Caring about Business in the Care Business
- how private elderly care providers can generate profit while maintaining care quality
Abstract

The social service care system for the elderly has undergone a number of changes during the last decades. These reforms, especially the purchaser-provider split, have changed the role of the state in this sector somewhat, from being a monolithic provider of tax-financed elderly care to primarily being a purchaser who might choose to purchase elderly care services from private providers. However, the state has still retained a public elderly care service. Needless to say, the reform paved the way for a number of private enterprises in the area, causing competition between public and private providers. Adherents of the reform have argued that private providers can improve efficiency, while opponents have claimed that the chase for profit might affect the quality of the care in a negative way.

This study focused on the basis for this controversy by examining the relationship between factors such as profit, efficiency, care quality, incentives, motivation and productivity. The study was performed by interviewing thirteen employees and managers in four different care organizations (of which half were public and the other half private). Their answers were analyzed from three theoretical aspects; incentives and motivation, efficiency and productivity, and care quality.

The findings were that, since the revenue size is beyond their control, private providers can only create profits by reducing costs in a number of ways. Some of these ways, such as cutting down on education, team building activities and salaries, might be detrimental for the company in the long term (and thereby increase costs over time) and have adverse effects on quality. Others, however, such as increasing the efficiency of non-care activities (less administration and optimized scheduling, for example), avoid hiring overqualified staff and instead providing them with enough education for the task at hand, and optimizing work hours, might be more enduring over time and have none or small adverse effects on quality. More dispiritingly, it was also shown that the purchasers do not have any real knowledge about the quality of the work performed, regardless of the provider being private or public, and that in some municipalities users are denied to choose provider for themselves.
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1. Introduction

This chapter introduces our study with a broad description of the changes to the welfare social service care system in Sweden brought on by the introduction of the purchaser – provider split model. The overview exposes gaps consisting by financial and quality measurement problems. This knowledge breaks down to an elderly care system problem, allowing us to construct the problem and the concrete purpose of this study. Additionally, we inform the reader of the limitations to this study, and the translation of some relevant concepts from Swedish to English.

1.1. Background

The impact of the economical crisis during the 1970:s led to new ideas concerning public and the welfare social service care in Sweden and Europe\(^1\). There was criticism of the state-delivered medical care and the entire public sector of being insufficient, inefficient and too expensive. This criticism of Sweden also circulated in the US and the UK. Moreover, in the 1980:s people were frustrated because of the increasing costs and the long lines for health care and social service care. It seemed that the priority of the working conditions was more important than that people needed care.

In the middle of the 1980:s a new reform, the “purchaser – provider split model” was introduced by the Social Democratic Minister of Finance between 1982-1990, Kjell-Olof Feldt, where the influential political control was reduced and the possibility to buy services from private providers begun. This reform created competition between providers on behalf of the elderly people\(^2\). From then on, the development of the reform has continued with the conservative coalition government between 1991-1994 and the Social Democrats between 1994-2006. There have been some politicians who have been optimistic and others pessimistic towards the reform\(^3\). Some politicians have warmly agreed to have a variety of providers where the public can freely decide the care provider they want. These politicians also believe that private providers can adapt new models of organization, leadership and develop new personnel attitudes. These new improvements can be applied on the public medical care and social service care to help the development of new knowledge-based and tested methods\(^4\). These improvements are more clearly seen in medium-sized private organizations because they allow better opportunities to differentiate and stimulate the public social care than large private organizations\(^5\). However, some representatives of the county council assume that there can be irrational structures in the public care organizations, which makes it difficult to implement new methods and attitudes. This is because an organization is a product of ideas and social construction and it is hard to break up old structures and attitudes even when introducing strong rules and norms\(^6\).

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2 Ibid, p 145
4 Ibid, p 81
6 Ibid, p 75
The Swedish purchaser-provider split model involves three entities: a financer/owner, purchasers, and providers\(^7\). The purchasers are the politicians who form the political committees. They represent and work on behalf of the public. The purchasers are supposed to find competing providers, who give the best service care for the best price. Providers are the hospitals and health care centers which are primarily owned by the county council. Financers/owners are directly elected politicians on the county council and indirectly politicians who sit on the county council board. They are funding the investment and supplying the purchasers with resources and management of their internal providers.

Purchasers are required to make sure that the providers fulfill their agreements on delivering care quality to the public. Nevertheless, the problem still is how the purchasers can evaluate good care. The purchasers are distant from the public, so they do not see the daily care work. Interestingly, the purchaser–provider relationship is closer other than the purchaser–public relationship\(^8\). Consequently, the purchaser gives more support to the provider than to the public.

Measuring the quality of social service care and medical care is very important when purchasers negotiate the best care provider and the best price\(^9\). Quality is a powerful instrument to compete with other providers. However, it is sometimes difficult to define quality. This is because politicians, managers and care personnel define quality in different ways. Managers and politicians work at a distance and define quality as following the directives of the assistance assessment and as maintaining positive financial results. Contrarily, care personnel work close to the elderly people and define quality as giving the elderly what they need and ask for even though it is not written in the assistance assessment\(^10\).

Moreover, there is potential for an inherent conflict of interest between many of the involved actors. When cost-cutting is in focus, personnel might be understaffed or lack time or resources to provide proper care quality. Different actors within and outside the organization might also have goals which are not in line with the actual care purpose of the organization. For example, owners of private care companies might be preoccupied with maximizing financial returns, perhaps giving CEO:s or top managers some kind of result-oriented bonus, which gives these executives incentives to cut costs. This is of course not in line with the wishes of the purchaser, who then has to establish certain quality criteria and make sure they are monitored regularly. Furthermore, staff at lower levels of the organization might have their own goals. Care personnel on one hand might not be able to influence their own salaries but some could still be motivated by giving the best care possible out of empathy, for example, while others might be more or less indifferent or oblivious to the needs of the care receiver. Mid level managers might be squeezed between demands coming from above and needs coming from below (through their staff).\(^11\)

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\(^8\) Ibid, p 406

\(^9\) Nutek (2000), p 60

\(^10\) K. Kraus, Sven, inter-organizational relationship and control, a case study of domestic care of the elderly, *EFI, Handelshögskolan i Stockholm*, 2007, p 173

However, is there an inherent conflict between *care quality* and *financial targets*? Even though a spontaneous reaction could be that they are naturally opposed, this might not be the truth. While time spent with a patient certainly costs money and more time thus means more money, there could be other ways of improving the patient's happiness or perceived quality within the same time frame, that is, improving the quality by "soft" measures other than time. For example, it might be more important for one patient to get help hanging up Christmas curtains than getting the floor swept, while another could have totally different wishes. If the social service contracts or other evaluation criteria are based on "objective" measures like cleaning frequency and thus ignoring individual wishes, they would not work as well as they should. On the other hand, basing evaluations purely on subjective opinions might be time-consuming and hard to maintain.

Or, if there is a strong correlation between time spent with the patient and the perceived quality of the care, this has some implications as well. For the managers this would mean incentive conflicts between delivering care quality and delivering good financial results. These incentive conflicts could be analyzed over the line; for example, there could be some caretakers who are more indifferent to the elderly's needs than others, in which case they might deliver only the "bare bones" care necessary to avoid problems with their supervisor. These incentive conflicts are possibly prevalent throughout the entire "supplier" chain.

Many researchers explain that quality can be achieved by improving health care management quality/performance. Beata Kollberg explains in her research that by appointing an Organization Change Manager (OCM) the organization can achieve development of the quality improvement in the elderly care. The OCM model implies that an organization which has enough resources to perform projects, analyze them, communicate them and get the feedback to discuss the results, achieves care quality. The Balanced Score Card (BSC) and The Flow Model are other multidimensional measurements of quality performance. The BSC focuses on the financial and non financial aspects as expressed from a customer and an organizational perspective, while the Flow Model focuses on efficiency (delays, booking, procedures and process control) and effectiveness of the health care performance (accessibility and quality of medical care).

The National Board of Health and Welfare analyzed various literature about different methods to describe the needs of the elderly and to describe care quality. The main purpose was to describe quality indicators and methods to measure the patients’ experience of quality. The conclusion was, that despite the fact that an optimal method of quality measurement does not exist, surveys give a superficial result. This means that surveys give an overall view of how patients experience quality. The most applicable survey to measure quality in social and health care is *Quality from the Patients' perspective (QPP)*. This method has been developed and applied in Sweden, showing good reliability and validity. Concerning interviews, *Multiattribute Utility technology (MAUT)* is the most applicable in the private and public care sector. The method makes it possible to study values and attitudes in an organization. To

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13 Ibid, p 21
15 Ibid, p 40
16 Ibid, p19
17 Ibid, p 15
value patients’ needs and measure them, *The Minimum Data Set (MDS) – The Resident Assessment Instrument (RAI)* are used\(^{18}\). These are indicators based on data access and register control, which follows up patients’ needs.

Improving the financial situation in the social service care and the health care was also an important goal for the purchaser and provider split reform\(^{19}\). For that reason, many districts have continuously focused on decentralization, reorganization and reduction of the expenses in many elderly care homes. In 1997, the elderly home care provider *Lidingö Stad* in Stockholm, attempted to change from a hierarchic organization to a flat organization\(^{20}\). The reorganization structure research showed budget deficiencies in the first year. Therefore Lidingö Stad requested 22 million kronor from the district delegation in order to solve the financial situation. Kalle Kraus also made a financial research situation of two districts in Sweden\(^{21}\). The research showed that in one of the districts, the elderly home care units showed budget deficits for four consecutive years. The managers of each elderly home care never discussed the problem and stated that it was more important to discuss how the patients were treated and whether they received good help or not. The financial issue came first when politicians changed the situation and a new district director was appointed. The principal issue was to reduce costs and they stressed that the elderly home care units do not need to do more than what is written in the assistance assessment. They also made an effort to teach the home helper’s managers about the importance of having control of the annual budget and personnel costs on the basis of previous years.

### 1.2. Problem

With this study we want to answer the following question:

How can private elderly care providers generate a profit and still deliver same level of quality as their public counterparts?

### 1.3. Purpose

The purpose of this study is to understand the differences between private and public elderly care providers and what implications these differences have on their respective abilities to deliver care quality. This might lead to new insights about practical measures that elderly care providers can undertake in order to increase efficiency and cut costs without affecting the end result of the care provided.

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\(^{18}\) Ibid, p 42

\(^{19}\) Siverbo (2004), p 405


\(^{21}\) Kraus (2007), p 114-117
1.4. Limitations

This study has explicit and implicit limitations. The explicit limitations are when the authors tell directly which areas that are not explored. The implicit limitations occur when the authors avoid or ignore studying certain areas unconsciously. This happens when a person is prejudiced in a way that influences the author’s areas of interest or other choices\textsuperscript{22}. People are prejudiced because everybody has different ways to see the world. Children grow up in different environments in which they will learn a certain way to think and act. It is impossible not to have implicit limitations in our study. However, these are the explicit limitations;

First, the focus is only on the elderly care suppliers and not the general health care due to a statistical study of the demographic trend study in Sweden that through population projections shows that the population of elderly people is increasing and will continue for the next fifteen years\textsuperscript{23}. That is the reason we consider it to be very important to study this sector. We focus on the personnel since their salaries make up almost all of the costs incurred by running an elderly care provider. However, the suppliers are still included in our theoretical model for completeness.

Second, we were more interested to know how managers and supervisor kept good quality and what methods they used to measure quality than how it was defined by politicians. We selected managers and supervisors because they are in charge of the care personnel and they are closer to the patient, facing every day’s new challenges and problems than those who work at distance like purchasers or politicians from the municipalities.

Last, we did not evaluate the specific difference between the quality or financial measurements used by the two municipalities that we chose to research, unless where this would have had any impact on our study.

\textsuperscript{23} Care of the elderly in Sweden today, \textit{Swedish Association of Local Authorities and Regions}, 2006, p 9
1.5. **Concepts and terminologies**

Since our study is written in English while we are studying Swedish elderly care, the field of study contains a number of Swedish terms which do not exactly correspond to English or international terminology. For the benefit of the Swedish readers, we include this list of terms we have used to substitute the Swedish expressions.

<table>
<thead>
<tr>
<th><strong>Swedish terms:</strong></th>
<th><strong>English terms:</strong></th>
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<tbody>
<tr>
<td>Beställare – utföraresystem</td>
<td>Purchaser – provider system</td>
</tr>
<tr>
<td>Äldreomsorg</td>
<td>Care of the elderly or elderly care</td>
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<tr>
<td>Sjukvård</td>
<td>Medical treatment, health care</td>
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<tr>
<td>Vård</td>
<td>Care</td>
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<tr>
<td>Hälsa</td>
<td>Health</td>
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<tr>
<td>Tjänstesektor</td>
<td>Service sector</td>
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<tr>
<td>Offentlig sektor</td>
<td>Public sector</td>
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<tr>
<td>Socialstyrelsen</td>
<td>The National Board of Health and Welfare</td>
</tr>
<tr>
<td>Omvårdnad</td>
<td>Nursing care</td>
</tr>
<tr>
<td>Vårdhem</td>
<td>Nursing home</td>
</tr>
<tr>
<td>Hemtjänst</td>
<td>Home service / Home care</td>
</tr>
<tr>
<td>Äldreboende</td>
<td>Housing care (for the elderly)</td>
</tr>
<tr>
<td>Biståndsbedömning</td>
<td>Assistance assessment (the social services office evaluates the care needs of the elderly and thereafter writes an assessment. The elderly can apply for housing care or home care, depending on their needs).</td>
</tr>
<tr>
<td>Sveriges Kommuner och Landsting</td>
<td>Swedish Association of Local Authorities and Regions</td>
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2. Theoretical method

This chapter presents the method we have used in the thesis. We present our experience in the field and preconceptions that may have affected the process of the research, as well as our choice of subject, perspective, scientific approach and the method through which we acquired our theory.

