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Towards Partnership?

Studies on public–private collaboration in health and elderly care services in Finland

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ACADEMIC DISSERTATION
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For my grandparents

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Abbreviations

A&E	Accident and emergency
EK	Confederation of Finnish Industries
HRM	Human Resource Management
PFI	Private Finance Initiative
PPP	Public-Private Partnership
RAI	Resident Assessment Instrument
RUG	Resource Utilization Group
TCE	Transaction cost economics

List of original publications

I Tynkkynen, L-K., Lehto, J. & Miettinen, S. 2012. Framing the decision to contract out elderly care and primary health care services – perspectives of local level politicians and civil servants in Finland. *BMC Health Services Research*, 12, 201.

II Tynkkynen, L-K., Fredriksson, S. & Lehto, J. A study on purchaser-provider co-operation in the local welfare regimes in Finland. Submitted to *International Journal of Public and Private Health Care Management and Economics*.

III Tynkkynen, L-K. & Lehto, J. 2009. An analysis of ophthalmology services in Finland – has the time come for a Public-Private Partnership. *Health Research Policy and Systems* 7, 24, pp. 2–12.

IV Tynkkynen, L-K., Sinervo, T., Elovainio, M., Koivisto, A-M., Lehto, J., Noro, A. & Finne-Soveri, H. 2011. Employees' Perceptions of Organizational Justice, Job Control and Job Demands: Do Ownership and Human Resource Management Practices Matter? *International Journal of Public and Private Health Care Management and Economics*, 1(3), pp. 19–37.

Abstract

Delegating public tasks to the private sector is not only a product of recent decades, but rather a much longer tradition in most Western societies. However, the nature of the collaboration between public and private sector is dynamic and changing. One of the most recent trends in terms of collaboration between public and private sectors is an aim towards partnership. The term "public-private partnership" has made its way into the political rhetoric in recent decades and is now increasingly appearing in both international and national debates on methods of accomplishing public tasks and the means to tackle social challenges in society. In Finland PPP was introduced as a national level policy option in 2007.

The collaborative relationship between the public and private sectors in Finland has not been studied to any large extent. In this study I addressed this area in the context of health and elderly care services in Finland. I discussed two types of collaboration between public and private sectors: contracting out and public-private partnership. The particular the research question was: *What kind of aspects of partnership could be identified in the collaborative relationships between public and private sectors in Finnish local health and elderly care systems in the first decade of the 2000s*?

The research consists of four sub-studies and a summary. Sub-studies I–IV focused on different aspects of collaboration between the public and private sectors in Finland. Collaboration was analysed from three perspectives drawn from the literature: goals set for and benefits sought through the collaboration, collaboration in practice and organizational properties. The collaboration between public service purchasers and private service providers was approached by discussing the aspects of contractual relationship and partnership.

The results suggest that in terms of the goals that municipalities set for collaboration with the private sector certain aspects of partnership can be identified. These include willingness to learn from the private providers in order to develop the service provision in the public sector and willingness to provide enriched selection of publicly funded services. In addition, the prerequisites for partnership in terms of organizational

properties seem to be no worse than they might be regarding partnership between public and public organizations or between for-profit and not-for-profit organizations. It seems that there is no specific leadership culture in public, for-profit and not-for-profit organizations. However, the public purchasers and the not-for-profit and for-profit providers have different perceptions of the nature of the collaboration in practice. Public actors perceived that they could trust to their partners, the services were developed together and that the contracts were evaluated also during the contractual period, while perceptions in the private sector among for-profit providers especially, were fairly much the opposite. That is, if the issue is discussed from the public actors' perspective there seems to be support for the existence of partnership aspects. However, if the issue is discussed from the private providers' perspective the aspects seem to be largely missing.

Tiivistelmä

Yksityisten palveluntuottajien (yritykset ja kolmas sektori) osallistamisella julkisrahoitteisten palveluiden tuotantoon on useissa länsimaissa pitkät perinteet. Julkisen ja yksityisen sektorin välisen yhteistyön luonne on kuitenkin muuttunut vuosikymmenten aikana. Yksi viimeisimmistä pinnalle nousseista yhteistyön muodoista on niin kutsuttu *yksityisen ja julkisen sektorin kumppanuus*. Kumppanuudesta puhutaan entistä enemmän, ja siitä on tullut myös osa poliittisen retoriikan sanastoa. Suomessa yksityisen ja julkisen sektorin kumppanuus sosiaali- ja terveyspalveluiden tuotannossa on noussut tavoitteeksi ennen kaikkea 2000-luvun alussa.

Yksityisen ja julkisen sektorin yhteistyösuhteita ei ole Suomessa juurikaan tutkittu. Tässä tutkimuksessa otin tutkimuskohteeksi nämä yhteistyösuhteet terveyspalveluiden ja vanhojen ihmisten palveluiden kontekstissa. Käytännössä tutkin kahdenlaisia yhteistyösuhteita: sopimuksellista yhteistyösuhdetta ja niin sanottua kumppanuussuhdetta. Tutkimuskysymykseni oli: *Millaisia yhteistyön elementtejä yksityisen ja julkisen sektorin välisistä suhteista on mahdollista tunnistaa paikallisten terveys- ja vanhuspalveluiden kontekstissa 2000-luvun ensimmäisen vuosikymmenen Suomessa*?

Tutkimus koostuu neljästä osatutkimuksesta sekä yhteenveto-osasta. Tutkin yhteistyötä kolmen kirjallisuudesta tunnistetun osa-alueen kautta: yhteistyölle asetetut tavoitteet ja yhteistyön kautta tavoitellut hyödyt, yhteistyön toimivuus käytännössä sekä organisaatioiden johtaminen. Kukin osatutkimus keskittyi yhteen näistä osa-alueista. Yhteenveto-osassa tarkastelin näitä osa-alueita kumppanuuden ja sopimuksellisen yhteistyön näkökulmasta.

Yhteistyöstä oli mahdollista tunnistaa kumppanuutta muistuttavia elementtejä, kun tarkastelin yhteistyötä tavoitteiden sekä organisaatioiden johtamisen näkökulmasta. Tavoitteiden osalta huomasin, että palveluja tilaavien kuntien tavoitteet heijastelevat tavoitteita, joita tyypillisesti tavoitellaan kumppanuuksien kautta. Näihin lukeutuvat muun muassa halu oppia yksityisiltä palveluntuottajilta ja näin kehittää omaa palveluntuotantoa sekä halu tarjota monipuolisempia palvelukokonaisuuksia palveluiden käyttäjille. Organisaatioiden johtamisen osalta edellytykset yksityisen ja julkisen sektorin

kumppanuudelle eivät näyttäytyneet ainakaan huonompina kuin edellytykset yritysten ja kolmannen sektorin tai julkisten organisaatioiden väliselle kumppanuudelle. Johtamiskulttuurit palveluntuottajaorganisaatioissa näyttäytyivät ennemmin yksikkökohtaisina kuin sektorikohtaisina.

Kuitenkin, kun tutukin yhteistyötä käytännön tasolla, tulokset osoittivat, että palveluiden tilaajilla ja yksityisillä palveluntuottajilla on keskenään hyvin erilaiset näkemykset yhteistyön luonteesta. Palveluiden tilaajat kokivat, että he kykenivät luottamaan yksityisiin palveluntuottajiin, että palveluja kehitettiin yhteistyössä ja että sopimuksia arvioitiin myös sopimuskauden aikana. Yksityiset palveluntuottajat sen sijaan kokivat yhteistyön luonteen jokseenkin päinvastaisena. Voidaankin todeta, että kun yhteistyöstä puhutaan palveluja tilaavien julkisten organisaatioiden näkökulmasta, yhteistyöstä on mahdollista tunnistaa kumppanuuden elementtejä. Jos taas tarkasteluun otetaan yksityisten palveluntuottajien näkökulma, kumppanuuden elementtejä ei ole juurikaan mahdollista tunnistaa.

1 Introduction

Mixing public and private means in order to pursue public ends has occurred throughout history. Thus, delegating public tasks to the private sector is not only a product of recent decades, but rather a much longer tradition in most Western societies (e.g. Wettenhall, 2010; Billis & Glennester, 1998). However, the nature of collaboration between public and private sector is dynamic and changing. In this study, I discuss the current state of collaboration between public and private sectors in the context of health and elderly care delivery in Finland.

The idea according to which health care services and other welfare services, should be publicly financed, owned and produced, has been deep rooted in those countries in which the provision of public services is based on tax-funding (Øvretveit, 1996). However, since the 1980s the realms of the public and private sectors have started to be redefined as in many countries the traditional boundaries have started to fade away and blur (Maarse, 2006; Saltman, 2003). In Finland this has partly been due to legislative changes in the 1980s and the 1990s that enabled the private sector to be increasingly involved in public service delivery (Lehto et al., 2012). Consequently a view of the public sector being an irreplaceable actor in correcting welfare differences and inequality in society, has been at least partially questioned (Øvretveit, 2003). This shift can be discussed from multiple theoretical perspectives (Lehto et al., 2012). A fairly common perspective is to link it to the New Public Management trend that emerged in the 1980s and according to which the public sector started to apply a more market oriented approach to the delivery of welfare services (Rissanen, Hujala, Helisten, 2010; Pollitt, van Thiel, Homburg, 2007; Green-Pedersen, 2002). Consequently collaboration between the public and private sectors has also started to call for more formal, institutionalized procedures such as contracting and competitive bidding, while previously it was mostly created through various often fairly loosely defined forms of collaboration.

One of the most recent "booms" in terms of collaboration between public and private sectors is the aim for partnership. The term "public-private partnership" (PPP) has made its way into the political rhetoric in recent decades and is now increasingly appearing

in both international and national debates on the methods of accomplishing public tasks and the means to tackle social challenges in society. The United Nations (2010) has stated that "*public-private partnerships have become a mainstay in bringing practical solutions to societal challenges*", while the European Commission (2004) has maintained that "*the development of the PPP is part of the more general change in the role of the State in the economy, moving from a role of direct operator to one of organiser, regulator and controller.*" In Finland PPP was first introduced as a national level policy option in 2007. At the time it was stated in the Government programme for the years 2007–2011 that "*the government will promote partnerships between public, for-profit and not-for-profit sectors in the delivery of health care and social service delivery.*"

What is interesting in this pursuit of partnerships is that no one, neither academics nor politicians, seems to be fully aware what is actually meant by the term "partnership". At least there is no unanimously accepted definition of the term. In the literature it is also debated whether partnerships are indeed new forms of collaboration between public and private actors or whether they are merely old policies under a new name (Hodge & Greve, 2010). In other words it is not clear how or whether partnerships differ from more traditional contractual relationships between public purchasers and private service providers.

So far the research on the interrelationship between public and private sectors in health care and social services in Finland has mostly focused on competitive bidding and purchaser-provider splits (e.g. Junnila et al., 2012; Syrjä, 2010; Fredriksson, Hyvärinen, Mattila & Wass, 2009; Mikkola, 2009; Forma, Niemelä, Saarinen, 2008; Okko et al., 2007; Fredriksson & Martikainen, 2006; Ollila, Ilva & Koivusalo, 2003). In addition, there are studies on municipalities' contracting out decisions (Vaara & Mikkola, 2012; Laamanen et al., 2008), comparative studies on public, for-profit and not-for-profit elderly care service providers (Sinervo et al., 2010), comparisons on the performance of public and private health centres (Kantonen et al., 2012; Myllymäki, Elonheimo & Linna, 2011; Vohlonen, Komulainen & Vehviläinen, 2010) as well as studies focusing on the private social service market in Finland (Rissanen et al., 2010; Sievänen, Rissanen, Kaarakainen, 2010; Kovalainen, Simonen, Österberg, 1996). However, the collaborative relationship between the public and private sectors has not been studied to any large extent.

In this study I will address this area in the context of health and elderly care services in Finland. First, I will review the literature and discuss collaboration between public and private sectors from the perspectives of contracting out and public-private partnership.

After that drawing on four empirical sub-studies I discuss the nature of collaboration between public service purchasers and private, for-profit and not-for-profit providers using a theoretical distinction between contractual relationship and partnership. The empirical part of the study is situated in the context of health care and elderly care services. By elderly care services I refer to sheltered housing, residential homes as well as to home care and home help services. The data from health care services come mostly from primary health care but also from the field of ophthalmology. By collaboration between public and private sectors I refer mainly to the relationship between public service purchasers and for-profit or not-for-profit service providers. Further analysis of the concepts of public and private is given in the literature review section in which I also provide definitions of contractual relationship and partnership. In this study my focus is on the public and private actors' experiences of collaboration not on the organizational or institutional forms of partnership (see e.g. Klijn, 2010; Weihe, 2010).

