare
Socialstyrelsen - National Board of Health and Welfare
Svenska Kommunförbundet - Swedish Association of Local Authorities
Vård- och omsorgsförvaltning - Department of Health Care
Vård- och omsorgsnämnd - Board of Health Care
Älderdomshem - Elderly home
Äldreomsorg - Elderly care