2.1. Choice of subject

Mery has worked as substitute care attendant at public housing care for the elderly in Umeå since 2003. She has worked in the weekends and summer times besides her studies. In September 2004 the housing care operation was overtaken by a private company, Carema Orkidén. Carema signed a contract with Umeå Municipality to run an elderly home care operation and four care homes with mentally retarded people. However, the company has run eight elderly care homes in Östersund since 1998 and has recently renewed the contract with the municipality until 2009. Her interest in the subject was aroused when drastic changes were made with the entrance of Carema, such as reorganization, new schedule, new working time and downsizing from six employees to five employees. Consequently, the employees were confused and afraid of loosing their jobs. Her interest in knowing the reasons for these changes made her want to investigate the subject.

Roger has always been interested in the differences between running private and public organizations, especially in the care sector because of the complex issue of ethics versus profit. His mother, a nurse specialized in psychiatric care, has been working in the care sector since 1987, the first four years with geriatric care.

2.2. Preconceptions

Preconceptions come in two flavors; one being the theoretical knowledge based on for example education, background and subject knowledge. While these kinds of preconceptions can help when defining the problem, they might also make the researcher hesitant to “think outside the box”. The second type of preconceptions are the ones related to the prejudices of the researcher. These can be anything from political and moral values to the personal background of the researcher. We have tried to list the preconceptions we have observed within ourselves.

Mery
My preconception can be divided in three parts: first, my experience working as a care attendant in an elderly care home, my academic knowledge in International Business and my background as foreign student. As mentioned above I have worked as care attendant in an elderly home care for five years, which was first public and then, three years ago, became a private company. I have seen firsthand what problems care attendants face delivering care to the patients. Second, I and the other care attendants saw privatization as negative measure due
to downsizing. Time is for example the biggest problem delivering care, because as care attendant you have to manage your time in order to fulfill the elderly patients’ needs. It is also important to have empathy and social competence in order to cooperate with colleagues and patients. This experience and knowledge means of course that I carry some preconceptions and values about what working in an elderly home care involves which has influenced the choice of research and formulation of research questions. Consequently, a possible risk is that my antipathy towards privatization could have influenced the construction of the interviews, my attitude towards interviewees, analysis of data, interpretation of data and perhaps my conclusions. Because of my experience of downsizing, seeing my colleagues being afraid of the drastic changes, I could become too emotional and perhaps focused more on the negative side of privatization than the problem being the focus of this study. However, my preconception or comprehension is related to the inter-relation between the patient and care attendant, or attendant and colleagues. The study includes organizational measurement and financial problems, subjects of which I have only theoretical knowledge from my studies with which to conduct the research. Moreover, the formulation of the research questions for the interviews was made together with Roger who has never experienced working as care attendant, and they were also reviewed by our supervisor.

As a student at the International Business Program I have basic knowledge about management and finance. These preconceptions may have influenced some of the literature selections. However I consider my comprehension in management of the domestic social service for the elderly to be limited due to the complexity of the issue.

I am originally from Peru and my background has certainly influenced our study. Privatization in Peru has had a negative impact in the last twenty years due to downsizing. However, many who had lost their jobs have been forced to become entrepreneurs. Most of them have opened restaurants, commercial shops and so on in order to support their families. Although, this experience, has always been seen from the workers’ side and never from the owners’ and managerial thinking perspective. Perhaps, these preconceptions could have influence when interviewing the care personnel. However, our main study was the financial subject and its strategies from the owner’s perspective, from which I do not have any experience in the field.

Roger
My experience of elderly home care is limited to a few mostly negative stories concerning the care of my grandparents in their last years. The negative aspects were focused on political decisions and not caused by the care givers, so I do not have any direct preconceptions in this area.

However, I work in the private service sector, have done so since the year 2000, and might therefore be inclined to find private enterprises superior to their public counterparts. The stories I have heard from people working in the public sector have often contributed to strengthen my beliefs, although it is altogether possible that I have chosen to listen selectively. My prejudices in this area might cause me to want to ask questions that can reinforce my stance, such as focusing on efficiency issues in public organizations. Moreover, I do not believe in the existence of sheer altruism but rather adhere to the view that humankind is driven by egoism, even though I acknowledge that humans can do seemingly altruistic acts because of for example needs for self-fulfillment (such as helping someone
without a reward). This view might cause me to view the actions or desires of the interviewees in a slightly more egoistical light than might actually be the case.

My years as a business student, focusing mostly on the private sector, might also have colored my preconceptions, and of course caused me to think in certain ways concerning organizations, enterprises, efficiency in free vs. regulated markets, maximizing shareholder value and so on.

However, by working with Mery, whose opinions on the subject are slightly different, I believe that most of the potential adverse effects have been canceled out. Also, our supervisor has by reviewing and approving our choice of theory, our interview scripts and other parts of our study contributed in ensuring the neutrality of our thesis.

### 2.3. Perspective

We chose to adopt an owner perspective since the focus on the study is on the differences between public and privately owned organizations. Also, the study focuses on aspects on many levels of the studied organizations, which would have made for example a managerial perspective a little one-sided.

### 2.4. Scientific ideals

Because of the nature of the study, we had to adopt somewhat of a mix between a positivist view and a hermeneutical, leaning towards the latter. The reason for this is that while there were some elements that could be evaluated in a strict scientific manner (such as salaries, profits and so on) there was little reason to believe we would be allowed to access that data. Moreover, even though quality can be measured in a variety of ways, we chose to take a less technocratic view of what constitutes quality, allowing factors such as perceived quality into the study.

### 2.5. Scientific approach

There are two main approaches to scientific studies. One is inductive, which is of an exploratory nature, where the researcher tries to create theory from observations. The other approach is deductive, where the researcher tries to prove (or disprove) a hypothesis through existing theory and collected data.

Had we chosen an inductive approach, we would not have tried to establish a theoretical framework around our area of interest, but instead tried to study the field and create new theory from our observations. But since we were interested in applying existing theory, and since our goal is to draw conclusions of the behavior of the studied organizations, we chose to approach the subject in a more deductive manner. However, had we been pure deductivists, we would have established a hypothesis first; something which we chose not to do but instead took a more humble approach (realizing that we perhaps do not completely comprehend the problem area and its boundaries) so there is a slightly inductive tinge to the approach. This is
mostly evident in the exploratory aspect of the study, something that is a not too uncommon approach in the field of social sciences.\textsuperscript{26}

\textbf{2.6. Choice of secondary sources}

Our study is a combination of sociology, economics, science of law and medicine. During the years, the influence of the economics thinking has increased and taken more place in the medical care and social service care.

We chose this theory because it gave us three perspectives which should cover the entire width of the problem and thesis. There are two aspects of the main problem, which are quality and efficiency/profit (since there is no way to increase revenue under the current purchasing model, the only way to increase profits is to cut costs which can basically only be done through increased efficiency). These aspects are covered by the quality and efficiency theory parts. Moreover, the inherent conflict is mentioned earlier, between delivering the best possible quality and having maximum efficiency (particularly in a pure cost-cutting setting) and for this reason we also included the principal-agent theory.

We started by searching for books related to elderly care. Since our study is limited to the elderly care in Sweden, we begun by searching books and scientific articles from Sweden, both in English and Swedish. Our first thought was to search books and articles that could help us understand the elderly care system in Sweden and its changes. Thus, we began to search in the directory ALBUM and DATABASES from the Umeå University Library. Our first key word was: “Äldreomsorg” which gave 1003 results, “elderly” gave 464 results, “Svenska Kommunförbundet” gave 1052 results, “Organization in the Public Care Service” gave 68 results, “Care service in Sweden” gave 42 results, “Organisation inom äldreomsorg” gave 2 results, “Ledningen” gave 418 results. From these results, we found interesting books such as Maria Wolmesjö (which gave us a broad understanding of leadership in public elderly care, although we never used this as a source in this thesis): “Ledningsfunktion i omvandling”, Ulrica Wallin: Är en platt målstyrd organisation möjlig inom äldre- och handikappomsorgen?”, Kalle Kraus: ” Sven, inter-organizational relationship and control” and others.

Moreover, we wanted to find peer reviewed scientific articles in order make our sources more qualitative and credible for our study. We used the databases Business Source Premier (EBSCO), Emerald, Libris and Google Scholar. Our key words were: “elderly care Sweden” which gave 557 results, “purchaser – provider model” gave 5 results, “elderly care organisation Sweden” which gave 6 results and “care service in Sweden” which gave 140 results. We found that many studies have been done since the introduction of the purchaser – provider split. We found among others Ingrid Karlsson (as we mention aboved, this source also gave us a good understanding of leadership in the elderly care system, although we never used it as a source in this thesis ) “Att leda i kommunal äldreomsorg” and Blomqvist Paula: "The Choice Revolution: Privatization of Swedish Welfare Service in the 1990s".

After we understood more of the care system, we started to focus more on the problem of this study. Therefore, our second thought was to search sources which were more specific for the

\textsuperscript{26} Holme & Solvang (1997), p 51-58
aim of the study. Our key words were: “kvalitet“ which gave 667 results, “Svenska organisationen” which gave 259 results, “quality in the health care” which gave 8 results, “privata” which gave 148 results, “kvalitet inom äldreomsorg” which gave 11 results, “effektivitet” which gave 329 results, “productivit y” which gave 430 results and “privat vård” which gave 11 results. We found valuable sources such as Paula Likkonen: “Ekonomisk styrning inom sjukvården”, Patrik Larsson: ”Kvalitet, arbetstillfredsställelse och effektivitet i hemtjänst för äldre”, Westlund Peter & Edvardsson Bo: “Tjänsteutveckling och kvalitet i äldreomsorg” and others.

In order to find the best sources on agency theory, we started by searching for “agency theory” which gave 86 results, “principal-agent incentive” which gave 11 results, “principal-agent healthcare” which gave 24 results. From the results we found a general review of the theory area, Kathleen Eisenhardt’s “Agency Theory: An Assessment and Review” (which actually was quoted by 613 works) and David Sappington’s “Incentives in Principal-Agent Relationships” as well as Carolyn Hughes Tuohy: “Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena”.

There are other sources such as Beata Kollberg: “Performance System in the Swedish health care Services”, Steve Tax:” Managing Service Quality”, Barbara Holcomb et al: “Defining and measuring nursing productivity: a concept analysis and pilot study” and others which were found by reading our previous sources.

2.7. Criticism of secondary sources

There are of course an almost infinite number of ways to measure quality, partly depending on how it is defined, being an inherently subjective concept. We have chosen to use theory concerning quality of service, since elderly care is a type of service, and care quality, since the service actually is care. However, these two theories do not constitute the entire spectrum of available quality theories and might therefore be lacking in some respects.

Moreover, we have in the thesis defined profit generation as possible only through cost reduction, since revenue is fixed in the current system. While we hold to that view, there might be some other way to increase profits that we have failed to think of. However, we believe the main aspects to be covered through our efficiency theory.

Finally, the principal-agent theory is seen by some as controversial, while others see it as a very important tool in determining and understanding incentive structures. We were however satisfied enough with the pervasiveness of the theory to pass by using it in this context.
3. Theory

This chapter presents the theories that we consider relevant to our research. First, we present a model of our own devising that summarizes our thoughts on the choice of and interrelation between the selected theories in order to give a quick overview of our theoretical framework. Second, we present the theories, suborganized in three parts. The first part is the agent-principal theory, the second part is about quality measurement, and the third part is about efficiency.

3.1. Model of theoretical structure

By using agency theory, we can explain the incentive structures that motivate the different actors in the studied area. Owners and purchasers are principals, management is both principal and agent, and field workers are agents. One important difference is that between a private organization (with a profit-demanding owner) and a public one.

Quality theory provides us with a means to explain, understand and explore what quality means to the different actors and how the purchaser’s view of quality can differ from the care personnel’s, since quality cannot be measured in objective terms. We begin this section with a review of the concept of service quality since care essentially is a service and there are many interesting similarities between the concepts of service quality and care quality.

Efficiency theory is useful when discussing the measures the care providers can undertake for creating profit (since revenue is fixed under the current model). This can only be done by cutting costs, which mainly arise from salaries since elderly care (especially home care) is far more labor-intensive than capital-intensive.