To set the stage I conclude this introductory part by briefly describing the context of the study. Municipalities' purchases from the private sector are not registered nationally. However, some estimates have been made (Ministry of Social Affairs and Health 2012). The market shares in sheltered housing in Finland in 2010 were at macro level 48 percent, 23 percent and 29 percent for the municipalities, for-profit providers and not-for-profit providers respectively. In social care as a whole the proportion of the services purchased from the private providers was 8.7 percent of municipalities' social care net costs in 1995. In 2008 the proportion was 21.3 percent. However, the proportions vary locally. (Arajärvi & Väyrynen, 2011.) In primary health care the volume provided by private providers is smaller than in the care of the older people. However, the share of the private sector has been on the increase since the mid 1990s. The total volume of primary health care services purchased from the private sector increased from 28 million Euros in 1995 to 154 million Euros in 2008. The proportion of the services purchased from the private providers was 1.9 percent of municipalities' health care net costs in 1995 while in 2008 it was 4.2 percent. (Ibid.) In 2009 there were 37 outsourced health centres in Finland serving some seven percent of the Finnish population (Mikkola, 2009). In addition, the municipalities in rural areas especially have experienced difficulties in recruiting physicians for their health centres. This has opened up a new market niche for private for-profit recruitment agencies that deliver physician and nursing workforce for health centres struggling with recruitment problems. Out-of-hours A&E services are also often purchased from the private sector due to recruitment problems. In primary health care the services purchased from the private sector are mostly provided by for-profit providers.

2 Perspectives on public-private collaboration – review of the literature

2.1 Ownership of an organization – the concepts of public and private

2.1.1 Defining public and private

The public-private distinction has been suggested to be among the oldest distinctions in modern history (Blomgren & Lindberg, 2009; Weintraub, 1997). Traditionally, public organizations have been defined as governmental agencies and private organizations as all other organizations (Perry & Rainey, 1988). However, the boundaries between public and private sector have begun to dissolve, which makes the question of public/private definition more complicated (e.g. Antonsen & Jørgensen, 1997; Perry & Rainey, 1988). Consequently, there are no univocal answers to questions about whether public and private organizations are different and in what respects (e.g. Boyne, 2002; Perry & Rainey, 1988; Allison, 1979). Rather, the division between public and private is dynamic (Elshtain, 1997), multidimensional (Perry & Rainey, 1988) and changing with the context in which the terms are used (Weintraub, 1997; Wolfe, 1997).

Despite the complex nature of the public/private definition, the use of the ownership status of an organization has, however, been one of the most popular ways to distinguish between different organizations (Boyne, 2002). However, the usefulness of ownerships status as a classification criterion has also been criticised by several scholars due to the fairly context-specific and empirical nature of the issue (e.g. Poòr et al., 2009; Eggleston et al., 2008; Koning, Noailly & Visser, 2007). Also, the comparisons can be made in a great many ways (Scott & Falcone, 1998). The use of the terms public and private has not been consistent and the meanings associated with the terms are multiple (Steinberg, 1999; Perry & Rainey, 1988). Finally, there are also several other factors that determine

the organizational properties and processes instead of ownership (Koning et al., 2007; Antonsen & Jørgensen, 1997; Bozeman, 1987; DiMaggio & Powell, 1983).

The concepts of public and private have been well analysed in the public management literature (e.g Antonsen & Jørgensen, 1997; Perry & Rainey, 1988; Bozeman, 1987; Ring & Perry, 1985). In their study Scott and Falcone (1998) divide the literature into three different approaches to the public/private distinction: the generic approach, the core approach and the dimensional approach. In the following I briefly review the literature using this distinction on the concepts of public and private. I conclude this section with the definitions applied in this study.

The generic approach suggests that management functions, organizational processes and managerial values are fairly identical across sectoral boundaries even though the objectives of organizations may differ between public and private sectors (Scott & Falcone, 1998). It has been argued that because public sector organizations increasingly rely on private organizations for public service provision, the organizational characteristics are beginning to fade and increasing similarity emerges between organizations (e.g. Cunningham, 2010; Antonsen & Jørgensen, 1997). Sørensen and Bay (2002) suggest that as to contracting out the ownership may only be a secondary matter while the factors that matter are those of contract design, competition among providers and suitable conditions for successful contracting. Finally, there is a growing body of literature on hybrid organizations (e.g. Billis, 2010), i.e. organizations, which possess characteristics of more than one sector (public, for-profit and not-for-profit) and which consequently make the distinctions between different organizations even more difficult.

In the context of the generic approach it may be also worth considering the study by DiMaggio and Powell (1983). They describe three processes which occur among organizations operating in the same organizational field (i.e. organizations that produce similar services or products) and through which organizations become increasingly similar. Firstly, legislative, financial and political factors affect the functioning of organizations in general and independently of the ownership. Secondly, organizations are likely to model themselves after those they perceive to be more successful or legitimate. Thus there is ongoing a continuous process towards the isomorphism of organizations. Thirdly, organizations potentially use similar technologies and employ professionals who have received similar training and role socialization. These three processes obviously also occur in the field of health and social care. A strong professional culture, strict public regulation and a substantial proportion of female employees among other things

are fairly obvious aspects that are likely to produce similarities and affect the processes taking place at the workplace.

The dimensional approach also makes its contribution to the discussion on context and organizational field. The dimensional approach distinguishes between different organizations according to the level of economic and political authority they are subject to. The difference between public and private is a matter of degree. (Antonsen & Jørgensen, 1997.) One of the important contributions to this approach is made by Bozeman (1987), who suggests that all organizations are public to some extent. Some are just more exposed to public control than others. The dimensional approach does not take the public-private distinction as dichotomous but defines it as moving along a public-private continuum where purely private or public organizations are rare (Goulet & Frank, 2002). Thus, the 'publicness' of an organization depends partly on the context in which these organizations operate (Antonsen & Jørgensen, 1997).

Compared to the other two approaches *the core approach* provides a fairly opposite view of the public/private question. The core approach is based on the idea that there are fundamental differences between public and private organizations. Billis (2010, p. 47), for instance, suggests that while all organizations have generic structural features, such as need for resources, their nature and operational logics are different in each sector. That is, they respond to the needs of the public in different ways (Billis & Glennester, 1998). Indeed, several scholars have suggested that public and private organizations are different in a number of respects. It has been argued that public and private organizations base their actions on somewhat different value bases (e.g. Cunningham, 1999). In addition, the goals set and strains put on public and private organizations are seen to be different (Nutt, 1999; Chandler, 1991; Perry & Rainey, 1988; Baldwin, 1987; Ring & Perry, 1987). Finally, the demands placed upon the decision-making also differ between public and private organizations (Nutt, 1999; Perry & Rainey, 1988; Ring & Perry, 1987).

In the core approach, too, the importance of the context is emphasized. Compared to the aforementioned discussion which could be set under the new institutionalism (Antonsen & Jørgensen, 1997), the core approach draws on the tradition of contingency theory. Ring and Perry (1985), for instance, argue that because public and private organizations often operate in different contexts, the organizational behaviour is also different. Consequently, public and private may be seen as different ways of being in the world, i.e. these public and private have different "manners of acting" (Steinberg, 1999). According to Jacobs (1992) the public and private domains are two ethical systems with different 'moral syndromes'. The public domain is characterized by the 'guardian

syndrome' and the private domain by the 'commercial syndrome'. Thus the different value bases, strategies for action as well as different definitions of the core tasks of the sector differ between the two domains and cause the organizations to behave differently (see also Klijn & Teisman, 2003.)

Quite often the literature addresses the issues of public and private in a fairly general manner. That is, the distinction is fairly often made solely between public and private (however see e.g. Scott & Falcone, 1998; Perry & Rainey, 1988). Yet this distinction is often inadequate, at least in regard to health care and social services. Rather, it should be acknowledged that the private sector comprises several actors with different interests, aims and background ideologies. To capture the diverse nature of the private sector a distinction should at least be made between *public*, *not-for-profit* and *for-profit* organizations (Amirkhanyan, Kim & Lambright, 2008).

Adopting this still quite general distinction it is possible to define certain properties peculiar to each of the three organization types. In general public agencies are mainly owned collectively by members of a political community, whereas private for-profit enterprises are owned by private entrepreneurs and shareholders (Poòr et al., 2009; Budhwar & Boyne, 2004; Boyne, 2002). In other words, for-profit organizations are traditionally assumed to follow a profit-maximization objective and create profit for their owners (Brooks, 2005) while the mission of public organizations is to serve the general public (Perry & Rainey, 1988). Not-for-profit organizations, in turn, can be seen to contemplate the public sector (Julkunen, 2000) and redress the market failures occurring in markets with for-profit firms (Koning et al., 2007). In addition, not-for-profit organizations are often guided by a certain ideology or a mission to serve special – often disadvantaged – population groups (e.g. Parry & Kelliher, 2009; Haley-Lock & Kruzich, 2008; Koning et al., 2007; Parry, Kelliher, Mills & Tyson, 2005). However, the definitions of not-for-profit organizations differ between cultures as well as between research traditions (6, 1994) and, compared to public and for-profit organizations, defining the non-for-profits accurately has proven to be more difficult.

Billis (2010) has made a notable effort in summarising the "ideal types" of public, for-profit[1] and not-for-profit[2] sectors. In this book I adopt his suggestion regarding a distinction between the different organization types (see Table 1).

1 Billis (2010) uses the term "private sector".

2 Billis (2010) uses the term "third sector".

Table 1 Ideal type sectors and accountability (modified from Billis 2010, p. 55)

Core elements	Public	For-profit	Not-for-profit
Ownership	Citizens	Business owners Shareholders	Members
Governance	Public elections	Share ownership Size	Private elections
Operational priorities	Public service and collective choice	Market forces and individual choice	Commitment about distinctive mission
Distinctive human resources	Paid public servants in legally backed *agency*	Paid employees in managerially controlled *firm*	Members and volunteers in *association*
Distinctive other resources	Taxes	Sales, fees	Dues, fees, donations and legacies

2.1.2 Empirical evidence of the impact of ownership – the personnel view

In the field of health and social care comparisons between organizations with different ownership status have been made from several different perspectives (see e.g. Schmid & Nirel, 2004). The studies have concerned *access* (e.g. Amirkhanyan et al., 2008), *quality of care* (e.g. Comondore et al., 2009; Hillmer et al., 2005; O'Neill, Harrington, Kitchener & Saliba, 2003), *costs* (e.g. Deveraux et al., 2004) and *performance differences* (e.g. Vaillancourt Rosenau & Linder, 2003) to name but a few. The results are fairly controversial, but it seems that as regards the quality of care not-for-profit organizations often perform better than for-profit organizations (e.g. Comondore et al., 2009; Hillmer et al., 2005; O'Neill et al., 2003). However, the observed impact of ownership seems to be dependent on the research context and study design (Sinervo et al., 2010; Eggleston et al., 2008), thus the results may not be comparable across different studies.

As to employees working in different organizations Mache and colleagues (2009) found that ownership status affects physicians' workplace wellbeing, work conditions and job satisfaction. It has also been suggested that the for-profit status of an organization is positively related to staff turnover (Castle & Engberg, 2006; Konetzka et al., 2005) and burnout (Hansen, Sverke & Näswall, 2008). In addition, working for a for-profit hospital has been found to be associated with higher stress levels and heavier workload

(Milestapping, 1992). It has also been reported that workers in for-profit long-term care units have lower levels of satisfaction with supervision in their work (Noelker, Ejaz, Menne & Bagaka's, 2009). Heponiemi and colleagues (2012) found that support for innovation, for instance, is often greater in not-for-profit organizations. Goulet and Frank (2002) in turn found that employees in for-profit organizations were more committed to their organizations than the workers in not-for-profit and public organizations.

As to the leadership and management, Boyne (2002) found some evidence of differences between public and private management: public organizations may be more bureaucratic, public managers may be less materialistic and they may have weaker organizational commitment. Nutt (1999) found that strategic decision-making tactics differed in public, not-for-profit and for-profit organizations. These findings gain partial support from the work of Parry and colleagues (2005), who studied human resource management in voluntary and public sector organizations. In Budhwar's and Boyne's (2004) summary of findings from comparative research in organizational and workplace related issues in public and private sectors it emerges that some differences can be found between the two sectors. However, Budhward's and Boyne's (ibid.) empirical study shows that the differences between the two sectors might be much smaller that be assumed (see also Baldwin, 1987). Parry and her colleagues (2005) also suggest that management in not-for-profit organizations is unlikely to differ from other sectors in any important respects.