The figure below summarizes and justifies this theoretical framework. The agency theory is pervasive throughout all of the studied entities, which constitute the boxes in the model (that is, the purchaser on top, the provider below and the care receivers in the bottom, and the owners and suppliers on the sides). The suppliers (clothing companies, work therapists and so on) are as mentioned earlier not included in this study since they make up a very small part of a care provider’s budget. The efficiency theory focuses on what happens inside the provider, which affects the “size” of the different arrows out of the box (the output) as a function of the input, the revenue from the purchaser, which is fixed. Since the profit indicated by the arrow pointing to the right must be taken from somewhere, which can be done by either decreasing any of the other output arrows or by increasing the output, or in other words, the efficiency. Finally, the quality theory focuses on the arrow in the bottom, consisting of the care produced by the provider, which after all is the purpose of the purchaser’s efforts. (As can be noted from the model, the purchaser is the ultimate principal (together with the owners for private providers), the personnel the ultimate agents, and the quality of the care the focus of the provider’s interest.)
3.2. Agent-principal theory

Agency theory focuses on the relationship between an actor that wants something to be accomplished (the principal) and the agent the actor contracts for the task. Focus lies on the contract between the actors.27

The theory focuses on two main problem areas that can occur in these kinds of relationships, the agency problem and the problem of risk sharing. The agency problem occurs when the goals of the agent and the principal are differing or conflicting, and the principal cannot accurately control or verify the agent’s behaviour. The risk sharing problem concerns the different risk preferences between the agent and the principal. 28

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27 Eisenhardt (1989), p 58
28 Ibid, p 58
For example, the shareholders (principals), normally working through some kind of representatives such as a board of directors, normally hire a CEO (as an agent) to run the day-to-day business for a company. However, while the shareholders’ (as represented by the board of directors) main interest is to maximize the stock value, the CEO might be more interested in maximizing his own salary, pursuing further career opportunities, creating a reputation for himself and so on. A solution might be to introduce some kind of profit-sharing program for the CEO, such as a bonus based on the actual profits. Such a solution would give the CEO incentives to maximize the profits, which would increase stock value. However, there are problems and drawbacks to such a solution. For example, what proportion of the CEO’s salary should be paid through the bonus program? While the board might prefer 100%, the CEO would probably be unwilling to agree to this because of the risk. (Agency theory often assumes that agents are more risk averse than principals, since the agent cannot diversify his work in order to spread the risk).\(^{29}\)

For this reason, the deal made between the principal and the agent, the contract, is the most important unit of analysis in the field of agent theory. Focus lies on determining the most efficient contract possible, based on a number of assumptions. These assumptions are that people have self-interest, a bounded rationality and are risk averse, while organizations have goal conflicts between their members, and that information is a commodity that can be purchased.\(^{30}\)

Agency theory has evolved in two somewhat different schools; the positivist agency theory, and the principal-agent. The first one is less mathematical and tends to focus on the relationship between owners and managers of large corporations. This school has given rise to important ideas such as the notion that outcome-based contracts make agents more likely to behave in the best interests of the principals, and so does also principals’ information about the agents’ behaviour. The second school of thought, the principal-agent research, features a more broad perspective on all kinds of principal-agent relationships. It is more abstract and mathematical, and its goal is often to calculate the most efficient contract in a given situation. Its simplest model assumes conflicting goals between principals and agents, a measurable outcome and agents that are more risk averse than the principals.\(^{31}\)

This model can be described in terms of two cases: the first one being where the principal knows exactly what the agent has done, in which case there is no need to provide an outcome-based contract, and instead use a contract based on desired behaviour. The second case is when the principal is not exactly sure of what the agent does or has done, in which case problems can occur, either because the principal and agent has different goals and desires, or because the principal cannot determine whether the agent has behaved correctly. These problems have two aspects; Moral hazard, when the moral of the agent results in unwanted behaviour (for example, the agent might be lazy and avoid working) and adverse selection (the agent is not the optimal agent for the job, and might for example have lied in his job application). One option might be to create some kind of information system to monitor the agent’s behaviour. This gives the principal better or complete information about the agent’s

\(^{29}\) Eisenhardt (1989), p 60-62  
\(^{30}\) Ibid, p 58  
\(^{31}\) Ibid p 59-61
behaviour, which reduces or eliminates the need for outcome-based contracts and increases
the need for behaviour-based contracts. 32

An assumption that might be adjusted is the one that agents are more risk averse (more prone
to want to avoid risk) than the principals, which might not always be the case. For example,
the agent might be economically independent and thus more willing to take risks. In these
cases, contracts could be modified to be more outcome-based. 33

Other factors that might be adjusted and have different impacts are for example the
assumption of goal conflict, which might not always hold true, and the level of
programmability of the task (which determines how easy it might be for the principal to
gather information about the agent’s behaviour), and how measurable the task outcome is.
Since the simple model assumes that outcomes can be readily measured, problems occur
when the outcomes are difficult to measure. For example, they might have long durations or
take a long time to create, require teamwork or produce some sort of “soft” outcome (like
well-being). 34

In the case where tasks require teamwork, a principal might use different schemes where the
agents are played out against each other. One variant is to have the agents act as monitors of
each other, through some sort of “squealing” compensation. Another is to arrange some kind
of “tournament” schemes where the agents are encouraged to compete against each other,
either for receiving compensation (if “winning” the tournament) or to avoid penalization (for
“losing”). Tournaments can also be utilized in situations where the principal is not really
aware of the agents’ maximum capacity; by simply awarding a prize for the best agent,
competition will ensure everyone doing their best (at least in a situation where outcomes are
measurable). 35

In some reoccurring principal-agent situations, another problem arises concerning the
principal’s knowledge about the agent’s maximum capacity. If the outcome of the agent’s
actions is measurable and some kind of evaluation is performed on a regular basis, the agent
might be unwilling to let the principal know about the maximum capacity, since that might
mean that future goals might be higher. In other words, if surpassing the expected
performance today causes higher performance demands tomorrow, there might be little
incentive to improve performance. 36

Another thing to note is that while an entity might serve as an agent in one principal-agent
relationship, the same entity could be a principal in another at the same time. This is
frequently the case in organizations, for example, where a manager serves as an agent towards
the shareholders, but as a principal in the relation to the employees, who then serve as agents.
A single agent can also have multiple principals at a given time, with different and sometimes
even conflicting goals between them. 37

32 Eisenhardt (1989), p 61
33 Ibid, p 62
34 Ibid, p 62-63
Number 2, 1991, p 54-56
36 Ibid, p 49-50
37 Ibid, p 62-63
Principal-agent relationships are not always dictated exclusively through incentive programs and contracts; there is also the issue of loyalty and pride. An agent might take pride in his or her work and perform tasks to further that pride. This may or may not further the principal’s goals, depending on the results.  

In a health care setting, the principal-agent theory can provide input to a number of relations. One of these is between the patient and the physician, where the patient is the principal and the physician the agent. In this case, the relationship is largely trust-based, or relationship-based, rather than contract-based. The reason for this is that the physician has much more knowledge about the medical area of expertise than the typical patient. Moreover, this has mostly been true about the secondary agent-principal relationship between the state (or politicians) and the health care provider as well. This means that the principals’ work has not been evaluated post-treatment, but instead being rated through a trust-based collegial evaluation mechanism by making would-be physicians (and other care personnel) pass through tests and screening processes before certification and employment. However, once past the needle’s eye, they have mostly been home safe.

This has somewhat changed through the introduction of more powerful information systems, however. When large databases containing patient and provider records were possible to “tap”, and thus reports on patient needs, provider costs and so on could be obtained, the information power of the state increased. This in turn created an opportunity for post-treatment evaluations, giving rise to contract-based accountability models. States could become “purchasers”, selecting between providers, negotiating deliverables and importing private market instruments into the public sector. However, the costs and complexity in implementing large-scale systems served as something of an opposing force to completely realizing the promise of contract-based care purchases.

### 3.3. Care and Quality

#### 3.3.1. Quality in services

Many researchers have tried to identify some aspects to measure quality. First, quality has to be visible and measurable. In order to know which of two products that has higher quality, measurable components have to be found. Suppose for example that a cake which has a higher proportion of sugar tastes better than one which has less. A factor related to this aspect in the service quality field, is for example time, which is measurable. Therefore, the number of hours worked by an attendant can be counted and compared to others.

Second, contrary to the first aspect, quality can also be invisible and impossible to measure. This aspect is about how people appreciate the phenomenon. A picture can be perceived as

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38 Sappington (1991), p 63
40 Ibid, p 198-200
beautiful, but why is hard to explain. It is wholly subjective and depends on the person’s knowledge of arts, taste, and emotions.\textsuperscript{42}

Third, quality is a customers’ experience. In the service sector, quality is also defined as the relation between customers’ expectations and customers’ quality of experience.\textsuperscript{43} Quality is hard to measure, because every person has different ways of seeing things. However, ISO (International Organization for Standardization), defines quality as based on a product’s or service’s properties which satisfies a requested need or un-requested need”. This means, sometimes the customers can not express their needs and it is necessary that the provider understand it\textsuperscript{44}. There is research identifying the factors that influence customers’ experience when they purchase a service. The factors are\textsuperscript{45}:

- Reliability: to trust the supplier’s work.
- Tangibles: it is important to take in consideration the work place, instruments, personal and communication materials to achieve customer satisfaction.
- Responsiveness: personnel social competence.
- Assurance: suppliers’ kindness, knowledge, credibility.
- Empathy: means the suppliers’ ability to understand individuals’ situation.

The last aspect is the price and quality: if there is any clear relation between price and quality. It is not always quality that satisfies customers, because they sometimes appreciate prices more than quality. For example, a businessman who has a car paid for by the company does not care whether the car is expensive or cheap.\textsuperscript{46}

Additionally, some research considers that workers’ conditions are also determinant factors in achieving good service quality. Bo Edwardsson and Bengt-Ove Gustavsson from the Service research Center, Karlstad University have studied work conditions in many different organizations, where the employees’ work environment was central in their study The following factors can help to improve employees’ performance and consequently service quality.\textsuperscript{47}

- a. An employee can exercise influence and control over his/hers own work situation. It is important that employees can plan his/her task, use his own methods, are allowed to set his/her own schedule. Naturally, it depends on the sort of work they do.
- b. Develop security and meaning. At work one needs security in life and good health, an income, good social relation and to feel that the work benefits others and him/herself.

\textsuperscript{42} E. Gummesson, Att förstå kundens upplevda kvalitet - vad kan offentlig sektor lära av näringslivet, Institute for Kommunale Ekonomi, Stockholms Universitet, p 7
\textsuperscript{43} I-L. Petterson & L. Backman et al, Personalen i fokus vid kvalitetssäkring inom vård och omsorg, Rapport från Arbets- och Miljömedicin, Stockholms Läns Landsting, 2003, p 9
\textsuperscript{44} Gummesson (1993), p 8
\textsuperscript{45} P. Larsson, Kvalitet, Arbetsstillförsel och Effektivitet i Hemtjänst för Äldre, Monograph from the Department of Sociology University of Gothenburg, no 51, 1993, p 21-22
\textsuperscript{46} Gummesson (1993), p 8
\textsuperscript{47} S. Tax, Service Quality: Crossing boundaries, Managing Service Quality, Vol 13, No. 2, 2003, p 153-156
c. Opportunity to keep a social distance to the job. This refers to employees who perform intensive service jobs. It is important that at the end of the day they can disengage from their work.

d. Maintain good health and avoid stress. Health and stress are consequences of having a bad work environment. This is an individuals’ subjective perception of how they are affected by the environment. Lack of time causes stress and can undermine the relationship between the customer and the personnel.

3.3.2. Care Quality

There exists neither a unique definition nor a standard for care quality measurement. One obstacle for finding a standard quality measurement or a national quality model stems from the fact that politicians, care staff and care receivers understand or define quality in different ways. Within the Health Care System, “good care” or care quality is about good health and welfare. In this case, there is more focus on the patients’ needs. According to the Health Authority, quality is an object’s- or phenomenon’s capacity to satisfy a need. The problem is that some studies have showed that it is difficult to find indicators to measure patient satisfaction, because, again, there is a lack of methods and definitions for quality. However, it is possible to measure patients’ experiences by measuring the quality process, which is how they receive care.48

Trying to solve this problem, the Health Care System and its statute called “Quality Assurance” was introduced to evaluate care quality. The statute was introduced for the first time in 1992. Since then on, it reinforces and improvements occurred, which did not have support from the leaders of the health care, or the methods were not sufficient for the quality control system. In January 1997, a new “Quality Assurance” statute was introduced to all kind of nursing care organizations which were run by the state, the county council, municipality or private organization. The new statute contained the importance of “doing the right things the right way”. There are three aspects to take into account; structure meaning the organizational structure, quality process meaning what happens when care is delivered; and quality production meaning how care has effected a patient. However, Erlingsdottir explains that even though Quality Assurance is a statute, this does not guarantee that the social authorities or other authorities have control over performance quality. That is because the lack of a standard quality measurement or model.49

Professionals (managers, executives or CEO:s) perceive care quality in different ways than patients do. Their research and definitions of care quality can be seen in The Health Authorities’ policy, State of the Art document and SBU’s (systematic evaluates health care technologies). Professionals have investigated how care quality is affected by the personnel performance. A care attendant who is very tired or unhappy does not deliver good care. Another factor that professionals stress is “time”; personnel who do not have enough time to help the elderly, will suffer from stress and might therefore deliver poor care.50

48 Socialstyrelsen, Övergripande kvalitetsindikatorer inom hälso- och sjukvården, Socialstyrelsens förslag, 2001, p 51
49 Ibid, p 10-12
50 Ibid, p 50
The social service law describes professionals as people with education and experience in service care, which is important in order to meet peoples’ needs and achieve good work care performance. The question is how do we know that the people’s needs of care are fulfilled, or more specifically, in what degree are the demands fulfilled by the providers? The social service law states among other things mandatory requirements for what the care provider has to do in order to accomplish the demands. If the provider does not comply with these requirements, they break the law. On the other hand, if their personnel manage to fulfill the mandatory requirements, all is well. This dichotomy means that here we are not talking about quality at all, but only take into account the legal demands.