All in all, the results of comparative studies draw a rather mixed picture of the importance of ownership. Research on differences in leadership also appears to have yielded mixed findings. This diversity of the results may be partly explained by the dimensionality of the ownership (Antonsen & Jørgensen, 1997) or by the isomorphism of an organization (DiMaggio & Powell, 1983). Whether ownership status matters in the case of managers' leadership practices is potentially also dependent on the theoretical perspective from which the question is approached (Poòr et al., 2009) as well as on the context in which the issue is studied. All in all, the majority of studies are cross-sectional, which inhibits the drawing of any reliable conclusions on the importance of ownership as an explanatory factor.

2.2 Collaboration between the public and private sectors

This section concerns collaboration between the public and private sector. Collaboration can be defined as "a purposive relationship between partners committed to pursuing

both an individual and a collective benefit" (e.g. Nelson et al., 1999). In this review I address two types of collaboration between the public and private sectors: contracting out[3] and public-private partnership (PPP). These two concepts are addressed separately because they can be seen representing collaboration with different intensity and depth (e.g. Klijn & Teisman, 2000). Distinguishing between the two forms of collaboration is not always simple as the definition of PPP may sometimes come very close to contracting out arrangements (e.g. Stejn, Klijn & Edelenbos, 2011; Vrangbaek, 2008). Some scholars make no distinction at all between these two types of co-operation (see e.g. Brinkerhoff & Brinkerhoff, 2011). However, it has also been suggested that PPPs are a form of collaboration which is something more than a purely contractual relationship involving other, often informal aspects of collaboration (Sullivan & Skelcher, 2002). Despite the various views of the concepts I endeavour to shed some light on the differences between the two forms of collaboration. The literature used in this review is drawn from the field health care and social services but also from other areas such as infrastructure and public administration as the literature on PPPs is frequently focused on other than health care and social service delivery. After discussing the two forms of collaboration I present a theoretical framework for analysing the collaboration between the public and private sectors and to identify contractual and partnership relationships.

2.2.1 Contracting out

Contracting out refers to a concept that is based on the public sector retaining the responsibility for the financing, commissioning and regulation of the services delivered by private providers as well as the responsibility for monitoring the providers' performance (Almqvist & Högberg, 2005, p. 231). In other words, contracting out refers to a form of collaboration in which public and private actors are involved in a principal-agent relationship (Klijn & Teisman, 2000; Rees, 1985). In this relationship a public service purchaser has part of the publicly funded services delivered by private – for-profit or not-for-profit – service providers. According to Vining and Globerman (1999) there are at least two types of contracting out in health care between which it may be useful to distinguish: (1) specific organizational contracting out, which refers to activities such as hospitals or health centres contracting for laboratory services; (2) purchaser/provider splits, referring to a situation in which municipalities, for instance, contract their home

[3] I do acknowledge that there are also other terms, such as outsourcing and privatization, referring to similar activities than contracting out. However, for sake of clarity and simplicity I have chosen to use the term contracting out to refer to all these activities throughout this review.

care services out to private providers. In this summary the interest lies in the latter form of contracting out.

Determinants of contracting out have been studied to some extent in the Nordic countries. Stolt and Winbland (2009) found that geographical proximity, population density, ideology and financial situation are important determinants as regards the contracting out of elderly care services. Green-Pedersen (2002) has in turn discussed the role of the Social Democratic parties in the implementation of market-oriented reforms such as contracting out. He found that in Sweden the Social Democrats have supported market-oriented reforms while in Denmark they have opposed them. Middtun and Hagen (2006) suggested that the public-private mix in terms of medical specialists is determined by the revenues of county councils and demographic conditions and partly by political ideology. Blomqvist (2004) in turn has discussed private service provision as a continuous process. She states that once the private service production is approved in the public sector, the private share in service provision is likely to increase in the future. In general the literature offers two main arguments for contracting out public services. One explanation discusses contracting out as a Liberal-Conservative strategy while the other major explanation is related to fiscal and economic crises. These explanations are not, however, universal but dependent on the context of the service system. (Pallesen, 2004.)

It is quite often believed that inviting private actors to participate in the delivery of public services brings about new opportunities to improve methods of service delivery (Almqvist & Högberg, 2005). Competition between providers and constant challenging of their performance is believed to lead to improvements in cost-control and quality (Niiranen, 2003; Grimshaw, Vincent & Willmot, 2002; Alexander & Young, 1996). In addition, the process is expected to bring about cost-efficiency of the services as well as improved service quality (Sørensen & Bay, 2002), improved resource allocation and better management (Almqvist & Högberg, 2005, p. 232), flexible organization and improved cost-control (Alexander & Young, 1996). As to the private providers' properties, the expectations relate to issues such as private providers' different competencies, technology, an urge to import additional resources in the public sector and the very belief in the private providers' ability to operate somehow more efficiently (Almqvist & Högberg, 2005; Coghill & Woodward, 2005; Entwistle, 2005).

Which services local authorities are and are not willing to contract out has been addressed in only few international studies (Laamanen et al., 2008; Entwistle, 2005; Sørensen & Bay, 2002; Keane, Marx & Ricci, 2001; Donahue, 1989, p. 131–149). From

these studies it is mostly possible to identify the services the public authorities are not willing to contract out. In the health and social services in particular the studies report a reluctance to outsource preventive services (Laamanen et al., 2008) and services related to regulatory issues or to the abilities to respond to crises (e.g. Keane et al., 2001). From the study by Keskimäki and colleagues (2012) it is possible to conclude that the services that are mostly contracted out are specialized health care and long-term residential services. For instance general practitioner services are, according to the international literature, mostly kept inside the public sector.

Entwistle (2005) lists five fairly general arguments against contracting out, which he was able to identify in the interviews conducted in six local authorities in the United Kingdom. Firstly, the local authorities argued that they had a duty to act as good employers and to employ the people in their region. The second argument concerned the local authorities' willingness to protect 'the public service ethos', i.e. to promote the role of the public sector in the delivery of local services. In addition, the local authorities took the view that the supply from the side of the private providers was not sufficient and that controlling external contractors was difficult (compare Hefetz & Warner, 2004). The final argument in Entwistle's (2005) list is the desire to protect 'core services'.

Keane, Marx and Ricci (2002) also discuss the 'core services' in their research on the choice of contracting out in the context of public health services provided by a local health centre. In their work the core functions included regulatory and enforcement functions, crises response (e.g. influenza pandemic) and retaining overall control over the organization's services and functions. In the study by Keane and colleagues (2001) the core functions are taken also to include activities identified by a national level regulative authority.

Contracting with private service providers has come in for several kinds of criticism especially in countries with strong tradition of public provision of health care and social services. However, it may be appropriate to point out initially that such general criticism mainly concerns the involvement of for-profit providers in public service delivery. This is probably because the role of not-for-profit organizations as a part of the public service system has traditionally been quite different from that of for-profit actors. In addition, not-for-profit providers share a long history of collaboration with the public sector, while the involvement of for-profit organizations is quite new a phenomenon in the European welfare states (e.g. Sullivan & Skelcher, 2002, p. 89). Consequently the following paragraphs focus mainly on criticism levelled at the for-profit providers.

On the one hand, the criticism relates to moral and philosophical issues. The choice between public and private is seen as a choice guided by an ideology rather than as a choice based on some objective measures. On the other hand, the opposing arguments may relate to the notion of "market failure", which may be caused by information incompleteness, externalities, imbalanced power structure in the market or by the nature of the good or service in question, to name but a few. (Donahue, 1989, p. 18–22.) Thirdly, the critics are concerned about the sustainability of democracy if the services are increasingly delegated to private providers (Flinders, 2005). Finally, it has been claimed that competition, which is often involved in the contracting out procedures, provides a poor foundation for equality of people (Warner, 2008, p. 165 & 171; see also Coghill & Woodward, 2005).

Hodge and Coghill (2007) state that contracting out services to private for-profit providers undermines political accountability while increasing the importance of managerial and market accountability. In other words, through increased involvement of for-profit providers in the public service delivery, the power relations between societal actors may change and the democratic state may incrementally change in a more corporatist direction (see also Coghill & Woodward, 2005). Warner (2008) takes this further and suggests that the movement from the public sector towards the market diminishes the room for citizen involvement, which may be seen as a key to democracy.

Regarding the provision of health and social services in particular, Vining and Globerman (1999, p. 79) suggest that the criticism concerning contracting with for-profit providers concerns at least the following issues. Firstly, in the area of health care and social services competition is often limited among service providers. Secondly, the complex nature of health and social services poses challenges for definitions of best quality as well as for quality monitoring. Finally, contracting out includes a risk of providers' poor performance but not necessarily the right to cancel the contract[4]. These criticism mainly concern problems occurring in the contractual relationship and in the procedures related to contracting out leaving aside the properties of the providers. However, there are some evidence[5] suggesting that compared to their public or not-for-profit counterparts, private for-profit providers may indeed be inferior, for example in service quality (Comondore et al., 2009), staff-density (Stolt, Blomqvist & Winblad, 2010), and costs of care (Warner, 2008, p. 176). The research evidence on the performance

4 Vining and Globerman call this as a 'hold-up' problem, which may also be a concern for contractors.

5 See Coghill & Woodward 2005 for general criticism and criticism concerning other sectors.

of public and private providers, however, in contradictory and opposite results have also been reported (Stolt et al., 2010; Warner, 2008).

As regards the contracting out process an important suggestion comes from Hefetz and Warner (2004), who argue that contracting out does not have to be seen as a one-way process directed solely towards the market. They argue that it would be more appealing to consider contracting out as a dynamic process that includes both, contracting out to the private sector, but also contracting back into the public sector. In particular, reverse contracting out it is refers to a situation where the public sector takes back a service, once delegated to the private sector, to be performed again by the public sector (Hefetz & Warner, 2004). However, this reverse of contracting out does not necessarily mean a return to the traditional public monopoly. Instead, it may result in novel compositions that integrate market, citizen voice and public involvement in the public service delivery process (Warner, 2008, p. 171).

2.2.2 Public-private partnership

Defining PPPs

Even though public-private partnerships have gained increasing popularity in the political rhetoric and substantial academic interest has been shown in the issue, the definition of the term is far from clear. Hodge and Greve (2010) have aptly stated that PPPs seem to be "*a board church of many families*". Indeed, the term has also faced criticism and several scholars have claimed that substantial variety in the definitions drawn from different research traditions has resulted in the imprecision of the concept and its use in a very broad fashion (e.g. Donahue & Zeckhauser, 2011, p. 256; Hodge & Greve, 2010; Weihe, 2008, 2005; Tomlinson, 2005; Wettenhall, 2003a, 2003b; Carroll & Steane, 2000, p. 37; McQuaid, 2000). Consequently, the literature on PPP is also diverse and draws on several disciplines (e.g. Bovard, 2010; Weihe, 2010; Vrangbaek, 2008; Weihe, 2005). Fortunately a few notable efforts have been made to organize the literature on PPP (see e.g. Brinkerhoff & Brinkerhoff, 2011; Hodge & Greve, 2010; Hodge, Greve, Boardman, 2010; Vrangbaek, 2008; Weihe, 2005; Wettenhall, 2003a, 2003b; Linder, 2000).

In their review, Hodge and Greve (2010) described different ways of understanding PPPs. On the one hand they suggest that PPPs are new tools to organize, govern, manage and measure public services (see also Linder, 2000). On the other hand, they contemplate whether PPP is only a language game, i.e. a new name given to describe old delivery patterns such as contracting out in order to make them politically more

acceptable (see also Wettenhall, 2003a). Brinkerhoff and Brinkerhoff (2011) in turn define PPP as a relative phenomenon, the depth of which depends on organizational identity and mutuality, also including the element of equality in decision-making. In ideal PPP the partners retain the particular characteristics of their organizations but are both committed to the partnership's goals, which are jointly determined. In addition, PPPs also include other features such as collaborative and consensus-based decision-making, non-hierarchical and horizontal structure and processes, trust-based and informal as well as formalized relationships, synergistic interactions among partners and shared accountability for outcomes and results.