The leadership (political leaders and administrative staff) perceive care quality at distance. For that reason their work is based on the legal target and statutes. The Health Authorities explain that politicians define “good care” as cost effective, efficient, high quality, readily available and accessible, good communication. However, access to the information sometimes is unfair, because not all the elderly people have access to information.

John Övretveit argues that service quality is more related to customers’ satisfaction, which is quite differently defined from care quality. Care quality is when someone needs something and wants something at the lowest price. Consequently, the authorities have to know how many people need care and see whether it is possible to supply those needs.

Now, what factors influence care quality? Researches show that control over one’s own work influences quality of performance. This argument is essential, especially in the service care system, where the politicians, administrators and personnel have different responsibilities. However, Westlund & Edwarsson argues that usually politicians and administrators states that good care quality performance depends on personnel competency (how to meet the elderly, how to inform the elderly, personnel’s further training). While, the personnel considers that care quality performance depends on the unit manager, nurses or the administrators and politicians. Politicians are blamed for a poor care quality performance because they have control over resources. Resources, which personnel, administrators and managers need to improve care quality.

Then, how professionals measure good care? To answer this question we have to look how Municipalities and the County Council measures good care. A report called “the open comparison 2007, the Elderly care” presented factors or as they call them indicators, which influence good care. The report also shows differences of giving “good care” between the municipalities, which we are not taking in this study. They use five indicators:

- Fall injury: many municipalities work on how to prevent accidents at home and outdoors that can cause serious injuries.

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52 Ibid, p 72
53 Westlund & Edvardsson (1998), p 70
54 Socialstyrelsen (2001), p 49
55 Ibid, p 51
56 Westlund & Edvardsson (1998), p 75
Planned care: it is important to plan on time and judge whether the elderly needs some kind of treatment. Many people get worse health as a consequence of wrong or forgotten diagnoses.

Proportion of the elderly who died in the hospitals: the goal is that the elderly can live as long as possible in their homes. It is important to offer help and care at home as long as they live.

When the elderly need more than three psychopharmacological drugs: the less the elderly needs the drugs, the better for their health. By taking too many drugs, the elderly’s health get worse.

Incorrect medication: the social service research has showed that people older than 80 years old typically use 10 different drugs. Especially elderly who live in housing care and those who live at home.58

Moreover, the report also has taken into consideration other prerequisites such as Personnel with education and experience deliver “good care”. However, the proportion of assistant nurses and home helpers with care knowledge have decreased in last few years. Employee turnover: this indicator measures security which includes continuity (the elderly feels secure when is helped by the same person). However, in the last few years, there are many workers who have retired and young people who have moved to other cities or changed jobs.59

As in service quality, “patients’ quality experience” is a factor related to the patients’ expectations and can be identified by qualitative or quantitative research.60 That is, patients are happy if their expectations are accomplished, and vice versa, patients are unhappy if their expectations are not accomplished. However, the patients’ expectations do not explain how the elderly understands quality and how it can be influenced. Despite an organization’s downsizing a survey did not show any negative quality experience. This makes it very difficult to define quality as the relation between the patients’ experience and their expectations. However, it is possible to define care quality by analyzing what providers do for the patients and how the service is performed. Quality can be measured technically or functionally. Technical quality is to help the elderly to the toilet, take a shower or otherwise help them with their hygiene. Functional quality regards personnel social competency, behaviour, availability, attitudes, internal relations and so on.61

There are many factors that can be taken into account when studying patient’s quality experience. These factors can sometimes overlap other factors, because they describe the same thing. Larsson (1996) have investigated factors that influence the elderly to experience care quality.62

The way personnel treat patients. Both care personnel and the elderly are happy with the relation they have.63
Influence and elderly adaptation. This factor deals with how much the elderly can decide for themselves and how much control the home helper has over the elderly. One problem emerges when the help is standardized which makes it hard for the elderly and the care personnel to evaluate what is good and what is not. For example, the care personnel have a list to help an elderly with breakfast in the morning and a shower in the evening. Perhaps some day, the elderly wants to take a shower in the morning instead of in the evening. This situation causes evaluation problems about what is the best for the elderly. Another problem arises when the elderly has little control over the resources. The control and decisions comes from the politicians who control the care providers and it can be a long process before the elderly obtain what they need, especially in the public service sector.

Time and stress. Many elderly experience that home-helpers are always stressed out because the time they have to help the elderly is short.

Continuity. This factor allows the patient and home helper to get to know each other and build trust, communication and evaluation of the situation. However, many studies showed that this factor does not influence the capacity for the elderly to experience a negative service. Many elderly says that it does not matter who comes to help them.

Personal competency. This factor refers to the personnel’s knowledge on house keeping, caring, morality and ethics which are very important for the elderly.

Relation. The social relation between the elderly and the home helper is important to create a comfortable environment for the elderly. There should be an informal system structure to maintain a closer relationship with the elderly.

Availability. It is defined availability as helping the elderly at any time.

Information. Some researchers assume that communication between the elderly and the home helper is the major factor of quality, because home helpers can work as messengers enabling contact with others. Good communication prevents conflicts between the elderly and the home helper.

Expenditure. This factor is difficult to study, because the elderly often have problems to understand the system fee.\(^\text{64}\)

3.4. Efficiency

Research has shown that efficiency and productivity are the keys to economical improvements. The word “efficiency” has many different meanings. Some books use productivity, rationality and even quality as synonyms of efficiency. However, some researchers separate these concepts. The most common definition of efficiency and productivity is\(^\text{65}\):

\(64\) Larsson (1993), p 31
“Efficiency is related to the organization’s target; this means doing the right thing in the right way, while productivity means doing things right”.

The following figure indicates efficiency and productivity measurement. The figure shows how the company/organization meets the target (efficiency), while productivity measures the relation between the amount of output and from a given amount of labor, capital and raw material.66

![Figure 2: Efficiency and productivity](image)

### 3.4.1. Efficiency in the service sector in Sweden

Every organization has a target which is more or less defined. Traditionally the target achievement indicates an organization’s efficiency. In the public sector for example, the administrative authority’s main target often comes from the general director or the leaders. Also, the administrative authorities or managers’ target are sometimes established by their superiors. That is, managers are in charge of meeting their superiors’ target or people from outside of the company or organization.68

In the case of the Labour Market Office, the target is part of national economic politics where targets are set by politicians. These targets are growth, stability in the labor market and fair allocation of labor, but they can be interpreted in many different ways69. For example, the Environment-Public Health Committee’s statistics show how many property owners have environmentally approved installations and they show how many installations. However, the statistics do not show owners’ attitudes to changes in the environment. Perhaps there are property owners with environmentally approved properties who use cheap but inappropriate installations which pollute more than those who are not environmentally approved but still are more environment-conscious.70

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66 P. Liukkonen, Ekonomisk styrning inom sjukvården, Liber Hermods, Malmö, 1994, p 91
67 Liukkonen (1994), p 91
68 Ragneklint (2004), p 31
69 Ibid, p 32
70 Ibid, p 33
In the same way, the Health Care’s target is to “give care to everybody”, “be available for everybody” and “give care at same conditions”. However, these targets do not tell us what these concepts means in practice. Many questions remain unanswered: How can they give care to everybody, how can they be available, and what does “care at same conditions” mean?  

3.4.2. Productivity

Productivity is also synonymously defined as internal efficiency which explains the correlation between output (for example, production quantity) and input (for example, working hours). In the health care system, productivity is defined as follows:

“the equilibrium between demand for and the supply of services” or “managing cost structure of system by integration of financial and clinical processes and providing high care quality in a cost effective manner” or “the level of nursing care that is adequate, affordable and acceptable to patients, nurses and physicians”

However, all of these definitions are explained using the relation between output and input. This means that productivity can be related to the care system, by measuring how much nursing will cost (input) and how much nursing will produce (amount of treated patients =output).

Apart from treated patients, what more can be measured? There four areas which are human resources, material resources, patient qualities and services provided, and each of them have their own measurement indicators:

**Human resources**: (these are executive, managerial, supervisory, licensed practical nurses etc). It is measured basically by counting the hours of work (productive time, non-productive time, meal, rest breaks, education activities, services etc) and also staff skills, nursing education level and salary.

**Material resources**: (equipment, supplies, and facilities). These are measured by purchaser cost, maintain and repair cost, number of beds or other indicators.

**Patient qualities**: (patient population and care staff population). It is measured by census, DGR:s (determine how much Medicare pays the hospital, since patients within each category are similar clinically and are expected to use the same level of hospital resources), Case mix index, acute levels, morbidity and mortality rates.

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71 Ragneklint, p 31
73 B. Abrahamsson & J.A. Andersen, Organisation – att beskriva och förstå organisationer, Upplaga 4,Liber AB, Malmö, 2005, p 195
75 Ibid, p 381
Services provided: (ambulatory care, home care, residential long-term care, surgical procedures, medical procedures, assessment and diagnostic procedures and monitoring) It is measured by unit service (ex how many patients, home care visitors, ambulatory care visits, completed procedure in a day), number of patients, how many minutes, hours or days for procedures or visit, etc.

In conclusion, what productivity actually measures it is the result of the relation of output and input. In order to be more productive an organization has to produce more with the same amount of employees, or it could produce the same with less employees. Secondary results of productivity are the satisfaction of the care personnel with their work, morale outcomes, patient’s attitudes and budget management.

Liukkonen has studied productivity measurement in the nursing care in Sweden. She uses performance related to resources (productivity = performance / resources). The factors that can be included in the numerator are the volume or amount of treatment, the amount of days to deliver care and the amount of patients. These measurements are not monetary. The factors that can be included in the denominator are the cost of the work force, operational cost, the amount of work days and amount of staff. However, she explains that the amount of staff and the amount of work days are inexact and it is better to use the hours of work and salary.

Holcomb have also measured productivity in the nursing care using the ratio of output and input (output/input = patient care hours/salary dollar paid) paid during a certain period. This means the number of hours of care provided to a patient, per salary dollar paid for a given pay period. For example, if the ratio was 0.04% then you get 2 minutes, 24 seconds per dollar. They also give some recommendations to develop productivity. One of these recommendations is that researchers have to take into consideration other factors that can influence the interpretation of productivity. One these influences is that if productivity is a result of some changes, factors such as staff experience or staff competency can influence these changes.

76 Nyström & Sjöberg (2007), p 3
77 Holcomb et al (2002), p 382
78 Liukkonen (1994), p 127
79 Holcomb et al (2002), p 383
4. Practical method

This chapter presents the research method used for the collection of the data in this study. We explain how our respondents were chosen as well as the proceedings of our semi-structured interviews, including the access we had to relevant information.

4.1 Choice of the research method

The reason for using a qualitative method for the interviews was that we were looking for information that might not come out well in a questionnaire or other quantitative measurement tool, such as opinions, attitude, and soft motivational factors and so on\(^80\). Since we wanted all kinds of opinions to be mentioned and lower the risk of incomplete answers, the interviewees will remain anonymous for everyone but themselves.

4.1.1 Choice of respondents

In order to evaluate the studied organizations, we have chosen to conduct a number of interviews with people working there. The criterion for selecting the respondents was based on the supposed knowledge of the respondents, that is, who could give us valuable information\(^81\). The respondents who we believed could give us information about the financial situation were: the CEO and/or owner from the private providers and the area commander and unit manager from the public provider. The respondents who could give us information about care quality were the CEO, the unit manager and the care attendants.

\[
\text{Structure of the public care provider} \\
\quad \text{Politicians} \\
\quad \downarrow \\
\quad \text{Superior Authorities (area commander)} \\
\quad \downarrow \\
\quad \text{Unit manager} \\
\quad \downarrow \\
\quad \text{Staff / care attendant} \\
\quad \downarrow \\
\quad \text{The elderly}
\]

\(^80\) Holme & Solvang (1997) p 76-80
\(^81\) Jacobsen (2002), p 199
Structure of the private provider

Owner
  ↓
CEO
  ↓
Unit manager
  ↓
Staff / care attendant
  ↓
The elderly

Figure 3: The authors’ own model of choice of respondents

Moreover, by interviewing respondents at different levels of the organization, we would hopefully gain a good understanding of how the different roles look on care quality. In other words, how the top management’s view of care quality differs from the field personnel’s view.

Next, we believed that interviewing three to four respondents from each care provider would be more than enough for our purpose, and that by choosing one respondent at each level of the organization we would get information from different perspectives on how they work with quality and efficiency. Since an interview has many details and information that we need to capture in each moment in order to make a good analysis, carrying out too many interviews would have made them impossible to analyze in reasonable way.

4.1.2 Choice of municipalities

When deciding what municipalities to study we thought that Umeå and Stockholm was appropriate due the facilities we had to make contact with the providers. This type of sampling called “convenience sampling” and belongs to the class of “non probability sampling methods”. We chose Umeå Municipality because Mery lives and studies in Umeå, and one of the Stockholm municipalities, because Roger lives and works in the Stockholm area. Furthermore, our strategy of choosing which care provider to interview was based on our problem statement. In our study, we aimed to find out how private providers of elderly care can generate a profit while maintaining at least the same quality of service. Therefore, we wanted to select care providers where the private and public provider had approximately the same measured level of quality, and the same approximate number of clients, to see how they differed from each other.

Umeå municipality

On the Umeå municipality website there is a lot of basic information of each care provider, through which we selected our providers.

83 Umeå municipality web site (2007-04-02)
First, we looked at all private and public providers in Umeå. Every year, the municipality conducts an elderly experience survey of the all private and public elderly homes in order to evaluate quality of the care service. The result is published on Umeå’s web site, making it easier for the elderly to choose the care provider they want. From this list, we selected two providers who had similar scores. We also wanted to identify organizations that have about the same volume of care receivers. Both organizations have housing care for the elderly and home-help service.