Some scholars have described PPPs as voluntary long-term relationships in which partners share the risks, profits and costs of the joint project (e.g. Klijn, Edelenbos, Hughes, 2007, p. 72). Bovaird (2004) defines PPPs as "*working arrangements based on a mutual commitment (over and above that implied in any contract) between a public sector organization with any organization outside of the public sector.*" To Donahue and Zeckhauser (2011, p. 256) the term partnership stands for a situation in which two parties are in parallel situations aligning their efforts to pursue the goals that motivate them both. McQuaid (2000, p. 10–12) has suggested that behind the definition of PPP, there are several basic assumptions such as a potential for synergy (also Carroll & Steane, 2000), involvement in both development and delivery of the services (also Klijn & Teisman, 2000), involvement of a public policy goal that benefits the wider community (Flinders, 2005). In addition, it has been suggested that PPPs should result in mutual benefit for both parties including common goals and the sharing of risks and skills (Klijn & Teisman, 2000).

PPPs in practice

PPPs have gained increasing popularity as methods of public service delivery. In many countries the governments have started to adopt policies which emphasize horizontal partnerships and strategic service purchasing instead of hierarchical models of steering (e.g. Donato, 2011). It is commonly assumed that public services delivered through organizational collaborations such as partnerships will be more efficient and have better outcomes than if single organizations acted independently (Steijn et al., 2011; Harris, 2010).

According to McKee, Edwards and Atun (2006) the delivery of health care in almost every country involves PPPs of some kind. The forms of PPPs vary from joint organizations, or institutional PPPs (e.g. Cappellaro & Longo, 2011) to looser forms of collaboration that fairly often reflect forms of contacting out arrangements (e.g.

Vrangbaek, 2008). Traditionally PPPs have been employed in the fields of transportation, technology, environmental policy and infrastructure (McKee et al., 2006; Vaillancourt Rosenau, 2000). In health care and social services PPPs were also initially introduced in the forms of infrastructure projects. Of these probably one of the best-known initiative is the Private Finance Initiative (PFI) introduced in the United Kingdom in the 1990s (see e.g. Hellowell, 2010; Ball, Heafey & King, 2007; Ghobadian, Gallear, Viney & O'Regan, 2004; for critique see e.g. Pollock, 2004).

In addition to the infrastructure projects the discussion on PPPs in health and social care has focused on the role of partnerships in developing countries. In this area the World Bank and the World Health Organization among others have introduced various forms of partnerships between public and private organizations (Reich, 2002). PPPs have occurred especially in the field of public health in the forms of national or local level programmes for the prevention and cure of communicable diseases such as malaria, HIV/AIDS and tuberculosis (e.g. Curtis, Garbrah-Aidoo & Scott, 2007; Dewan et al., 2006; Lonnroth et al., 2004; Newell et al., 2004; Schwartz & Bhushan, 2004). They have also been seen as new solutions to deliver health care services for the people with poor access to health care (Garcia Prado & Lao Peña, 2010) and as tools for the public sector to better coordinate and govern mixed health care systems with a relatively large and diverse private sector in several developing countries (Lagomarsino, Nachuk & Singh Kundra, 2009). There has also been a growing interest in international level global health partnerships involving public intergovernmental organizations, such as the World Health Organization and private philanthropic foundations, academics and other not-for-profit organizations to bridge the gap between developing and developed world in the areas such as access to new technologies, availability of treatment and medication as well as access to education (e.g. Rushton & Williams, 2011; Reich, 2002; Widdus, 2001).

In the literature on public management PPPs have often been seen as solutions for a dynamic environment in which better coordination of the service system is needed (Pierre & Painter, 2010, p. 53; Klijn & Teisman, 2000). It has been suggested that PPPs are deemed attractive because of the underlying belief that more intensive co-operation between public and private parties will produce better, more efficient, outcomes (Harris, 2010; Klijn, 2010). In addition, it has been suggested that increasing use of the term public-private partnerships reflects an underlying public sector desire to develop and sustain close working relationships with the external market (Domberg & Fernandez, 1999).

In regard to health care and care for older people the reasons for closer collaboration can also be sought from the perspective of transaction cost economics (TCE) (Donato, 2011). In this context partnerships are seen as a tool to tackle uncertainty relating to contracting with private service providers. The idea proposed by TCE is that contracting involves costs that depend on the behavioural and informational properties of contracting parties, context and on the characteristics of the given service or product (Williamson, 1975). The main focus of TCE is to minimize these transaction costs and other potential hazards related to contracting. The choice of the ideal governance model (market, network/hybrid, hierarchy) is made on the basis of this criterion. In particular the TCE framework defines three dimensions that affect the choice of the ideal governance model: asset specificity, uncertainty and transaction frequency that relate to the service or product in question (Geyskens, Steenkamp & Kumar, 2006; Williamson, 1975).

Health care and social services have a number of features which often cause high transaction costs and incomplete contracts (Allen, 2002). The complexity of the services has been suggested to be one of the underlying rationales behind PPP arrangements (Cappellaro & Longo, 2011). The outcomes are also often intangible and complexity in the measurement of outcomes makes this field of services prone to transaction costs (Feiock & Jang, 2009). Thus there are potentially many informal arrangements that communicate the information missing in formal contracts between the individuals and organizations (e.g. Ouchi, 1979). In the absence of full knowledge of either the future circumstances or of the actual performance of the contracting parties, trust and cooperation are crucial for effective contracting because they sustain the informal aspects related to contracting (Allen, 2002; Geyskens et al., 2006). One way of supporting the informal aspects of contracting is integration through informal networks or more formal forms of partnerships (Allen, 2002). The idea is that contracts may remain incomplete as contingencies can be dealt with as they arise (Donato, 2010, 6; 2004).

Establishing partnerships can also be argued for through growing and complex client needs which require services from more than one provider or professional (e.g. Tynkkynen et al., 2012; Ahlgren & Axelsson, 2007; Yung et al., 2005; Mur-Veeman, Hardy, Steenbergen & Wistow, 2003; Yung & Grigg, 2000). This applies especially to older people, who often need both health care and social services. It is necessary that a multitude of professionals and provider units, public and private organizations, health care and social service sectors as well as service purchasers and providers work together in order to provide adequate services for clients with diverse and multiple needs. In this context the service purchaser should foster cooperation especially between the different

providers. This in turn is possible only if the purchaser co-operates closely with the service providers.

PPPs have also faced criticism. According to some scholars PPPs do not actually reflect collaborative arrangements in which both public and private sector organizations can benefit from working together. Rather partnerships are underpinned by the norms and rules of private sector management. (Grimshaw et al., 2002.) Indeed, it has also been contemplated whether PPP is ultimately a codename for full privatization of public services (Hodge & Greve, 2010; Linder, 2000). PPP can be seen as a political term in a sense that politicians use it to make collaboration with the private sector look more desirable for the public (Klijn, 2010). Finally, PPPs may be seen as impediments to fair and free competition due, for instance, to their often relatively long duration (e.g. Rajala, Tammi & Mecklin, 2008).

Suggested typologies for PPPs

Due to their ambiguous character several scholars have endeavoured to distinguish between different PPPs rather than trying to formulate one all-encompassing definition addressing all PPP arrangements at a same time.

Firstly there are scholars who have looked at the issue of PPPs from the point of view of research traditions and theoretical approaches. Weihe (2005) distinguished between five approaches to analyse PPPs: the Local Regeneration Approach, the Policy Approach, the Infrastructure Approach, the Governance Approach and the Development Approach. Each of the approaches has different origins in the literature and they emphasize different aspects of co-operation. For Weihe the most essential defining characteristic of each of the approaches is their context. Following Weihe (2005) Hodge and Greve (2010) also defined five families of PPP arrangements all of which emphasize different aspects of co-operation and governance. These include institutional cooperation for joint production and risk sharing, long-term infrastructure contracts, public policy networks, civil society and community development, and urban renewal and downtown economic development. These "families" of PPPs all emphasize different characteristics and mechanisms of collaboration.

Bovaird (2010) provides an analysis of the meta-theories from which different PPP approaches have developed since the 1970s. These meta-theories, which rationalize the role of PPPs in public policy, include government regulation of business, regional and urban dynamics, New Public Management, criticism of PFIs, strategic management from a collaborative advantage point of view and public governance. From this point

of view, the differentiation between PPP arrangements comes from the rationalization given by its theoretical roots.

Another way to approach different partnership arrangements is to focus on the purposes for which they are adopted. Bovaird (2004) suggests a purpose-based framework to analyse PPPs. He proposes that partnerships can be established for purposes such as policy design and planning, policy coordination, policy monitoring, policy review and evaluation, policy implementation and service delivery, resource mobilization and resource management. According to Bovaird (ibid.) each of the different purposes is likely to require partnerships with differing membership, strategies, structures and operational processes. Moreover, there are likely to be different criteria against which the partnership will be monitored and evaluated. Brinkerhoff and Brinkerhoff (2011) also proposed the adoption of "*a purpose-based taxonomy*" (Table 2). They distinguished between policy PPPs, service delivery PPPs, infrastructure PPPs, capacity building PPPs and economic development PPPs. According to them each of the PPP types involves different organizational structures, measurements for the performance and also normative dimensions.

Fairly similar to purpose-based typology is Linder's (2000, 1999) differentiation between different meanings of PPPs. He distinguished between six meanings for PPPs. Firstly PPPs can be seen as management reforms. That is, partnerships are promoted as tools to change public sector operations, largely relying on the discipline of the market. The assumption is that the skills needed to survive in the world of market competition are beneficial and can improve public sector operations. The second meaning emphasizes PPPs' abilities to contribute to problem conversion. Partnerships are seen as solutions to the problems occurring in public service delivery. Private business growth and the involvement of the private sector in public service delivery are supported as they are seen as tools to complement the public service. The third aspect is PPP as moral regeneration. In this approach partnerships are seen as a means to improve public managers' managerial and problems solving skills. Fourthly, PPPs can be defined as a means of risk shifting. The attempt is to curb public spending through PPP arrangements. The fifth approach is to define PPPs as tools to restructure public service. Partnerships are seen as attempts to restrain the growth of the public sector, decrease bureaucracy and make the public sector more flexible and ready to adapt to a changing environment. Finally, PPPs can be seen as a means to power sharing. According to this approach partnerships spread power horizontally between the public and private sector, thereby providing a means to alter private-public relationship fundamentally. On the one hand, PPPs change

Table 2 Public-Private partnerships: a purpose-based taxonomy

Type of PPP	Purpose of PPP	Organizational structures and processes	Performance metrics	Normative dimensions
Policy	To design, advocate for, coordinate or monitor public policies	Network Task force Joint committee Special commission	Technical quality Responsiveness Consensus-building Legitimacy	Equity/representativeness Citizen participation Transparency
Service delivery	Engage non-public actors in delivering public service through separating the payment for the public services from the provision	Co-production Joint venture Contract Partnership agreement	Quality Efficiency Effectiveness Reaching targeted beneficiaries	Accountability Business values and incentives Access Responsiveness
Infrastructure	Bring together public and private actors to finance, build and operate infrastructure	Joint venture Build-operate-transfer Build-operate-own-transfer Design-build-operate	Quality Efficiency Value for money Maintenance and sustainability	Accountability Business values and incentives Access Responsiveness
Capacity building	Help to develop skills, systems and capabilities that allow those groups or organizations targeted for assistance to help themselves	Knowledge network Twinning Contract Partnership agreement	Skills transfer Intellectual capital Social Capital Organizational systems and output	Ownership Agency Empowerment Autonomy/independence
Economic development	Cross-sectoral collaborations that promote economic growth and poverty reduction.	Joint venture Contract Partnership agreement	Poverty reduction Profitability Sustainability	Equity Social inclusion Empowerment

Source: Brinkerhoff & Brinkerhoff, 2011, p. 8.

the relationship from competition to cooperation. On the other hand, partnerships are likely to involve mutual benefit, shared responsibility and also shared knowledge and risk. Thirdly, partnerships compel public and private actors to negotiate differences between the parties which in other circumstances might have been litigated.

I approach partnerships – and collaboration in general – from the purpose based point of view. I will thus adopt the views presented by Brinkerhoff and Brinkerhoff (2011) and Bovaird (2004). I focus on partnerships, which, if adopted, are established for purposes of service delivery. In other words, non-public actors are engaged in "delivering public services through separating the payment for the public services from the provision" (Brinkerhoff & Brinkerhoff, 2011).

2.2.3 Building a framework for analysing collaboration

In order to analyse the nature of collaboration between the public and private sector a distinction between contracting out and public-private partnerships has to be made. As presented above, a comprehensive definition of PPP is difficult to make. Both concepts, contracting out and PPP, are ambiguous and vague. It has even been suggested that it is not beneficial to define any general elements applicable for all PPP arrangements because of their contingent character and different purposes (Weihe, 2005). Due to this, I do not attempt to provide any specific definition of PPPs. Instead, I build a framework in which contractual relationship and partnership are defined in relation to each other.