**Organization Pri090** - a privately owned company with about 14 residents in its housing care and 20 who receive home-help service. 89% of their elderly were very happy (37%) or quite happy (52%).

**Organization Pub090** – a public organization with about 8 residents in its housing care and 45 who receive home-help service. 90% of their elderly were very happy (15%) or quite happy (75%).

**Stockholm municipality**

In the Stockholm area municipality, the municipality sometimes performs a quality review where an independent reviewer is sent out with a number of quality criteria to analyze the conditions at each care provider. From the results of the latest one, published on the municipality’s web site, we selected two organizations which had similar evaluation scores and about the same number of clients.

**Organization Pri08** – a privately owned company with about 100 clients. In the quality review, they had a summarized score of 6 points (out of 10). They passed the authorization condition review but had some remarks on a couple of administrative processes.

**Organization Pub08** – a public organization with about 100 clients. In the quality review, they had a summarized score of 5 points (out of 10). They too passed the authorization condition review but also had some remarks on a number of administrative processes.

### 4.1.3 Choice of interview type

We chose to do a semi-structured interview. The major types of interviews such as structured, standardized, semi-structured, unstructured, intensive, in depth, focused, group, and so on are all, except the structured and standardized forms, used in qualitative interviews. In a semi-structured interview, the interviewer has a series of questions used as a guide for the interviewer. However, it is possible to vary the sequence of the questions if the interviewer finds it necessary. The interviews were carried out using an interview script with an option for the interviewee to elaborate on each answer should they desire to do so. The answers were recorded by tape recorder and/or by hand.

Since we conducted a deductive study; we used the theory to guide us to collect the data and answer the main questions. However, as we mention earlier, we are not pure deductivists,

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84 Withheld in order to ensure anonymity  
85 Bryman & Bell (2007), p.213
because we researched for relevant theories, and used them to construct research questions that could give the answer of our main question, but without deducing any hypothesis.

The questions’ structure was based on the purpose of our study and the theory. Bryman and Bell give some advice about how to structure an interview:

First, we listed our main topics in order to make questions in each area. However, we could change the order if we needed to. After reading our theory, we understood that the main problems in the elderly care system could be ordered in three main topics: motivation and incentives (agent theory), quality (care quality and service quality) and efficiency and productivity.

Second, we needed to formulate questions that were going to answer our main purpose. With the help of our supervisor and some friends we made sure that the questions were not too specific and leading. Jacobson explains that using specific questions deliver limited answers and answers that interviewees consider to be important, instead of capturing information that respondents consider to be important.

Planning the interview process depended on the respondents’ willingness to respond, time, and situation. The respondents were free to choose to conduct the interview personally or by telephone. We used the script interview to make sure that we captured the main information of this study. However, some questions were more or less general (related to both care quality and financial), such as “what are the purchaser’s requirement on care quality? (Question nr 5: Owner and the Area Commander) and “what measures do you take in order to improve quality? (Question nr 5: Owner and the Area Commander). These questions covered several areas.

4.2 Process of the interviews

In order to obtain a variety of relevant information we needed to create trust between the respondent and the interviewer, so the respondent can freely talk. For this reason, we began every interview by explaining about us, our thesis, our target and how the information was going to be used. Afterwards, we started asking questions from our interview script.

In Umeå, we conducted the interviews in person. After selecting the respondents, we called them and asked them for an interview. First, we contacted the public provider and first spoke to the unit chief who immediately answered and decided the day and the time of the interview. Then we requested interviews with two care attendants and the area commander too. The unit manager gave us the telephone number of two care attendants and the area commander. The unit manager and area commander had their office in Umeå city. The two care attendants were located in the housing care in a village three Swedish miles from Umeå city.

Meanwhile, we contacted the private provider and first spoke to CEO of organization Pri090. We also requested interviews with two care attendants and the owner. However, it turned out

86 Bryman & Bell (2007), p 483
87 Appendix 1, p 43
88 Jacobsen (2002), p 169
89 Ibid, p 168
that the CEO in fact was one of the four owners, CEO as well as unit manager of the company.

**Organization Pri090 (private)**

*Owner, CEO and unit manager, Pri090*: the interview was carried out at April 22 at 1:00 p.m. The respondent had all three positions in the company. The respondent seemed to be a little stressed, because they were about to begin an activity that they had every Tuesday. There were quite a lot of people outside of the office preparing coffee and some cakes. However, the respondent did not say anything about being short of time. As soon as the door was closed, no one interrupted us during the interview. The answers were very clear and direct to the point.

*Care attendant 3*: the interview was carried out at April 24 at 12:30 p.m. The interview was quite stressed, because the only time that we could interview was during their lunch time, although the respondent never mentioned wanting to hurry up the interview. The respondent was very glad to be useful for our project. We sat in the dining room, but on three occasions other care attendants came asking questions. However, the respondent never forgot what was being said.

*Care attendant 4*: the interview was carried out at April 24 at 1:00 pm. The interview was stressed and brief due to the lack of time. We sat in the dining room where on two occasions some people came in to room to do something. However, we were alone most of the time. The respondent was a very glad person and this made the interview a little easier.

**Organization Pub090 (public)**

*Unit manager (Pub090)*: the interview was carried out at April 14 at 8:00 am. We used a meeting room, where nobody interrupted us. The respondent had a very calm and comfortable behavior and showed interest in answering the questions. Some questions took longer time to answer, compared to others. There were no signs of time shortage.

*Care attendant 1*: the interview was carried out at April 17 at 11:00 am. We sat in the office. The respondent was very enthusiastic but a little nervous in answering the questions. In two occasions we were interrupted by a nurse who wanted to pick up some things from the office. However, it did not affect the respondent’s answers because, she requested me to ask the question again, not showing any signs of stress or pressure to end the interview.

*Care attendant 2*: the interview was carried out at April 17 at 12:00 a.m. After the interview with care attendant one, the meeting room was free and we could sit and talk there without any interruptions. The respondent showed self-confidence and seemed willing to answer the questions. On one occasion we were interrupted by one of the patients who opened the door and wanted to talk with the respondent. We stopped recording and after that we begun by repeating the question. There were no signs of a lack of time.

*The Area Commander (Pub090)*: The interview was carried out at April 17 at 3:00 p.m. The respondent had requested the questions in advance in order to prepare the answers. We sat in the Social Service offices without any interruptions. The respondent had a formal and calm tone. No signal of having short of time or any problem in responding. The respondent showed a tendency of drifting away from the interview script. This made it a little harder for the
interviewer to understand the answers. However, there was no problem of asking for an explanation. In many occasions the respondent mentions that it was fine to mail or call by telephone if we did not understand some answers, which we did.

In Stockholm, the interviews were made by phone since the interviewees were short on time.

Organization Pri08 (private)

The first respondent was the CEO and owner of the private company. That interview was carried out at April 21 around noon. At the beginning of the interview, the respondent seemed to be a bit stressed for time, however none of this was evident in the length of the answers, and the interview took quite a long time to finish. Overall, the respondent seemed happy to participate and eager to help.

Then came the unit manager for Pri08, who was interviewed at April 29 around noon. This respondent seemed to have plenty of time and took care to answer the questions as exactly as possibly. The respondent seemed worried about how to answer some of the more complicated questions, but after some explanation, everything worked out fine.

The personnel representative (no 5) for the same company was harder to get a hold of and was interviewed at May 2 at 4:30 in the afternoon. Earlier the same day, the respondent desired a callback at that particular time. At the beginning of the interview, there was a tangible feeling of stress, which however quickly evaporated and the respondent took more than enough time to answer the questions.

Organization Pub08 (public)

For the public provider, the first interview was conducted with the area manager of Pub08. This interview was at April 18 on the afternoon. There was no sense of stress during the interview and it was easy to return to earlier questions for clarification.

On May 5 at 10:00 am, the care attendant 6 from the public provider was interviewed. This was done as a callback from five minutes earlier since the respondent was taking care of a patient at that time. This respondent had plenty of time and seemed eager to answer the questions as good as possible.

Finally, the area commander from Pub08 was interviewed at 1:07 pm on May 6. This respondent seemed skeptical at first but this soon changed and turned into a very interesting interview where the respondent was noticeably interested in understanding the questions and answering them in full. The respondent even expressed a spontaneous desire to see the transcript and filled in some missing information before returning it, which was very helpful.
4.2.1 Summarizing the interview process

<table>
<thead>
<tr>
<th>Organization</th>
<th>Respondents</th>
<th>Date</th>
<th>Time</th>
<th>Interview type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pub090</td>
<td>Area commander</td>
<td>April 17</td>
<td>15:00 - 16:23</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td></td>
<td>Unit manager</td>
<td>April 14</td>
<td>08:00 - 08:35</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 1</td>
<td>April 17</td>
<td>11:00 - 11:35</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 2</td>
<td>April 17</td>
<td>12:00 - 12:37</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td>Pri090</td>
<td>Owner, CEO and unit manager</td>
<td>April 22</td>
<td>13:00 - 13:35</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 3</td>
<td>April 24</td>
<td>12:30 - 12:45</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 4</td>
<td>April 24</td>
<td>13:00 - 13:17</td>
<td>Semi-structured Person interview</td>
</tr>
<tr>
<td>Pub08</td>
<td>Area commander (C)</td>
<td>May 6</td>
<td>13:07-13:57</td>
<td>Semi-structured telephone interview</td>
</tr>
<tr>
<td></td>
<td>Unit manager C</td>
<td>April 18</td>
<td>16:00 - 16:30 (approx)</td>
<td>Semi-structured telephone interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 5</td>
<td>May 5</td>
<td>10:00 - 10:30</td>
<td>Semi-structured telephone interview</td>
</tr>
<tr>
<td>Pri08</td>
<td>Owner and CEO (D)</td>
<td>April 21</td>
<td>11:15 - 12:00</td>
<td>Semi-structured telephone interview</td>
</tr>
<tr>
<td></td>
<td>Unit manager D</td>
<td>April 29</td>
<td>12:00 - 12:30 (approx)</td>
<td>Semi-structured telephone interview</td>
</tr>
<tr>
<td></td>
<td>Care attendant 6</td>
<td>May 2</td>
<td>16:30 - 16:50</td>
<td>Semi-structured telephone interview</td>
</tr>
</tbody>
</table>

Table 1: The authors’ summarizing table of the interview process

4.2 Access

The collection of data is extremely important for the credibility of the research and for how credible our data is. The respondents can lie; maybe they do not have knowledge or information about the questions, or perhaps they give us wrong information\(^{90}\).

The personnel respondents of the both public and private care providers had difficulties to answer question nr 2, about quality evaluation in their organisation. After we explained it, they understood. Some of them claimed that they have never been in any kind of quality research. However, they asked whether having meetings with their managers and talking about how they experience their work was part of the quality research. We answered that those meetings can be part of quality work research in their organisation. We believe that the fact that they did not understand the questions does not affect the credibility of our study, because our study focuses on the owner perspective and it is not related to the problem. Our intention was to know the awareness of the personal of quality in their organisation. The fact

\(^{90}\) Jacobsen (2002), p 195
that they were unaware or failed to understand the concept at first is also a rather interesting form of response, although to an unasked question.

Selecting the care staff of each care provider was not possible. In both cases, the unit manager gave us the names of the persons who were able to answer. However, the care attendants are not our main focus on our study and therefore the selection would not affect our analysis.

When interviewing the care attendant nr 3 and 4 was a little difficult due to the short of time. The interview was more like asking and answering questions. They were stressed, because the interview was conducted during their lunch time. For that reason, we did not want take too much of their time. However, as we explained earlier, it does not affect our study because we aim to focus more on the owners’ perspective of quality and profit.

Most of the providers did not allow us access to their financial data for uses such as calculating salaries, number of care hours and so on. Consequently, we were not able to make any exact calculations of the providers’ productivity or internal efficiency. However, this did not affect the study too negatively since our method was qualitative anyway.
5. Analysis

In this chapter, we present our empirical findings together with our analysis based on the theory used.

After transcribing the interviews, we classified all the statements which were related to incentives, efficiency and quality, in order to analyze them in a structured manner. Some of the answers were used for more than one theory area, depending on their nature. The statements were studied carefully in order to find the answer what incentives we could identify, what efficiency measures were taken, and what quality means for the care attendants and what differences were between the private and public providers. All the interviewees were grouped according to the table of the private and public providers’ interview process that we presented earlier.

5.1. Motivation and incentives

5.1.1. Personnel

When asked why they have chosen to work with elderly care, all of the respondents in the private sector state that it is because they enjoy working with and caring for people. One of them adds that it is the only thing she naturally knows how to do. This reason is also given by most of the respondents in the public sector except one, who says it is because the government paid for her assistant nurse education (which is also given as the first reason for one of the other public sector respondents. Curiously enough, all of the respondents in the public sector have an assistant nurse education while only one out of three in the private sector has the same level of basic education. One of the respondents in the public sector spontaneously said that she does not have any use for her education.

Two out of six do not want to continue working in elderly care in the future. One of these works in the private sector and one in the public sector. The one working in the private sector says she wants to move on to health care instead (and therefore pursues an assistant nurse education on her spare time), while the one in the public sector says that the work is too hard and takes its toll on her body. It can be noted that the one in the private sector works 50 hours a week (although claiming it is by her own free will) and the one in the public sector works 40 hours a week and wants to go down to 30 hours, but she is not allowed to do that.