Klijn and Teisman (2000, p. 85–86) provide a fairly convenient way to distinguish between contractual and partnership arrangements. According to them the distinguishing features between the two collaborative arrangements are the power relations, the existence of joint decision-making and problem solving as well as the goals collaboration aims at. In a contractual relationship public and private actors are involved in a principal-agent relationship while partnerships involve joint decision-making and potentially also production of services or goods. Furthermore, in contractual relationships the public actor defines the problem, specifies the solution and selects a private actor able to produce the results in the most cost-efficient way (also Edelenbos & Klijn, 2009). Partnerships, in turn emphasize joint decision-making and the development of the services or goods in question (also e.g. Vrangbaek, 2008; McQuaid, 2000). Finally, in a contractual relationship the main goal is to obtain the services in the most efficient way (i.e. faster and cheaper), while in partnerships the focus is more on synergy and enriched services.

Edelenbos and Klijn (2009) suggest that a contractual relationship emphasizes contracts while in a partnership the focus is more on mutual trust and the role of the contract is smaller (also Klijn & Teisman, 2000). In addition, the time frame in which partnerships are often embedded is broader than in a contractual relationship. In a contractual relationship co-operation is limited to the time before the contract is signed; in partnerships the co-operation continues throughout the process (also Klijn, 2010; Vaillancourt Rosenau, 1999).

Linder's (2000) definition of PPP as power sharing also comes close to these distinctions. According to this approach PPPs are likely to involve mutual benefit (also Brinkerhoff & Brinkerhoff, 2011; Edelenbos & Klijn, 2009; Simon & Fielding, 2006; Faulkner, 2004; McQuaid, 2000), responsibility sharing as well as sharing of knowledge and risk. Partnerships spread power horizontally between the public and private sectors, and thus provide a means to fundamentally transform the private-public relationship. PPPs change the relationship from competition to cooperation and compel public and private actors to negotiate the differences between the parties (Linder, 1999). Flexibility and the ability to adapt play an important role as in a partnership it is likely that partners have to adopt characteristics that are alien to their partner. It is important for the organizational cultures and leadership practices to be compatible to the extent that the realization of a partnership is also possible in practice (Lewis, Baeza & Alexander, 2008; Yung et al., 2005; Grimshaw, Vincent & Willmott, 2002; Nelson et al., 1999). Finally, according to Bovaird (2004) partnership can be distinguished from purely contractual relationships[6] by analysing e.g. the depth of transparency (also Sullivan & Skelcher, 2002; Linder, 2000), accountability (also Carroll & Steane, 2000, p. 37), and the willingness and ability to collaborate for a common goal (also Brinkerhoff & Brinkerhoff, 2011; Edelenbos & Klijn, 2009; Simon & Fielding, 2006; Flinders, 2005; Sullivan & Skelcher, 2002; Carroll & Steane, 2000, p. 37; McQuaid, 2000).

In light of the literature reviewed above I have build a framework in which contractual relationship and partnership are analysed through (1) goals set for co-operation and benefits sought thereby; (2) power relations and decision-making; (3) transparency and mutual trust; (4) organizational properties (Table 3). The analysis of goals, benefits and organizational properties aims at conclusions on the prerequisites of partnership. The analysis of power relations, decision-making, transparency and mutual trust for its part reflects the partnership in practice.

6 Bovaird (2004) talks about "transactional contractual relationships" and "collaborative partnerships"

Even though the framework is presented as a dichotomous distinction between contractual and partnership relationship, I will use it as a continuum on one end of which there is contractual relationship and on the another partnership. The descriptions of contractual relationship and partnership are ideal models, which do not exist in the real world as such.

Table 3 An analytical framework of contractual relationship and partnership

	Contractual relationship	**Partnership**
Goals and benefits	Efficient service delivery	To provide added value to the customers, synergy gains for the parties, sharing knowledge and learning from others, win-win situation.
Power relations and decision making	Principal-agent relationship. Problem definition and solution specification by a public actor. Co-operation only before the contract is signed.	Horizontal power relations. Joint decision making and problem solving throughout the contractual period.
Transparency and mutual trust	No knowledge and information sharing to any great extent. Low level of trust between the parties.	Fairly open knowledge and information exchange between the partners. High level of trust between parties.
Organizational properties	Each actor preserves its own characteristics and properties. Compatible organizational cultures not needed.	Actors may adopt characteristics from other actors. Potential need for compatible organizational cultures.

3 Aims of the study

This research consists of four sub-studies and a summary. Sub-studies I-IV all focus on different aspects of collaboration between the public and private sectors in Finland. In particular I analyse the perceptions of collaboration between public and private actors. Collaboration will be analysed from three perspectives: goals set for and benefits sought thereby, collaboration in practice and organizational properties. These perspectives are summarized using the framework built in Section 2.2.3. The collaboration between the public service purchasers and the private service providers is approached by discussing the aspects of contractual relationship and partnership. By using the framework I search an answer to the following question:

> *What aspects of partnership can be identified in the collaborative relationships between public and private sectors in Finnish local health and elderly care systems in the first decade of the 2000s?*

Sub-study I focuses on the goals set for and benefits sought through collaboration. The interrelationship is sought from the service purchasers' point of view. The study addresses the municipalities' reasoning behind the decisions to purchase elderly care and primary health care services from private service providers. Drawing on the results the aim is to analyse whether the goals set for collaboration reflect the goals typically sought through partnerships.

Sub-studies II and III focus on collaboration in practice. Drawing on these sub-studies the aim is to analyse the actual collaboration between the public and private actors. In particular I consider it from the perspectives of power relations, decision-making, transparency and mutual trust. *Sub-study II* sheds light on the issue from the perspectives of private service providers and public service purchasers, the focus being specifically on their perspectives of collaboration between municipalities and private service providers. *Sub-study III* explores the prerequisites for establishing public-private partnership. It takes as its subject the field of ophthalmology services. Ophthalmology

services were selected because this has traditionally been a branch of health care services in Finland in which the use and provision of private services has been more common that in health care on average[7]. The specialists' work is divided between the public and private sectors: the majority of ophthalmologists operating part-time in both the public and private sectors. Hence there is competition for workforce between public and private employers. In this situation establishing a PPP could be a solution to optimize resource allocation between the public and private sectors.

In *Sub-study IV* the interrelationship is analysed from the point of view of organizational properties. The study discusses whether in the employees' perception public and private providers differ in terms of their leadership practices. The issue is explored in the context of sheltered housing services for older people, the scope of which has extended in recent years in Finland. In addition, the market of sheltered housing has attracted several large firms often owned by multinational investment companies. This has a potential to make the private market more competitive and for-profit oriented than the market in which small entrepreneurs and not-for-profit organizations have traditionally had a prominent role. Drawing on the results of this study I endeavour to discuss whether the organizational cultures and leadership practices are sufficiently compatible for the realization of a partnership to be feasible in practice.

7 Other specialities with a relatively large proportion of private provision are dental care and gynaecology

4 Methodology and data

A summary of the research questions addressed in the sub-studies, the data and methodology is presented in Table 4. In the following I describe the data and the methods in more detail.

4.1 Describing the data of the sub-studies

Sub-study I

The first sub-study addressed the question of how local level politicians and civil servants describe the issue of contracting out primary health care and elderly care services to private sector. The study was part of the TILTU 3.0 Project exploring the separation of purchasing and provision functions in *primary health care and elderly care* services in Finland (Junnila et al., 2012). Interview data drawn from six medium or large Finnish municipalities was used. In this sub-study the selection criterion for the municipalities was their administrative structure: the participating municipalities were selected from municipalities having separated purchasing and provision functions in their health care and social service organizations. The six municipalities participating in this study were selected because they represent different geographical areas in Finland (south, west, and north) and because they were in different stages in the process of separating purchasing and provision. All these municipalities had also outsourced some of their services to for-profit and not-for-profit providers.

The interviewees include civil servants and political decision-makers. Of the civil servants it was chosen to interview those responsible for purchasing health and social services for their residents. They play a crucial role especially in the preparation of the political decisions as well as in the implementation of the purchasing decisions. Of the elected officials those responsible for setting the annual budget for health and social care and for the political decisions on purchasing services from private providers were interviewed. In all the interviews a thematic interview format concerning the purchasing

practices of the municipality was used. The interviewees were asked directly about their justification for purchasing services from the private sector, but the interviewees also referred to contracting issues elsewhere.

Sub-study II

The second sub-study explored the level of co-operation between the municipalities and private providers. The study was a part of the same larger research project as was Sub-study I. During the TILTU 3.0 Project also survey data was also collected with two separate surveys: one of the municipalities and the other of the private elderly and health care providers. The survey questionnaire was sent to 124 municipal organizations of which 80 responded (65%). The median size of the municipalities was 8,734 inhabitants (min=1,936; max=588,549). The survey questionnaire was sent only to those Finnish municipalities that organize the services only for their own residents. That is, they do not belong to collaborative areas in which municipalities organize the services together (see e.g. Kokko et al., 2009). The survey questionnaire to private providers was sent to 443 private for-profit and not-for-profit providers of which 94 for-profit and 78 not-for profit providers responded, resulting in a response rate of 39% for the whole sample. The providers were contacted through the Association of Social Services Employers and Businesses and Private Health Care Association that are member associations of Confederation of Finnish Industries (EK). The median number the organizations employed full-time employees was 10 (min=1; max=1863) in the for-profit organizations and 29 (min=1; max=500) in the not-for-profit organizations.

Both questionnaires contained the same set of questions on co-operation between service purchasers and providers. The responses to these questions were compared across the municipalities, for-profit and not-for-profit providers, using cross-tabulation and chi2-test for statistical significance. Kruskal-Wallis one-way analyses of variance by ranks supported the findings of the cross-tabulations. However, I decided to report only the results of the cross-tabulations as percentages are more illustrative in regard to the distribution of the responses in different categories.

In order to achieve a more detailed baseline picture of the level of co-operation interview data collected from the civil servants and private providers was used. The public sector interviewees included civil servants responsible for purchasing health and social services (see sub-study I). Private sector interviewees included the management level in for-profit and not-for-profit primary health care or elderly care provider organizations. The selection of the providers was conducted with the help of the study municipalities. Representatives of the municipalities were asked to name one primary care and one

elderly care provider they would consider to be among their most important private service providers. With two exceptions the elderly care service providers were not-for-profit organizations. All the primary care providers were for-profit organizations. The data from civil servants was collected through six group interviews with 2–6 participants. The data from private providers was collected through 11 interviews with 1–2 participants.

Sub-study III

The third sub-study addressed the prerequisites for PPP in the context of ophthalmology services. The study was part of a research project known as INNOTE addressing the management and promotion of innovations in the health care sector (Kivisaari, Kokkinen, Lehto & Saari, 2009). One of the aims was to explore the development of a systemic innovation in ophthalmology services in the catchment area of Tampere University Hospital. One of the alternatives discussed during the innovation development was public-private partnership between the public hospitals in the catchment area of Tampere University Hospital and private firms who at the time were competing for medical practitioners. For the purposes of the study interview data was collected in 2008. The data included 17 expert interviews and interviewees included representatives from the private sector (n=5), specialized health care (n=10) and primary health care (n=1). All the interviewees were key stakeholders in regard to the on-going innovation development process in the catchment area of Tampere University Hospital.

Sub-study IV

The fourth sub-study explored the employees' perceptions of organizational justice (Colquitt, 2001), job demands and job control (Karasek & Theorell, 1990; Karasek, 1979) in municipal, for-profit and not-for-profit sheltered housing units in Finland. The study was a part of a research project known as KILPA exploring whether organizational ownership has an impact on the quality of care, cost of care and employee wellbeing in the context of elderly care in Finland (Sinervo et al., 2010). As part of the project a cross-sectional postal survey to assess employees' working conditions and job characteristics was conducted in 2008. Questions concerning perceptions of organizational justice, job demands and job control as well as questions on units' human resource management (HRM) practices and employees' socio-demographic status were included in the survey. Data on the units' modified case-mix were drawn from the RUG classification system for long-term care (Björkgren et al., 1999) and home care (Poss et al., 2009). These data were obtained from the Finnish RAI benchmarking database (Finne-Soveri, Björkgren,

Vähäkangas & Noro, 2006; Noro, Finne-Soveri, Björkgren & Vähäkangas, 2005). Data on units' structural factors such as staffing level and inpatient days were gathered via separate questionnaires at the unit level.

4.2 Describing the methods

4.2.1 Frame analysis (Sub-study I)

Frame analysis is a qualitative research method initially introduced by Goffman in 1974. One of the leading ideas behind the method is that framings of policy problems create rationales that authorize some policy solutions and not others (Coburn, 2006). For instance, framing policy reforms in a certain way can help politicians to win public support for their initiative (Slothuus, 2001). In other words, framing brings certain aspects of the issue to the fore while leaving other aspects hidden. Frame analysis provides a tool for exploring the rationales used when policy solutions or problems are discussed. It also makes it possible to uncover the underlying beliefs, perceptions and appreciations of the policymakers who argue for or against particular policy options (Schön & Rein, 1994). Finally, it provides a tool to depict and engage in the array of arguments and their counterarguments surrounding the complex and controversial policy issues that are characteristic of health care and social services (Creed, 2002).

Rein and Schön (1996) have distinguished between four ways of looking at frames. A frame can be seen as a scaffolding, i.e. a frame has a similar underlying structure to keep it in shape as a house has its own frame to keep it standing. Another way to look at frames is to understand them as boundary setters in the same way as a picture frame separates a picture from the rest of the environment. Thirdly frames can be defined as schemas of interpretation. A fourth way to understand frames is to perceive them as strong and general narratives.

In Sub-study I the frames are interpreted as general narratives (Rein & Schön, 1996). The frames were built by following the suggestion of Gamson & Lasch (1983) on frame building, where each frame has certain "signature elements" that help to reveal its core and position. These elements include metaphors, exemplars, catchphrases, depictions, roots, consequences and appeals to principle. These elements were employed in order to describe the eight combinations established in the first phase. Finally, analysing the signature elements of the initial frames, the eight initial frames were then aggregated into five final frames.

4.2.2 Theory-driven content analysis (Sub-studies II and III)

Content analysis is a research method for analysing written, verbal or visual communication. It dates back to the 18th century (Hsiu-Fang & Shannon, 2005) and was first used for analysing hymns, advertisements, political speeches and newspaper and magazine articles (Elo & Kyngäs, 2008). Research using qualitative content analysis focuses on the characteristics of language as communication and pays special attention to the content and contextual meanings of the text (Hsiu-Fang & Shannon, 2005).

In general, content analysis can be used either inductively or deductively (Elo & Kyngäs, 2008). Theory-driven content analysis, or directed content analysis as Hsiu-Fang and Shannon (2005) call it, can be grouped under the deductive approach, because it moves from the general to the specific (Elo & Kyngäs, 2008). In other words, local problems in the data are drawn from a general theory using deductive reasoning (Eskola & Suoranta, 1998, p. 81).

Theory can be defined as "a set of concepts used to define and/or explain some phenomenon" (Silverman, 2000, p. 77). A researcher should be theoretically informed, i.e. aware that data can be approached from several different perspectives (Alasuutari, 1996; Alasuutari, 1994, p. 69–72). In the analysis a theory provides a researcher with an explicitly defined framework within which the data can be assessed (Alasuutari, 1996). A framework can be generated from earlier inductive studies (MacFarlane & O'Reilly-de Brun, 2012) or from other sources of existing knowledge on the problem at hand (Elo & Kyngäs, 2008).

The critics of the theory-driven method point out that a researcher approaches the data with an informed but still fairly strong bias. The dominance of a theory during the analysis can blind a researcher to contextual aspects of the problem at hand. (Hsiu-Fang & Shannon, 2005.) On the other hand, however, the use of theory as a bases for an analysis is well justified if the purpose of the study is to test an existing theory in a different situation or to compare established categories across different time points (Elo & Kyngäs, 2008). Thus, the specific type of content analysis varies according to the interests of the researcher and the problem studied (Hsiu-Fang & Shannon, 2005).

4.2.3 Multilevel modelling (Sub-study IV)

Multilevel models or hierarchical linear models are applicable to situations in which it may be assumed that the responses of the study participants depend on both their

individual characteristics and the environment in which they are embedded (Leyland & Goldstein, 2001). The idea is that by studying only individuals it is not possible to understand individual phenomena. People belong to several micro-level groups, such as family, school, workplace or place of residence and macro-level groups such as nationality. (Ellonen, 2006.) These are all likely to affect the behaviour of an individual. Multilevel models have been applied e.g. in studies on school well-being (Konu, Lintonen & Autio, 2002), regional variation in public health policy (Leyland & Groenewegen, 2003), food shopping environment (Giskens et al., 2008) and in studies on variation between hospitals (Ogbu et al., 2010).

In Sub-study IV it was assumed that the unit characteristics such as ownership status, organizational structure, staffing level, in-patient days/year, case mix of the patients and HRM practices as well as individual characteristics such as age, job tenure, education, employment status and employment contract influence the employees' perceptions of organizational justice, job demands and job control.

Table 4 Summary of the research questions/hypotheses, data and methods used in the sub-studies

Sub-study		Research questions	Data	Methods
I	Framing the decision to contract out elderly care and primary health care services – perspectives of local level politicians and civil servants in Finland	What frames do Finnish local authorities and civil servants use in their talk about contracting out primary health care and elderly care services?	Interviews (n=17) with 1–6 participants each. Collected from service purchasers and local politicians in six Finnish municipalities	Frame analysis
II	A study on purchaser-provider co-operation in the local welfare regimes in Finland	Do public service purchasers/private providers 1) trust that their partners will operate as agreed in the contract? 2) perceive that their partners provide them with adequate information they can trust regarding the service delivery? 3) find that the services are appropriately developed in co-operation with their partners? 4) perceive that the contract and its implementation are evaluated with their partners and does this have relevance to the interpretation of the contract?	Survey directed to 124 municipalities (65% response rate). Survey to 443 private for-profit and not-for-profit providers (response rate 39%) Group interviews (n=6) with 2–6 participants each collected from service purchasers in six Finnish municipalities Group interviews with 1–2 participants each collected from for-profit (n=5) and not-for-profit (n=6) service providers	Cross tabulation and Chi-Square test for statistical significance Theory driven content analysis
III	An analysis of ophthalmology services in Finland – has the time come for a Public-Private Partnership?	Is there an open window of opportunity for PPP in ophthalmologic services in Finland, and if so to what extent?	17 expert interviews including following representatives – private providers (n=5) – secondary health care (n=10) – primary health care (n=1)	Theory driven content analysis
IV	Employees' perceptions of organisational justice, job control and job demands – do ownership and human resource management practices matter?	**H1**: HRM practices are positively associated with perceived organizational justice and job control as well as negatively associated with perceived job demands **H2**: The perceptions of organizational justice, job demands and job control are not determined by the ownership as such, but mediated through HRM practices	– Cross-sectional postal survey to 128 sheltered home units in Finland with 929 respondents in the final sample (response rate 64%) – Finnish RAI benchmarking database	Multilevel linear regression

5 Results

5.1 Summary of the results

The main results of Sub-studies I–IV are summarized in Table 5. In the following I describe the main results in more detail.

5.1.1 Sub-study I: Why do municipalities contract out health and social services to private sector?

The results show that municipalities engage in collaborative relationships with private service providers for various reasons. Five argumentation frames were identified in the data. *Rational reasoning* refers to a situation in which contracting out services to the private sector is argued for strategic, economic or other "objective" arguments. *Pragmatic realism* refers to situations in which engaging in a contractual relationship is the only possible option due to exogenous factors such as lack of personnel or other resources. *Promoting diversity among providers* suggests that the municipalities were willing to promote service provider diversity, which was believed to result in improvements in public service provision and in increased opportunities for service users' choice. The improvements in public provision were seen especially to result from increased competition and benchmarking opportunities with private providers. These, in turn, were believed to lead to improved quality of care and efficiency in service delivery in the public sector. *Good for the municipality-argument* was based on the aim to boost the municipal economy through job creation and increased tax revenue. There was mainly a willingness to contract with the private sector only if it meant purchasing services from local, often third sector providers. Thus the prevalent opinion was that multinational for-profit companies would not be the most desirable partners due to their relative market strength compared to the small local providers. Finally, *good for the local people* referred mostly to the willingness to provide the residents with more opportunities to

choose their service providers themselves. Throughout the interviews it appeared that the orientation towards the role of the general public seems to be changing. This applied especially to elderly care services. In several interviews it was stated that older people are becoming active consumers willing to "shop around" in the marketplace of health care and social services.

5.1.2 Sub-study II: Perceptions of purchaser-provider co-operation

The perceptions of the co-operation during the contractual period differed substantially between the private providers and the municipalities. In the survey, the differences occurred notably between the for-profit providers and the municipalities, while the not-for-profit providers were more content with the state of co-operation. As to contract compliance, the representatives of the study municipalities expressed more trust in their partners than did the private providers. The respondents from the municipalities were also more likely to respond that their partners provided them with adequate information. The majority of the municipal respondents reported that they were able to trust the information provided by their partners, whereas the for-profit providers especially reported that they could rarely or never trust the information provided by the municipalities. The representatives of the municipalities and not-for-profit providers reported that they did indeed develop the services in co-operation with their partners while the for-profit providers reported mostly the opposite. The vast majority of the municipalities reported that the contracts were appraised with their partners while especially the for-profit providers again reported the opposite. The interview data, for its part, paints a picture in which the private providers form a more unanimous stakeholder group. The private providers would be willing to work together with the municipalities, while the respondents from the municipalities considered that contracting is mostly a tool to lighten their administrative load.

5.1.3 Sub-study III: Is there an open window of opportunity for partnership?

Both public and private actors reported that there were problems concerning the demand for services and the division of labour. However, the problems were defined differently from the public and private sector perspectives. In the public sector it was considered that the growth in demand is excessive in relation to the existing resources. In the private sector, in turn, it was perceived that the problem was uncertainty about

the demand for services. As to the division of labour, it was reported that in the public sector the biggest problems was the uncertain roles of public and private actors in the field of ophthalmology. In the private sector, there was a willingness to divide the workforce and operational tasks between public hospitals and private clinics, but the problem was that the public actors were not interested in this. The main results suggest that the change in the relationship between public and private actors has been put on the agenda. However, the time was not yet ripe for the establishment of PPP involving mutual trust, joint decision-making and horizontal power sharing. The results suggest that there was a lack of a win-win situation that would have benefited the both parties. Moreover, the establishment of PPP would have required an active policy entrepreneur to promote the initiative.

5.1.4 Sub-study IV: Does ownership matter in terms of organizational justice, job control and job demands?

The results suggest that the public, not-for-profit and for-profit organizations are not fundamentally different in terms of HRM issues. From the results it may be assumed that organizational procedures potentially play a more significant role in employees' perceptions of their work and their superiors. The results supported the hypothesis that HRM practices are positively associated with perceived organizational justice and job control as well as negatively associated with perceived job demands. Ownership was associated with interpersonal justice, job demands and job control, but it was not the only determinant behind the perceptions. However, its effect remained significant after the HRM variables were added in the model. Thus it may not be said that the effect of ownership is mediated solely by HRM practices which were the focus in this study. All in all, the results for ownership confirm the complexity of the issue of ownership and its use as an explanatory factor already reported by several scholars.

Table 5 Summary of sub-studies and their results

Sub-study		Main results
I	Framing the decision to contract out elderly care and primary health care services – perspectives of local level politicians and civil servants in Finland	– The interviewees used five argumentation frames: • Rational reasoning • Pragmatic realism • Promoting diversity among providers • Good for the municipality • Good for the local people – Contracting with the private sector was seen mostly as a means to improve the performance of public providers, to improve service quality and efficiency and to boost the local economy. – The decisions to contract out were mainly argued through the good for the municipal administration, political and ideological commitments, available resources and existing institutions.
II	A study on purchaser-provider co-operation in the local welfare regimes in Finland	– The perceptions of the co-operation during the contractual period differed substantially between the private providers and the municipalities – The private providers were not satisfied with the situation while the municipalities seemed to be fairly content – In order to be able to gain benefits that are sought through contracting the municipalities should invest in contract management and also be active during the contractual period
III	An analysis of ophthalmology services in Finland – has the time come for a Public-Private Partnership?	– Competition of workforce worked as a main driver behind the attempt to establish a PPP – The change in the relationship has been put on the agenda but the time was not yet ripe for establishment of PPP – Establishment of PPP would have required • an active policy entrepreneur to promote the initiative • a win-win situation that benefits the both parties
IV	Employees' perceptions of organisational justice, job control and job demands – do ownership and human resource management practices matter?	– Compared to ownership status, HRM –practices played more significant role in regard to the employees perceptions of organizational justice – The results support the argument for increased convergence in organizational practices between public, not-for-profit and for-profit organizations

5.2 Conclusions of the summary

In this section I draw conclusions from the results of the four sub-studies and answer the research question of this summary. The research question was:

> *What aspects of partnership can be identified in the collaborative relationships between public and private sectors in Finnish local health and elderly care systems in the first decade of the 2000s?*

I use the theoretical framework on partnership and contractual relationship formulated in Section 2.2.3. Collaboration is analysed from three perspectives drawn from the literature: goals set for and benefits sought through the collaboration, collaboration in practice and organizational characteristics.