Working hours differs markedly between the personnel sectors, with a mean of 43 hours a week for the private sector and 33 hours in the public sector. One of the respondents in the public sector works 28 hours and wants to work more, which she cannot because of work shortage. Another public sector respondent is as mentioned above unhappy since she wants to cut work to 30 hours. The respondents in the private sector, meanwhile, express no desires to change their number of working hours except for one who wanted to work 100 % instead of 98 %.

Among the staff, there is an interesting difference in semantics as related to the elderly people in their care. However, this does not seem to be correlated to whether the respondents work in
the private or public sector, but rather to their geographical location. While all of the respondents in Umeå use the term “the elderly”, “our elderly”, “the care receivers”, all of the respondents in the Stockholm municipality use “the customers” exclusively instead. This could be attributed to the fact that in Umeå, the elderly are not free to choose their care giver for housing care (instead, the municipality chooses for them in their role as purchaser) while in Stockholm, the elderly are free to choose individually between a number of private and public providers both for home care and housing care.

There does not appear to be any differences between the personnel’s experience of their level of participation between the private and public sectors. In both cases, the managers seem to plan work both in terms of scheduling and nature, but they all seem to feel that their input is regarded and that they can change things.

Concerning education, there seems to be a more marked difference between private and public providers. While the respondents in the private sector has a low level of basic training (that is, relevant to the job) they seem to think that they get more education at work, during paid work time. The respondents in the public sector seem to have less access to education at work, they only give one example of courses taken while the respondents in the private sector gives five examples. However, as mentioned earlier, the respondents in the public sector have a higher level of basic education, all of them being assistant nurses.

5.1.2. Unit managers

The threat of competition motivates the respondents in the private and public sector differently. While the unit manager of the private provider replies that she does not feel any threat but instead focuses on them doing their best, the respondents from the public providers both feel the threat. One of them says that the private providers “are coming on to our customers all the time, promising them milk and honey”. The other one thinks that the threat of competition makes them focus on doing things right, while she thinks that some of their personnel takes it seriously while others regard it as an empty threat.

The unit manager of the private provider motivates her personnel to deliver quality by telling them if something does not work, and if someone is doing something wrong the tells them that straight to their faces. One of the public unit managers motivates her staff through education and explaining to them, while the other thinks money would be a motivator.

The respondents reply differently regarding what they think motivates their personnel besides their own actions as managers. The private provider’s unit manager says she thinks they are motivated by an interesting job, to help the elders and to meet people. One of the unit managers from the public providers thinks that they are motivated by having a simple job which is free in nature that you do not bring home with you when the day is over and does not require much thinking. The other public provider unit manager thinks that it is hard to motivate unmotivated personnel. She wants to be able to replace some of them but since that is not possible, she instead encourages them to work less hours or change workplace (either another unit within the elderly care sector or a different job altogether).

Regarding how they follow up and monitor their personnel’s work, the respondents answer differently. The unit manager from the private provider works with care herself while on duty,
and she carries a special cell phone which all personnel and customers can call if something goes wrong. Meanwhile, the first unit manager from the public provider strives to be in the office all day, having her door open for them to come in. She also has lunch with the personnel in the lunch room 2-3 times a week. The second unit manager from the public provider states that she has ”complete control over her personnel” since they are not so many (23 ordinary + 20 extras). She also mentions that they” even have regular development talks with all personnel”.

5.1.3. Area Commanders / CEO:s

The top executives of the four organizations have a number of different views regarding the subject of motivation and incentives.

The private provider Pri08 tries to motivate its personnel by having activities like "Ladies Night", participating in running competitions, going to restaurants and other teambuilding activities. The other private provider, Pri090, holds several gatherings around the year such as a Christmas party, a spring party and an autumn party, as well as health activities like walking sticks, gym memberships and massage. The public organization Pub08 motivates their personnel by observing holiday traditions and a daily morning assembly, as well as individual salaries. The public organization Pub090 motivates their staff by trying to get them to think about things from the perspective of the elderly care receivers.

Both of the private organizations claim to offer their personnel continuous competence development by sending them to seminars and so on. The public organizations do not claim to offer the same on a continuous basis, but one of them hands out an annual staff survey that among other things contain this issue. The other one mentions an activity two years ago.

The ownership structure, in the case of the private organizations, and political structure, in the case of the public organizations, are a little different through the four organizations. The private providers have few owners (organization Pri08 has one and organization Pri090 has four). The public organization Pub08 has its top executive reporting to "the production board" which is a board containing all of the municipality’s producing organizations. This means that they are totally disconnected from the social services board in terms of reporting and responsibility (however, they are still under review by the social services board, and that board are also the ones who set the size of the payments made to the providers in the municipality). The public organization Pub090, on the other hand, reports directly to the social services board.

From an incentive and agency perspective, the question about how profit demands are set and met should be the most interesting one, and the question closest to the heart of this study. As it turns out there are some surprises as well as some answers that could be expected. The findings in this area will be listed in these four consecutive paragraphs, one for each organization:

Organization Pub090 (public) naturally does not have any profit demands. Last year, however, the politicians demanded they should cut expenses, which they did by downsizing

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91 Eisenhardt (1989), p 58
the personnel. As for balancing between cutting costs and quality, she replies that since the politicians have demanded costs to be lowered, they should be prepared to lower the quality demands.

**Organization Pub08** has, somewhat surprisingly, set profit goals. The production board expects the elderly care organization to run with a profit that should provide 1.5% of their total operating budget each year, money which is used to fund municipality spending. However, the respondent also claims that these demands are rather flexible and as long as she can express why her costs are larger than expected they will provider her with resources to cover up any losses.

**Organization Pri090** claims that it is very immodest or impolite to discuss profit for private companies in their line of business. However, she also claims that profit is necessary for development, and that some years are better and some worse. She also states that profit must never be more important than quality.

**Organization Pri08** has no set profit goals. The CEO and owner instead states that there is no way the company can operate at a loss. Instead, if costs should increase too much, she cuts down on the personnel’s activities and refrains from spending on their extras. She claims that it is the only way they can save since they can by no means reduce care quality.

### 5.1.4. Summary

By viewing the motivational factors from an agency perspective, there are a number of aspects to discuss. The first one concerns the principals’ knowledge about the agents’ work. As mentioned earlier\(^2\), a number of principals and agents can exist simultaneously for any given situation. In the model presented in this case, the purchaser is a principal, the owners are principals (for the private organizations), the municipality is a principal in its role as provider, the top manager is a principal for the unit manager and/or the personnel and the unit manager is a principal for the personnel. Moreover, the top manager is an agent for the owners, the unit manager an agent for the top manager, and the personnel are agents for the management.

In this study, an important information asymmetry\(^3\) exists; none of the principals know exactly what the agents have done. This is because the outcome cannot be measured objectively- for example, it is hard to quantify the value of personnel talking to an elderly person.

Another agency-related problem in this study is that the principals do not know the agents’ maximum capacity. For example, the employer cannot tell whether their personnel are performing 100% of their ability. Neither can the purchaser tell if the provider is delivering full value.\(^4\)

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\(^2\) Sappington (1991), p 62-63
\(^3\) Eisenhardt (1989), p 61
\(^4\) Sappington (1991) p 54-56
All in all, there is potential for trouble, such as moral hazard\textsuperscript{95} (if for example the personnel shirks on the job, or a morally abject provider starts delivering care) or adverse selection (hired personnel is not suited for the line of work, or a new provider does not really know how to perform elderly care).

What then are the differences between the public and private providers from an agency perspective? One difference is between the level of direct, non-payment, motivational activities performed. While the private providers set up their staff with a number of activities for team-building and motivation, the public providers seem not to do so.

Another regards education. The public providers seem to hire qualified (over-qualified?) people and neglect to educate them further, while the private providers seem to hire unqualified workers and educate them.

Concerning profits, the picture is both clear and unclear. While the private providers more or less have to at least break even financially (or risk having to close down permanently), the public providers can always ask for more money from the municipality. Both of the private providers of course claim that there is no way that profits are prioritized before care quality, however, even if they were they would hardly come out and say so. However, since the provider is paid for the actual number of care hours performed, there is no way they could save money by cutting down the number of care hours delivered. However, they can still save money in ways that could potentially lower quality, such as paying lower salaries (which would increase the risk of adverse selection), cutting down on education, and teambuilding (and thereby risk decreasing loyalty). In the long term, this might lead to their customers leaving them and choosing another provider.

The public provider Pub08 has a clear incentive to increase profits, since they have explicit profit demands. However, since their customers could easily switch to one of the private providers, they also have clear incentives not to lower service quality. The public provider Pub090, who does not have any incentives to increase profits whatsoever is interestingly enough the only provider whose top manager openly claims to be ready to lower quality if the politicians decrease spending.

\section*{5.2. Efficiency and productivity}

\subsection*{5.2.1. Personnel}

One striking difference between the private and public sector personnel is the number of hours worked, as mentioned above. The respondents from the private sector works 50, 40 and 40 hours a week, for a mean of 43 hours, while the respondents from the public sector works 40, 33 and 28, for a mean of 33 hours. This is of course highly inefficient even though they are paid for the hour, since every employed person demands overhead resources (administration, clothes, equipment, insurance and so on) and know-how about the specific working situation. However, since the study only features six personnel, which have not been randomly sampled, we will not draw any major conclusions from this.

\textsuperscript{95} Eisenhardt (1989), p 61
When asked about how initiatives for change were handled, more or less all personnel said they would take it with their manager if there was something they wanted to discuss. The only difference between the private and public sector in this aspect seems to be a slightly higher level of bureaucracy in the case of the public organizations. One of the respondents in this sector mentioned that their manager comes around about once a week, while the other one speaks with her boss once a month. The private sector respondents seemed to have more easy access to their managers; however, one of them represented a rather small organization.

5.2.2. Unit managers

The unit manager from the private provider Pri08 mentions that problems can sometimes arise regarding personnel since the care attendants need to know what to do. Therefore, they do not work with any substitute personnel, but they have some employees paid by the hour which they can use if they need extra help.

When asked about the problems they face as middle managers, the private unit manager and one of the public unit managers both claim to have no problems and good communications both ways. However, the unit manager of provider Pub090 listed a number of problems including an organization that is hard to change, hierarchic, absence of strong leadership and self-prioritizing top management that does not act decisively. Either there is something very wrong with her organization, or the other two managers are afraid to speak up.

Concerning pragmatical efficiency measures taken by them, there were some differences between the private sector respondent and the public sector ones. The private sector unit manager focused on reducing hard costs (by efficient planning that makes sure staff does not have to go on overtime, and by switching their cars to environmentally friendly ones). The public sector respondents focused on routines, structure, collective meetings and so on. One of the public providers’ unit manager stated that she did not want to increase efficiency further since that would lower quality.

5.2.3. Area Commanders / CEO:s

Generally, the highest managers in the public sector seem a little detached from the actual care work, which however probably is natural since their organizations are larger than the private ones in the study. An interesting difference is the number of administrators, where one of the private companies had 1 administrator (out of 35 personnel) while a public provider had 10 administrators (out of 100 personnel). The private administrator had outsourced all administrative work and said “Care comes first.”

None of the studied organizations claimed to have any problems with neither personnel turnover nor short-term sickness (or long term for that matter). One of the private providers added that if personnel call in sick without really being ill, they cannot remain in the organization. She also added that this behaviour was more common among employees fresh out of high school.

Concerning efficiency, the public sector area commanders distinguish themselves by both using Balanced Score Cards. The private sector managers had no formalized way of calculating efficiency. One of them claimed that the nature of the work made it impossible to
talk in terms of efficiency, since each patient must be allowed to take their time. One of the public sector managers, on the other hand, said that efficiency was about reprioritizing between different social priorities (like handicapped people and elderly care), something that was not up to her to decide.

5.2.4. Summary

The private organizations seem to utilize their staff more effectively, as far as the study can tell at least. The public organizations seem more bureaucratic.

The private organizations seem to view efficiency as more related to reducing hard costs while the public ones seem to view the subject as working more effectively or reprioritizing.

The public organizations seem to be heavier on administrators per capita. However, they are also potentially better in quantifying efficiency since they are using a formalized system.

As to whether the organizations studied are meeting their targets, it can be argued that they do. None of them have any quantifiable targets in an efficiency perspective, but rather strives to deliver care within budget and with satisfied customers. To increase external efficiency, they can either try to increase their quality of delivered care (output), or decrease costs (input). The only organization that actually mentions trying to decrease costs is the private provider in Stockholm.

Concerning internal efficiency, or productivity, the main activity seems to be schedule optimization, increase hours worked, and reducing the number of administrators. We were sadly not given access to such data that would allow us to quantify these aspects (such as calculating salaries/number of care hours and so on).

5.3. Care and quality

5.3.1. Personnel

Our purpose in interviewing the care attendant from the private and public care providers was to see if there was any difference between them, in delivering care to elderly. In other words, what is care quality for them and how they deliver?

The care staff from the public providers explain that good care is to “give the elderly all they need”. Further, good care is that the care staff is available for them all the time, listen to their anxieties, give them their medicine on time, and give them good food. Another factor that Attendant 2 mentioned was is “working conditions”. This person assumes that it is important to have a good relationship with colleagues and that every one has the same objective in doing a good work. Care attendant 5 emphasizes shortage of care staff as an important factor to

deliver good care. By having more care personnel, the elderly could perhaps be taken out for a walk, and perhaps they could have more time to spend with them.