Municipalities set multiple goals and seek several kinds of benefits trough collaboration with private service providers (Sub-study I). On the one hand contracting with private providers reflected forms of contractual relationship. Contracting was seen as a means to deliver services in the most efficient way, to boost local economy and as a means to adapt to the changing environment, for instance in terms of supply of workforce. At the same time, however, there was also a willingness to learn from the private providers in order to develop the performance of the public service providers. Moreover, through co-operation the municipalities aimed at providing a more diverse range of services for the residents – namely added value and enriched services. Thus the municipalities did not aim solely at the most efficient way of service delivery; other benefits were also sought through co-operation. From the perspectives of goals and benefits the results suggest that the municipalities' aims towards collaboration with private providers include certain elements that can be regarded as goals often set for partnerships.

Even though the goals set for co-operation and benefits sought through it partly reflected aspects of partnership, the actual willingness to establish partnership involving mutual trust, joint decision-making and horizontal power and knowledge sharing is not evident. The results suggest that a win-win situation, which both parties of partnership would perceive as beneficial, can be hard to achieve in practice. (Sub-study III.) In addition, the perceptions of collaboration in terms of joint decision-making, knowledge sharing and mutual trust differed between the municipalities and the private providers (Sub-study II). While the majority of the municipalities reported that the services were developed together and that the contracts were evaluated during the contractual period, the private providers, especially the for-profit providers, reported largely the opposite.

The situation was fairly similar in terms of knowledge sharing and mutual trust. In this sense, the collaboration does not seem to involve aspects of partnership to any great extent.

The final perspective of the collaboration focused on the organizational characteristics. The assumption was that cultural issues between public and private organizations have to be acknowledged and accepted in order to achieve a successful partnership. In partnerships actors may adopt characteristics from other actors and there may be also a need for compatible organizational cultures. In this sense Sub-study IV provides an interesting perspective on the issue. As to the organizational properties the public, for-profit and not-for-profit providers may not be fundamentally different in terms of leadership. In other words, the leadership practices as perceived by the employees are heterogeneous among public, for-profit and not-for profit providers. It seems that there is no specific leadership culture in public, for-profit and not-for-profit sectors.

In sum it can be claimed that in terms of the goals that municipalities set for collaboration with the private sector certain aspects of partnership can indeed be identified. These include a willingness to learn from the private providers in order to develop the service provision in the public sector and a willingness to provide a more diverse range of publicly funded services. In addition, the prerequisites for partnership in terms of organizational characteristics seem to be no worse than they might be in the case of partnership between public and public organizations or between for-profit and not-for-profit organizations. The results suggest that there is no specific leadership culture in public, for-profit and not-for-profit sectors. However, the public purchasers and the not-for-profit and for-profit providers have different perceptions of the nature of collaboration in practice. Public actors perceived that they could trust to their partners, the services were developed together and that the contracts were evaluated during the contractual period, while the private, especially the for-profit providers, perceived mostly the opposite. That is, if the issue is discussed from the public actors' perspective there seems to be support for the existence of partnership aspects. However, if the issue is discussed from the private providers', especially for-profit providers', perspective the aspects seem to be largely lacking.

6 Discussion

The majority of the literature on public-private partnerships in health and elderly care has focused on infrastructure projects and public-private partnerships in the developing countries. There is also a large body of literature drawing on the field of public management and approaching the issue often from mainly theoretical perspective. In relation to the existing literature this study contributes new knowledge on the actual co-operation between public and private actors as well as on the goals set for the collaboration in the context of health and elderly care services. It also contributes to the discussion on public-public private partnerships in the field of health and elderly care service delivery. The study discusses the perceptions of both public and private actors, which has not so far been studied to any large extent.

Each of the sub-studies makes its own contribution to the current partnership research by studying partnership from the perspectives of goals and benefits, actual collaboration, and organizational properties in terms of leadership. Sub-study I studied how civil servants and political decision-makers argue for their contracting out decisions. The results suggest that in the municipalities several arguments are used to explain contracting out decision, some of which reflect partnership elements. Sub-studies II and III explored the collaboration and its initiation in practice. The results from these studies permit the conclusion that collaboration is perceived differently by public, for-profit and not-for-profit actors. That is, if the issue is discussed from the public actors' perspective there seems to be support for the existence of partnership aspects. However, if the issue is discussed from the perspective of private providers, especially for-profit providers, the aspects seem to be largely lacking. Finally, in Sub-study IV employees' perceptions of organizational justice, job demands and job control were studied. This study also provides an additional viewpoint for the discussion on partnerships. If the partnership and its elements are studied, neither cultural preconditions nor organizational properties should be omitted in the analysis.

6.1 Discussing the concept of partnership

The results of this study suggest that the current forms of collaboration do not reflect the assumed forms of partnership as given by PPP definitions, while at the same time policy rhetoric seems to emphasize partnerships. The very nature of partnerships may provide at least a partial explanation for this discrepancy.

PPP is an ambiguous concept, thus its use for scientific purposes is not uncomplicated. While I have adopted PPP as a scientific concept I am aware that it can also be treated as a concept created for practical and political use (see Klijn, 2010; Linder, 1999). These two meanings, the day-to-day meaning and the scientific one, potentially hold different definitions for different people and the purposes for using them are potentially different. Klijn (2010) suggests that partnership can be seen as a brand, i.e. a set of the meanings and identity given to a product. From this point of view he suggests that it is not so much the product (here the nature of collaboration) that matters but the image that is created by branding it. Thus branding the collaboration between public and private sectors as a partnership has a potential to make the collaboration with private providers look more acceptable to the general public (Hodge & Greve, 2010). In this sense partnership can be seen as a political concept (Klijn, 2010; Grimshaw et al., 2002).

Due to this value-laden nature of the concept of partnership and its multiple meanings, the use of the term was to a large extent avoided in the data collection of sub-studies. In the data collection and analysis partnership has been split into different elements suggested in the literature such as trust, information sharing and co-development of the services. The data were then analysed by using a theoretical framework taken from the literature. In so doing I have tried to analyse the nature of collaboration behind the different meanings associated with the concept of partnership. The aim of this study was not to analyse the meanings associated with the concept of partnership as such, but to explore whether the collaboration as experienced by different actors reflects the theoretical concept of partnership. The different meanings for partnership given by different stakeholders would, however, be an interesting subject for further research in order to better understand the expectations related to partnership by different stakeholders.

Testing the theoretical concept of partnership empirically is not without problems. At least it one must considered whether the theoretical concept of partnership drawn from the diverse literature and used in this study reflects the nature of partnership in practice (see e.g. Tomlinson, 2005). The conceptual variation in definitions and meanings for

partnership pointed out by several scholars (e.g. Donahue & Zeckhauser, 2011, p. 256; Hodge & Greve, 2010; Weihe, 2008; Tomlinson, 2005; Weihe, 2005; Wettenhall, 2003a, 2003b; Carroll & Steane, 2000, p. 37; McQuaid, 2000) does not provide a solid base for using partnership as a scientific concept. However, I have chosen to enjoy this diversity of definitions and to provide my own framework for analysis of collaboration between public and private sectors. I chose not to provide any all-encompassing definition. Instead I located the concept of partnership on a continuum of collaboration and discussed it in relation to a more purely contractual relationship. I suggest that as theoretical concepts partnership and purely contractual relationship differ qualitatively from each other. However, as the term partnership really appears confusing at least as a scientific concept I would, in the future, prefer to use the term collaboration which can assume closer or more distant forms in terms of relationship between different parties.

6.2 Considerations of the data and methods

The data of this study is drawn from core political decision-makers and managers of Finnish municipalities, managers of private health and elderly care service provider organizations, managers of public hospital organizations and from employees working in public, for-profit and not-for-profit sheltered home units. In Sub-study I and II the interviewees from the public sector represented large or medium sized municipalities in Finland. These municipalities are probably also among those with the most positive position on contracting with private providers. These municipalities had all adopted a market-oriented administrative model in their own organization, the so-called purchaser-provider split. The respondents to the questionnaire in Sub-study II mostly represent medium sized or large municipalities as the survey was directed at municipalities that organize the services only for their own residents. That is, they do not belong to collaborative areas in which municipalities organize the services jointly (see Kokko et al., 2009). Finally, the data of the Sub-study III was collected in the catchment Tampere University Hospital, where the private market is smaller than in the Helsinki metropolitan area but better developed than in most of Eastern and Northern Finland. Taking these considerations into account it can be suggested that the results concerning the perceptions of municipal social and health care management can be generalized at least to large and medium sized cities in Finland.

The data from private providers is mainly drawn from providers of elderly care. In the questionnaire used in Sub-study II most of the providers were elderly care providers.

These were mainly small but the range in size was fairly big. The response rate was 39%, which is lower than in other successful surveys targeted at care service enterprises in Finland (e.g. Rissanen et al., 2010). It cannot, thus, be said that the survey data from private providers fully represents the perceptions of private service providers in Finland. The results have to be interpreted keeping this limitation in mind. The private market in health care services is mostly dominated by a few private companies (Junnila et al., 2012; Mikkola, 2009). Most of these companies were interviewed and they also responded to the questionnaire targeted at private providers. Thus their perspective is covered fairly well.

In Sub-study IV, survey data collected from sheltered housing facilities was used. The data is rare in the Finnish context as it enables comparison between public, for-profit and not-for-profit provider organizations (Sinervo et al., 2010). The data is also fairly large, which has been suggested to be a sterenght of this study compared to some other studies on psychosocial working environment and leadership in organizations providing elderly care services (Pekkarinen, 2007).

Mostly the data represents primary care services in Finland. Sub-study III is an exception as the data comes from the field of ophthalmology and mainly from the level of specialized care. In ophthalmology there are procedures such as cataract surgery, which can fairly easily be formulated as a product purchased from the private sector. In other words, the asset specificity is high (Williamson, 1975). According to Williamson (ibid.) these kinds of services could be well be delivered through the market, while products and services with low asset specificity should be delivered through networks, partnerships or hierarchies. Elderly care and primary health care in turn could be regarded as complex services with diverse service needs and client groups. However, if ophthalmology is seen as a branch of services many times taking care of older people and other patients such as diabetics with multiple diagnoses closer collaboration between public purchasers and private service providers might be beneficial in order to better integrate the different service providers in the care, for instance, of older people. Moreover, ophthalmology is a service branch in which the public and private sectors compete for workforce. Closer collaboration between public and private employers might be needed in order to find, for instance, a more appropriate division of labour. Thus, keeping the limitations in mind, I would argue that ophthalmology services are a justifiable part of this study.

I have distinguished between private for-profit and not-for-profit providers and treated them separately when necessary. The results however, suggest that the different organization types in terms of ownership may not be so different than is sometimes

assumed. Sometimes the borderline between for-profit and not-for-profit is theoretical rather than practical. Several not-for-profit organizations, for instance have established limited companies in order to be able to compete in the market. In addition, it is debatable to what extent small local enterprises and large multinational social and health care companies should be understood as belonging to the same category as I did by including them all in a single category of for-profit providers. Thus in part the distinction between for-profit and not-for-profit may in part be too superficial or misleading.

Difficulties also relate to the distinction between public and private. Formulating boundaries between what is public and what is private is a difficult task (Steinberger, 1999). In practice, there are several service arrangements that cannot be defined being purely public or private (Saltman, 2003). Consequently, not only one but multiple boundaries between public and private sectors exist in health care (Maarse, 2006). According to some scholars all organizations are public to some extent (Bozeman, 1987) and the 'publicness' of an organization is dependent partly on the context in which it operates (Antonsen & Jørgensen, 1997). In regard to health care and social services the context has potential to make organizations increasingly similar due to the characteristics of the organizational field in which they operate (DiMaggio & Powell, 1984). Thus in the future, it might be interesting also to consider other characteristics, such as size, age, service branch or organizational structure and to explore whether and how they influence different forms of collaboration.