The staff of the private providers describe that the elderly need to feel secure and receive all the help they request. Other factors that are mentioned by them are that the elderly expectations are fulfilled, security, responsiveness, empathy. The were only one care attendant who mentioned how the low salary and the low status influence that many people do not work in the care service and therefore there are many care attendants with no education.

We can see that the care attendants in the private and public care provider do not perceive good care very differently. Both private and public staff seem convinced that shortage of staff and working conditions are influential. Having more personnel gives them time to listen to their anxieties and perhaps take a walk when it is nice weather. Lack of time is a consequence of shortage of staff and it is a negative factor in delivering good care. Despite that quality care can only delivered by the care staff, we are surprised that there seems to be lack of information about quality evaluation, that is to say that the care staff do not know anything about the elderly experience survey that the municipality conduct every year.

### 5.3.2. Unit managers

Interviewing the unit managers was made in order to see whether private and public providers have the same understanding of good care as the care personnel and the area commanders. The most important thing was to find out if there were any differences between the private and public providers.

For the public care providers the unit manager from Pub090 defines quality as the good relationship between the care personnel and the elderly to create security, time to deliver their care. However, staff’s attitudes towards the elderly is the most important factor. Since care attendants are close to the elderly it is crucial that the care attendants can evaluate what the elderly needs the most. Perhaps some days they do not need to have help with the breakfast and instead they need to buy something. The respondent explains this as the right evaluation of the situation. When there is shortage of staff, managers have to optimize schedules in order to have care personnel when the elderly needs them the most.

Moreover, both managers agree that the care personnel needs a continuous education, good relationship between the care staff and the unit manager, continuity, empathy and access to information are factors that influence good quality.

As for the private care providers, the unit manager from Pri090 follows mandatory statutes of care quality from the municipality and other regulations and then defines good care by saying: “I deliver the care quality that I want for my parents when they become old”. To accomplish this, the respondent educates the care staff about the outlook on people that the organisation has. Moreover, happy care staff delivers good care, which is why the care staff is evaluated constantly by the unit manager in personal meetings as well as by the elderly relatives. If there is a shortage of staff, schedule optimization is a primary priority to have care personnel when the elderly needs them the most.
The unit manager from Pri08 considers, on the other hand, time as the most important factor to deliver good care. Moreover, she wants to give the elderly all the care they need. For this reason, it is important to have educated care staff in order to know what it is important for the elderly.

5.3.3. Area Commanders / CEO:s

From the public care providers, the area commander of Pub090 never defines care quality from the elderly or care staff perspective. Instead, the respondent puts forward the elderly experience survey of the all private and public elderly homes which the municipality conducts every year in order to evaluate care quality. Moreover, the respondent defines quality as targets established by politicians which are presented by the Social Service office. Every year the Social Service sets targets about what they need to improve, in certain areas. The target for this year is for example to give early support to the elderly and methods to prevent accidents. The respondent works also in other areas improving care quality by using BSC (Balanced Scorecard). It sets a number of targets in certain areas that need to be improved. This year the area commander’s target is to improve how to treat the elderly, by improving information and availability.

On the other hand, the area commander of Pri08, perceives quality as participation, influence, respect, and confidence for the public provider. The respondent also mentions the elderly experience survey. It measures function (how well the elderly is helped) and meaning (how important the help is for the elderly). From the results, the area commander takes measures to improve the result.

Both commanders explain that further training and information about clear expectations are ways to meet the elderly important factors in delivering care.

As for the private care provider, the CEO and owner of Pri08 claims care quality is to fulfill the customers’ (elderly) needs. In this area the organization’s care personnel are more service targeted as a consequence of hard competition. The organization has to work hard with keeping up good care quality so they keep their customers too. To meet this they work as all care providers with further training, seminars and so on. Communication improves by constant meetings in which they discuss and follow up care quality and customers or the elderly situation.

Contrary to the public care providers they explain that NKI (kundnöjdhet = happy customers) is a customers’ survey where they measure how happy the customers are. The customers can also manifest their satisfaction or dissatisfaction with the help.

5.3.4. Summary

The care attendants’ definitions are subjective. In both private and public organization, there is not much difference in defining care quality. We find the most important factors that define good quality, all of them related to customers’ satisfaction⁹⁷:

⁹⁷ Pettersson et al (2003), p 9
- Giving the elderly all the help they need,
- Treating them with respect,
- Giving security,
- Fulfilling their expectations,
- Listen to their anxieties,
- Having empathy
- Work environment (work environment influences their performance and consequently influences the care they deliver)\(^98\)
- Shortage of care staff (this factor causes lack of time, stress and undermine the relationship between the elderly and personnel\(^99\))

Care attendants try to understand and satisfy the un-requested and requested needs, by giving the elderly all the help they need. These concepts are individualistic and subjective. Care attendant sees the relationship they create between the elderly and themselves as determining factors in giving them all the help they need (customers’ experience and customers’ expectations)\(^100\). Moreover, care attendants feel that they are doing a good job if they see the elderly happy (empathy).\(^101\)

We found that none of the care attendants in the private or public provider have any knowledge about the evaluation that the Municipality of Umeå conducts to all private and public housing care and home care. This problem can be a consequence of hierarchic levels in the elderly care system\(^102\). Every level has different concepts on care quality. In that way, care staff, managers and politicians understand quality in different ways. One question that comes to mind is why the managers and area commanders do not take the trouble to inform them?

We found that the schedule work in both public providers is done by the care staff. According to Bo Edwardsson and Bengt Ove Gustavsson\(^103\), better work conditions help to improve performance. In this study the public care staff has the possibility to influence and control their own work situation; consequently this can improve care quality.

The **unit managers in the public provider** sector defined quality using the following factors:

- The good relationship between the care personnel and the elderly
- Staff’s attitudes,
- Good schedule
- Empathy and personnel’s attitudes and knowledge of care
- Continuous education

While the **unit managers in the private provider sector** explain care quality taking into consideration the following factors:

- “I deliver the care quality that I want for my parents when they become old”

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\(^{98}\) Tax (2003), p 153-156  
\(^{99}\) Tax (2003), p 153-156  
\(^{100}\) Gummesson (1993), p 9  
\(^{101}\) Larsson (1993), p 21-22  
\(^{102}\) Socialstyrelsen (2001), p 51  
\(^{103}\) Tax (2003), p 153-156
- Happy care staff delivers good care
- Mandatory and statutes of quality from the Municipality and Health Care
- Good schedule
- Give the elderly all the care they need
- Time

Curiously, only one of the four unit managers mention the mandatory rules and statutes that they have to follow when delivering care quality. The question would be, do the providers follow these statutes or do they ignore them? As Erlingsdottir explains from our theory, having quality statutes does not guarantee that the social authorities are in control over the care provider’s performance\(^{104}\).

All the unit managers in both private and public providers define quality as depending on how good the care staff’s performance is. That is, they consider the kind of care given to the elderly to be in the hands of the care staff. To know how well the care staff deliver good care, they conduct surveys measuring the functional quality\(^{105}\) (staff attitudes, empathy, educated staff, good scheduling, social competence, education, care staff’s kindness, knowledge and last and most important, the care staff’s ability to understand the elderly’s care situation).

On the other hand, the area commanders from the public providers explain that good care is measured by the elderly experience survey which the municipality conducts every year. The research measures factors that influence the elderly to experience “good care” and the results are compared to other providers. These factors are: the relationship between care staff and the elderly, care staff competency and communication. In this way quality can be measurable\(^{106}\). Moreover if the provider obtains good evaluation, then it has opportunities to compete and stay in the market.

Another remarkable observation is that the area commander the public provider Pub090 explains that the politicians establish targets every year, whether they like it or not. Their job is to work to fulfill those expectations. Since they work at a distance, it’s logical that they have to follow the provider’s work about good care throughout the demands that the politicians establish every year\(^{107}\). The survey will tell them if quality has been improved or not.

Contrary to the public providers, the private area commander’s providers are more service targeted. The area commanders explain that good care is: customers’ or patients’ satisfaction\(^{108}\), further training, happy staff and good communication\(^{109}\). These factors are more subjective than those of the public providers. We observe that the private provider in Stockholm is more focused on the customers’ satisfaction in order to survive the hard competition between providers. Happy customers will lead to good profit, but also happy employees and consequently the service quality improves\(^{110}\). One reason for the difference between the private and public provider in perceiving good care is the owner and CEO of

\(^{104}\) Socialstyrelsen (2001), p 10-12
\(^{105}\) Westlund & Edwardsson (1998), p 67
\(^{106}\) Pettersson et al (2003), p 9
\(^{107}\) Socialstyrelsen (2001), p 50
\(^{108}\) Westlund & Edwardsson (1998), p 67
\(^{109}\) Ibid, p 65
\(^{110}\) Socialstyrelsen (2001), p 50
Pri08 has founded her organisation herself. Having worked with the elderly for many years before starting the organisation, the respondent explains that working with the elderly is valuable and that is the reason the respondent is in the business. However, the public area commanders are workers who work with the elderly at distance and therefore they perceive quality in different ways.
6. Conclusive discussion

This chapter summarizes our discussion and lists the conclusions we came to by analyzing our problem from the three theoretical aspects.

Our problem as stated in the beginning of this paper was:

How can private elderly care providers generate a profit and still deliver the same level of quality as their public counterparts?

6.1. Motivation and Incentives

First of all, we analyzed the motivational and incentive structures at play and found that there is an information asymmetry; no one, except for the care attendants themselves, really knows what the care attendants do (at least not perfectly). There is no absolute way of measuring the quality of the care they deliver, and neither can their employers tell if they are performing to their maximum capacity.

We also found an important factor; none of the providers have any incentives to decrease the number of hours spent with each patient. Rather, they have incentives to increase the number of hours since that is the factor determining how much they will be paid, and it is the time not spent with patients that is incurring net cost (and thereby creating losses or reducing profits). However, it is not the providers who decide how many hours of help each patient should get, but an aid officer employed by the municipality. This implies that patient time is more or less out of the providers’ control, and since we also found that time seems to be an important determinant of quality, it is highly unlikely that any provider would try to raise profits by reducing care time, and thereby care quality.

The providers however have incentives to decrease salaries, cut down on team-building activities and education. These activities would create profits, at least in a short perspective. However, if salaries go too low and thereby creating dissatisfaction among their personnel, they might need to recruit new personnel (which are expensive) and risk lowering the care quality (which might lose those clients) so they also have countering incentives, especially in the long term.

The personnel seem to be motivated primarily by the social nature of their work, which allows them to work with and care for elderly people. However, some of them were also dissatisfied by not having full use for their education (in the public sector) and wanted to move on to “real” health care. Another demotivational factor was the heavy nature of the work. The private providers seemed more eager to motivate their personnel through team-building activities and by giving them paid education, while the public providers tended to hire more qualified personnel from the start.

An interesting finding was that one of the public providers had a set profit goal, while one of the private providers claimed to have no profit goal (except breaking even, which was seen as fundamental for staying in business).
6.2. Efficiency and productivity

By increasing productivity, however, the providers can deliver the same level of care (in terms of hours spent with the patient) and still reduce costs (for example by cutting hours not spent with patients through schedule optimizing or by reducing the number of administrators). The private providers in the study seemed to be more focused on these kinds of optimizations than the public ones. For example, one of the private providers had 1 administrator for 35 employees, while one of the public ones had 10 administrators for 100 employees, which means almost four times the number of administrators per employee.

Another aspect is the number of hours worked per week for each care attendant. Since each attendant inevitably will occur some form of fixed overhead costs (administrative costs, education, training, work clothes and so on) and so it logically follows that the cost per hour worked is a declining curve, making it more efficient to have each employee work more hours (as long as this does not incur any negative effects such as being overworked).

Only the public providers had formalized methods of calculating efficiency, while a private provider claimed that efficiency could not be calculated in a care setting since all patients have unique needs.

*This implies that a more long-term reduction of costs is best established by methods that do not interfere with care quality.*

6.3. Care and quality

As we knew when beginning the study, there is really no objective way of measuring care quality. We also found that while several of the studied providers and both purchasers evaluate the elderly care in some way, most of them did not use any formal methods or quantifiable goals (with the exception of one purchasing municipality who did that once, two years ago). Instead, the predominant evaluation tool was surveys sent out to the care receivers. However, several respondents noted that the surveys in many ways were too hard for the patients, who might have bad eyesight, slight or severe dementia or otherwise are unable to complete them in a good way. Some of the patients even ask the care attendants how to fill them in, which raises some questions about whether the patients would really dare to express dissatisfaction with their provider’s representative sitting next to them.

This effectively means that the *quality of care is in the hands of the care attendants*. When interviewing the care attendants on this subject, they mentioned a number of factors they felt influenced the quality of the care. These factors were giving the elderly all the help they need, treating them with respect, giving them security, fulfilling their expectations, listen to their anxieties and having empathy. While a notoriously bad attendant might be exposed after a while, there is a large grey zone in which attendants can be more or less lazy. In other words, the only way of increasing quality is to make sure the attendants will somehow chose to deliver it. This is also congruent with the ideas expressed by the attendants’ closest bosses, the unit managers, who mention the staff’s attitudes, empathy and happiness as important
factors for delivering care (together with education, time and scheduling). However, if the personnel lack these traits, underperform or otherwise do not behave as desired, the elderly might receive poor care, without the purchaser knowing. However, the elderly that are still in full possession of their wits, or have relatives looking after their interests, and are lucky enough to live in a municipality that allows them to choose their care provider can “vote with their feet” and move on to a better provider.

6.4. Summary of conclusions

- No one has absolute knowledge about the care attendants’ work quality or performance, except for the care attendants themselves.
- The providers have no incentives to reduce care time, but instead to increase it. However, the decision is not theirs to make.
- The providers have short-term incentives to reduce education, team-building and salaries, but these measures might be problematic in the long run.
- Care attendants claim to be motivated by the social nature of their work, not salaries.
- Private providers seem to hire less educated personnel and educate them at work, while public providers seem to have personnel with higher education.
- Public providers may have profit goals and private providers may lack them.
- Some of the methods used by providers might decrease costs (and thereby increase profit) without affecting the care quality. Examples include optimizing schedules and reducing the number of administrators per care attendant.
- The private care provider attendants in the study work considerably longer hours each week than the public ones. If this holds true over the line, this might help explain higher efficiency, since the cost of each worked hour is decreasing on the margin.
- Care quality is very seldom measured in any objective or quantitative manner. The reliability of the methods employed is questionable.
- The care attendants have their own subjective ideas of care quality. If they do not deliver care quality in the meeting with the care receiver, chances are no one will know.
- In order to increase quality, management must hire the right type of care attendants, motivate them and make sure they have enough resources to deliver care quality.
- Elderly who live in municipalities where free choice is allowed are less likely to be stuck with a bad provider.

So the answer to our question, “How can private elderly care providers generate a profit and still deliver the same level of quality as their public counterparts?” is that private providers can, theoretically, increase the efficiency of their non-care activities, provide their attendants with relevant education and avoid hiring overqualified staff, and by having them work more hours per week. Done well, there are profits to be extracted from these activities.

In practice, however, the talk of “quality” amounts to little, as no one outside the elderly household really knows what care quality any provider delivers, be they public or private.
7. Truth criteria

In this last chapter we want to prove how well our study has managed to capture reality and avoid the pitfalls of science. In order to do this, we examine our proceedings from the following aspects.

7.1. Credibility

To achieve credibility, we had to make sure that the results were believable. Since we conducted semi-structured interviews, in which we had to interpret and understand the phenomena of interest, we had to confirm that we had understood our respondents. This is called “respondent validation”. The respondent creates legitimacy by evaluating the results, through reviewing them and request amendments\textsuperscript{111}.

For this reason, after transcribing and writing down the interviews, we e-mailed the top managers and asked them whether they wanted to change, remove or make amendments to their answers. Three of the respondents wrote and wanted some changes. One of them was owner and CEO of organization Pri090 who wanted to change some details in the transcription. We changed “patients” for “tenants” (old people who live in the housing care) and other minor spelling changes (such as “Kalix” should be “Kalix”, kl 11:00 should be kl 23:00 if we refer to the evening). The second respondent who wrote back was the unit manager of the organization Pub090. The correspondent wanted to remove one sentence: “I have a close relationship to the care personnel”. The third one who wrote back was the area commander of Pub08 who wanted to fill in on some answers.

7.2. Transferability

The main purpose of qualitative research is to deeply understand a general phenomenon, not to generalize the phenomenon\textsuperscript{112}. Some of our findings, such as differences between hours worked in the public and private sector, cannot be reliably transferred for two reasons; first, we have researched only two municipalities with one private and public care provider in each of them (Umeå and Stockholm). Second, the criteria for selecting the respondents was based on the supposed knowledge of the respondents, that is, who could give us valuable information. Consequently, we cannot say that the sample is representative for a bigger population. However, the general findings as applied to incentive structures, problems with quality measurements in elderly care and so on are in line with other findings referred to in the study which agree with ours.

\textsuperscript{111} Bryman & Bell (2007), p 411
\textsuperscript{112} Jacobsen (2002), p 266
7.3. Dependability

This criterion is related to reliability. Bryman and Bell points out that to succeed in creating trustworthiness, the researchers should try to explain how the problem formulation has been done, how the respondents have been selected, how the interviews have been transcribed, and how data was analyzed and so on. All this method information has to be available so the same study could be repeated and gain similar results\(^\text{113}\).

Using some method literature as a guide, we are confident that we have explained transparently how our research has been conducted step by step. The process of this research can be used by other researchers; however, we are not sure if other researchers can obtain the exact same result as we have obtained.

7.4. Conformability

Even though it is impossible to be completely objective, the researcher must try not to influence the respondents with personal values and preconceptions. However, our research was based on the hermeneutical scientific ideal, thus interpretation is an important element\(^\text{114}\).

We believe that we have succeeded in maintaining a good balance between our preconceptions. Roger does not have any preconceptions the elderly care system because he has never worked for either an elderly care organization or any other kind of care organization. He has only worked in the private service sector and had negative preconceptions about the politicians governing the public sector. Mery had some negative preconceptions about the private provider after working for an elderly care organization, which was first public and later made private.

To make sure that our preconceptions did not influence the interviewees we have followed our script interview and acted in the same way with every respondent. We have also both reviewed and analyzed all of the transcriptions independently and cross-checked each others’ findings and interpretations.

\(^\text{113}\) Bryman & Bell (2007), p 414
\(^\text{114}\) Ibid, p 418
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9. Appendix 1: Evaluation questions

9.1. As asked (in Swedish)

9.1.1. Frågor till VD / områdeschef

A. Beskrivning av:
   - Oss
   - Uppsatsten och intervjun

B. Kvalitetsfrågor

1. Hur länge har organisationen funnits? Vilken historia har den?
2. Vad menar ni med omsorgskvalitet i er organisation?
3. Sker det någon uppföljning?
4. Vilka gör denna uppföljning? Hur ofta?
5. Vilka krav ställer upphandlaren på kvalitet?
6. Hur återrapporterar ni till dem?
7. Vilka praktiska åtgärder vidtar ni i ledningen för att förbättra kvaliteten?
8. Vad tycker du är de viktigaste faktorerna för att lyckas leverera god kvalitet?

C. Ekonomiska frågor

9. Hur många anställda har ni som jobbar praktiskt med vård? Hur har detta förändrats under de senaste åren?
10. Hur många anställda har ni som jobbar med övrigt? Hur har detta förändrats under de senaste åren?
11. Hur många patienter har ni? Hur har detta förändrats under de senaste åren?
12. Hur hög är personalomsättningen?
13. Hur hög är sjukfrånvaron? Hur har den förändrats under de senaste åren?
14. Vad har ni för lokalkostnader?
15. Hur arbetar ni med effektivisering och produktivitet?
16. Hur går era upphandlingar till?
17. Vem tar fram anbudsunderlaget?
18. Hur länge löper avtalen?
19. När betalas pengarna ut?

(För privata företag)
20. Hur ser företagets ägarstruktur ut?
21. Vilka vinstkrav finns?
22. Hur balanserar verksamheten mellan vinstkrav och krav på kvalitet?
23. Hur ser er finansiering ut? Är hela det egna kapitalet aktiekapital eller finns det andra finansiärer än aktieägarna?

(För offentlig verksamhet)
24. Hur ser den politiska styrningen ut?
25. Har ni några sparbetning på er?
26. Hur balanserar ni mellan kvalitetskrav och sparkrav?

D. Incitament

27. Hur tillser ni att personalen levererar den bästa kvaliteten?
28. Hur utvärderas deras arbete?
29. Hur ofta och av vem?
30. Hur jobbar ni med personalfrågor? Uppmuntran, motivation etc.
31. Hur jobbar ni med kompetensutveckling?

9.1.2. Frågor till mellanchefer (gruppchefer)

A. Beskrivning av:
- Oss
- Uppsatsern och intervjun

B. Kvalitetsfrågor

1. Hur är du involverad i uppföljning av omsorgskvaliteten?
2. Vilka fördelar ser du med sättet man bedriver kvalitetsuppföljning på?
3. Vilka nackdelar?
4. Vad innebär kvalitet inom äldreomsorgen för dig?
5. Vad tycker du är de viktigaste faktorerna för att lyckas leverera god kvalitet?
6. Vilka praktiska åtgärder genomför ni för att förbättra kvaliteten?

C. Incitament

7. Hur länge har du haft din befattning? Vad har du arbetat med tidigare?
8. Hur ser du på bemanningssituationen?
9. Vilka dilemman upplever du i rollen som mellanchef?
10. Hur många anställda finns i organisationen?
11. Vilka åtgärder vidtar ni för att vara mer kostnadseffektiva?
12. Hur anser du att de åtgärderna påverkar kvaliteten?
13. Hur motiverar du din personal att leverera den bästa kvaliteten?

D. Ekonomiska frågor

14. Vad anser du är verksamhetens viktigaste mål?
15. (För offentliga) Hur tycker du ni påverkas av ”hotet” att kommunen lägger ut er verksamhet på entreprenad om den blir för kostsam?
16. Kan någonting de gör påverka deras lön?
17. Hur följer du upp deras arbete?
18. Vad tror du motiverar dem utöver vad du som chef gör?
9.1.3. Frågor till personal

A. Beskrivning av:
   • Oss
   • Uppsatsen och intervjun

B. Kvalitetsfrågor

1. Vad tycker du är det viktigaste att göra för att få patienterna att må bra?
2. Vad tycker du om kvalitetsuppföljningen? Mäter den rätt saker?
3. Hur tas initiativ till förändringar?
4. Vad innebär god vård för dig?
5. Hur kan man uppnå god vård?

C. Incitament

6. Varför har du valt det här jobbet? Hur länge har du haft det?
7. Vill du fortsätta jobba med det i framtiden? Motivera!
8. Händer det att du för patientens skull gör saker som du inte får uppskattning för? Exempel?
9. Händer det att du för uppföljningens skull gör saker som inte är för patientens bästa? Exempel?
10. Är du delaktig i planeringen av arbetet? Har du tillgång till den information du behöver?
11. Känner du att du utvecklas i din roll? Vilken utbildning får du?

D. Ekonomiska frågor

12. Har du tidigare jobbat inom en privat/offentlig organisation? Om ja, vilka skillnader har du upplevt?
9.2.  Translated for our English readers

9.2.1.  Questions for the CEO / area commander

A. Description of:
   • Us
   • The thesis and the interview

B. Quality related questions

1. For how long has the organization existed? What history does it have?
2. What do you mean by care quality in your organization? Sker det någon uppföljning?
3. Who performs this evaluation? How often?
4. What demands does the purchasers set on quality?
5. How do you report this to them?
6. What practical measures do you in management perform in order to increase quality?
7. What do you consider the most important factors for delivering good quality?

C. Economical questions

8. How many employees to you have who work with actual care? How has this number changed during recent years?
9. How many employees do you have who work with other tasks? How has this number changed during recent years?
10. How many patients do you have? How has this number changed during recent years?
11. How high is the personnel turnover?
12. How high are your sick leave rates? How has this number changed during recent years?
13. What office costs do you have?
14. How do you work with efficiency and productivity?
15. How does your tendering process work?
16. Who creates the offering?
17. For how long are the contracts?
18. When are the rates paid to you?

(For private enterprises)
19. How does the company ownership structure look?
20. What are the profit demands?
21. How does the enterprise balance between profit and quality requirements?
22. How are you financed? Is the entire equity shareholder related or are there any other financiers?

(For public organizations)
23. How does the political control work?
24. Do you have any demands to save money?
25. How do you balance between quality and money-saving demands?
D. Incentives

26. How do you check that your personnel delivers the best quality?
27. How is their work evaluated?
28. How often and by whom?
29. How do you work with human relations issues? Encouragement, motivation and so on.
30. How do you work with education?

9.2.2. Questions for unit managers

A. Description of:
• Us
• The thesis and the interview

B. Quality related questions

1. How are you involved in evaluating care quality?
2. What advantages do you see with the way quality is being evaluated?
3. What disadvantages?
4. What does quality in elderly care mean to you?
5. What do you consider the most important factors for delivering good quality?
6. What practical measures do you in management perform in order to increase quality?

C. Incentives

7. How long have you held your current position? What did you do before?
8. How do you experience the staffing situation?
9. What dilemmas do you face as a mid level manager?
10. How many employees are in the organization?
11. What measures do you perform to be more cost effective?
12. How do you reckon those measures affect care quality?
13. How do you motivate your personnel to deliver the best quality?

D. Economical questions

14. What do you consider to be the most important goals of the enterprise?
15. (Public organizations only) How do you think you are affected by the threat of the municipality outsourcing your organization if it becomes too costly?
16. Can anything your personnel does affect their salary?
17. How do you evaluate their work?
18. What do you think motivates them except for your actions as a manager?
9.2.3. Questions for care personnel

A. Description of:
   - Us
   - The thesis and the interview

B. Quality related questions
   1. What do you consider to be most important to do in order to make the patients to feel well?
   2. What do you think about the quality evaluation? Does it measure the right things?
   3. How are initiatives for change taken?
   4. What does good care mean to you?
   5. How can good care be achieved?

C. Incentives
   6. Why have you chosen this line of work? How long have you had it?
   7. Do you want to continue working with it in the future? Motivate!
   8. Does it happen that you do things for the sake of the patient that you do not get credit for? Examples?
   9. Does it happen that you, in order to satisfy the evaluation, do things that are not in the patient’s best interest? Examples?
   10. Do you participate in planning the work? Do you have all the information you need?
   11. Do you feel that you grow in your role? Which education do you get?

D. Economical questions
   12. Have you previously been working in a private/public organization? If so, what differences have you experienced?
   13. How many hours do you work? How do you feel about that?