The study is based on four empirical sub-studies with cross sectional designs. Cross-sectional studies allow a researcher to draw conclusions only on the current state of affairs (Hirsjärvi, Remes, Sajavaara, 2007, p. 173). Consequently I am not able to conclude anything about the change in the nature of collaboration between public and private sectors. To analyse whether the collaboration is actually changing in any direction a longitudinal study design should be used. Repeating the surveys used in Sub-study II, for instance, would allow us to say whether the nature of collaboration is changing and in what direction (compare Rissanen et al., 2010). The change would be an interesting study objective, because there is also the notion that the nature of collaboration is always contingent and not following any observable trend. If this were the case, the contingencies directing the relationship towards closer collaborative relations would be an interesting research area. This research could also help in identifying the situations and service areas in which closer collaboration might be beneficial.

In this study the collaboration between public and private sectors was approach by using qualitative and quantitative data. This can be regarded as a strength of this study.

Approaching a research question using both qualitative and quantitative data is often referred to as mixed methods research (e.g. Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 1998). A combination of both kinds of data has been suggested result in a more complete analysis of the problem in question. In addition multiple forms of evidence are also needed by policy-makers, practitioners and other applied areas. (Creswell & Plano Clark, 2007, p. 13.)

Mixed methods have been recommended for research on complex problems (Creswell & Plano Clark, 2007, p. 13). In terms of collaboration between the public and private sectors both qualitative and quantitative data are needed. When it comes to future research qualitative approaches would help in elucidating the meanings associated with different types of collaboration. Also further development of theory of collaboration would benefit from different qualitative approaches. It would, for instance, be important to ascertain who uses the term partnership, how, why and with what purpose and effect (Tomlinson, 2005). In turn, the research on the determinants of different kinds of collaboration as well as on broad trends in the change in the nature of collaboration could be well analysed within quantitative research designs.

6.3 Ethical considerations

Discussing on ethical issues often involves the issues related to the conduct of research and reporting. These include issues such as honesty (i.e. no plagiarism, distortion of the results or biased reporting), diligence (doing the best one can), *openness* as to the methods, theories and other tools used in the research, *acknowledging* other researchers (i.e. referencing), and reporting the results when they are meaningful to society (Clarkeburn & Mustajoki, 2007, p. 43–44). As far as these issues are concerned I would say that this study withstands ethical inspection. However, when it comes to unbiased reporting, one can always argue whether research, especially qualitative research (e.g. Jokinen, 2008), can be unbiased or objective. It is often claimed that it cannot as the choice of the method, conduct of the analysis, and reporting of the results are based on the subjective interpretation of the researcher. The quality of the research can, however, be assessed if the researcher has adequately presented the data, methods and conduct of the data analysis. The reader should be able to assess whether the interpretation has been made based on the basis of sufficient evidence and whether it has been argued properly. I hope that I have been able to report my studies so that readers can make their own

assessments of my interpretations and propose their own arguments in order to bring the scientific discussion forward.

Another important aspect to consider is whether the choice of my research topic is appropriate from the ethical point of view. That is, does it have any significance[8] in our society or even beyond? If not I would have been wasting the precious resources of my supervisors, the university and the public. However, I would say that this study has its rightful place in the field of health services research due to the arguments I have provided in the preceding pages.

Ethical conduct of the research is not restricted solely to the researching itself but also to communicating and reporting it so that it can have an impact on society. That is reporting so that decision-makers are able to use that information (Clarkeburn & Mustajoki, 2007, p. 252–253). The significance of the research topic is of little use if no-one knows about it. Thus for now on my duty is to communicate my results to the media, which is one of the main information sources for politicians (e.g. Meriläinen, 2008). The decision-makers in Finland read short Finnish reports, not academic research papers and thus, these are something we researchers should provide as well (Jussila, 2012).

6.4 Discussing the policy implications of the study

In Finland the discussion on partnership has to a large extent focused on the discrepancy between increased emphasis on competition on the one hand and on closer collaboration on the other. The discussion on the use of competitive bidding in health care and social services has been on-going since the early 2000s. Already then it was questioned whether the two approaches, competition and partnership, could be reconciled (e.g. Niiranen, 2003). Currently the discussion focuses largely on the Act on Public Contracts (348/2007), which has often been seen as a barrier to successful partnerships between the public and private sectors. It has been claimed that since the law came into force the interrelationship between the municipalities and private providers has to a large extent withered to purely contractual relationships. (Ministry of Social Affairs and Health 2012, p. 27.) According to some scholars it seems that currently the collaboration between public purchasers and private providers emphasizes competition rather than partnership (Rajala et al., 2008).

[8] I focus on the significance in Finland, even though an option could be also to widen the perspective to the global context of research (Clarkeburn & Mustajoki 2007, 57).

However, it has also been argued that even though the Act on Public Contracts (348/2007) has been seen as a barrier to the establishment of closer partnerships it still provides a fairly large amount of flexibility for public service purchasers (Aho, 2012). There are several options for collaborative elements to be included in the contract on public services (Ministry of Social Affairs and Health 2012, p. 29). Thus, the main problem in the establishment of partnerships may not be the strict regulation but rather the lack of know-how and resources to prepare the public procurement process properly (Aho, 2012). In addition the results from the study by Sievänen and colleagues (2010) indicate that much depends on the municipal decision-makers' willingness for closer collaborations with the private providers.

One option to move forward in the discussions would be to abandon the term partnership and start discussing its different aspects. By speaking solely of partnerships it is not possible to capture the complex nature of collaboration between the public and private sectors. This study provides one example of deciphering the meaning of partnerships and collaboration in general. By analysing goals and benefits, power relations between public and private actors, level of information sharing, trust and organizational properties one can observe that at least these aspects of collaboration may actually be fairly independent of the legislation. Rather, the prerequisites for and impediments to closer forms of collaboration potentially exist at the organizational and individual levels of action.

Even if the legislation did not form a barrier to closer collaboration, implementing new organizational arrangements inside existing service systems has often proven to be difficult (e.g. Saltman, Calltorp, de Roo, 2011). The forces affecting the success of reforms in health and social policy can be understood by contemplating the logic of the policy cycle, which consists of multiple stages (Rushefsky & Patel, 1998, p. 16). Making policy issues and policy solutions meet often calls for a policy entrepreneur, who promotes certain policy solutions to meet current policy issues (Kokkinen & Lehto, 2011; Kingdon, 1995). In terms of collaboration between the public and private sectors we need policy entrepreneurs with an understanding of the complex nature of collaboration between the public and private sectors. It can assume closer and more distant forms. An adequate policy solution is dependent on the nature of a policy problem, thus closer forms of collaboration are suitable solutions only for certain policy problems. The results of this study suggest that some of the goals set for collaboration might be easier to achieve through closer forms of collaboration. These include learning from private providers and developing the performance of public providers as well as

providing added value for citizens by creating more alternatives of which to choose. In addition, clients with complex health conditions requiring services from more than one provider or professional might benefit from closer collaboration between public and private sectors (e.g. Tynkkynen et al., 2012; Ahlgren & Axelsson, 2007; Yung et al., 2005; Mur-Veeman et al., 2003).

Aiming at closer collaboration should not, however, be taken for granted and the problems related to closer forms of collaboration should be acknowledged. There are also aims which are served better by more distant forms of collaboration or aims, which even see partnerships as threats. These include e.g. prevention of corruption and separation of public and private interests, which may, in many cases, be in conflict. For-profit organizations are assumed to follow a profit-maximization objective and yield benefit to their owners (Brooks, 2005) while public organizations' mission is to serve the public in general (Perry & Rainey, 1988). Not-for-profit organizations, in turn, can be seen contemplating the public sector (Julkunen, 2000) and correcting the market failures occurring in markets with for-profit firms (Koning et al., 2007).

There are scholars who suggest that instead of collaboration partnerships with private sector are underpinned by the norms and rules of for-profit private sector management (Grimshaw et al., 2002). It has also been contemplated whether partnership is ultimately a codename for the privatization of public services undermining the role of the public sector in correcting the welfare differences and inequality in the society (Hodge & Greve, 2010; Linder, 2000). Indeed, partnership can be seen as a political term in the sense that politicians use it to make collaboration with the private sector to look more desirable to the public (Klijn, 2010). All in all, partnerships are rather a general discourse which may include questionable working arrangements such as corruption, cronyism, trusts and other attempts to impede competition or generate profit for private providers to name but a few. On the other hand, however, partnerships can mean collaborative arrangements built around the needs of a certain client group or a societal problem.

Finally, as the Finnish public service delivery is reformed different forms of collaboration between the public and private actors are potentially needed. However, the discussion should not be focused solely on the problems related to public service delivery and the solutions provided by the private sector. Rather it should be acknowledged that also inside the public sector there is change and development potential which should be harnessed for the improvement of public service delivery.

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Original publications

BMC Health Services Research

RESEARCH ARTICLE Open Access

Framing the decision to contract out elderly care and primary health care services – perspectives of local level politicians and civil servants in Finland

Liina-Kaisa Tynkkynen*, Juhani Lehto and Sari Miettinen

Abstract

Background: In the literature there are only few empirical studies that analyse the decision makers' reasoning to contract out health care and social services to private sector. However, the decisions on the delivery patterns of health care and social services are considered to be of great importance as they have a potential to influence citizens' access to services and even affect their health. This study contributes to filling this cap by exploring the frames used by Finnish local authorities as they talk about contracting out of primary health care and elderly care services. Contracting with the private sector has gained increasing popularity, in Finland, during the past decade, as a practise of organising health care and social services.

Methods: Interview data drawn from six municipalities through thematic group interviews were used. The data were analysed applying frame analysis in order to reveal the underlying reasoning for the decisions.

Results: Five argumentation frames were found: *Rational reasoning; Pragmatic realism; Promoting diversity among providers; Good for the municipality; Good for the local people*. The interviewees saw contracting with the private sector mostly as a means to improve the performance of public providers, to improve service quality and efficiency and to boost the local economy. The decisions to contract out were mainly argued through the good for the municipal administration, political and ideological commitments, available resources and existing institutions.

Conclusions: This study suggests that the policy makers use a number of grounds to justify their decisions on contracting out. Most of the arguments were related to the benefits of the municipality rather than on what is best for the local people. The citizens were offered the role of active consumers who are willing to purchase services also out-of-pocket. This development has a potential to endanger the affordability of the services and lead to undermining some of the traditional principles of the Nordic welfare state.

Background

This paper addresses the types of framings used by local Finnish authorities when they argue about contracting out primary health care and elderly care services to the private sector. Thus, in this paper contracting out is addressed in the context of a health care systems mainly based on so called Beverigian model, i.e. on tax-funding and the dominance of public providers. By contracting we mean a relationship between a public purchaser and a private, not-for-profit or for-profit providers that engage in a contractual relationship in order to deliver public services [1]. The selection of the private providers usually involves a process of competitive bidding organised by the public sector. We also include vouchers in this definition because in Finland the providers eligible for delivering services purchased by vouchers, are selected by the municipality via competitive bidding. In general, contracting here refers to a notion according to which the public sector retains the main responsibility for financing and regulating the services as well as for monitoring the performance of service providers [2]. We acknowledge that there are also other terms, such as outsourcing and privatization of the provision, referring to similar activities. We use the term contracting out to refer to all these activities throughout the paper.

Contracting out public services has gained substantial popularity in several countries such as the Nordic

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countries, United Kingdom, New Zealand, Australia and Canada e.g.[2-5]. The developments towards increasing privatization in the welfare have been described as a long historical process reflecting the broad transformations in the western societies influenced by economic and cultural changes and policy diffusion [6]. These societal changes have been suggested to create an environment in which the public-private boundaries may start to melt [7] and through which health care and social service systems might become more private in nature [3]. It has indeed been argued that, during the past decades, health care and social service systems in Europe have incrementally started to shift towards private provision, financing, management and investments [7]. In spite of this, not much literature exists concerning the motivations that drive the decisions to contract with the private sector in health care and social services see, however, e.g. [8-11]. The decisions on the delivery patterns may be seen, however, to be of great importance as they have a potential to influence citizens' access to services and even affect their health [12].

The aim of this study is to explore the argumentation frames used by local politicians and civil servants when they argue about contracting out health care and social services. In order to do this we employed frame analysis initially introduced by Goffman [13]. The framing of the policy problems creates rationales that authorize some policy solutions and not others [14]. Thus, frame analysis provides a tool for uncovering the underlying beliefs, perceptions and appreciations of policy makers [15].

The study is based on interview data collected through thematic interviews in six municipalities in Finland. The interviewees include civil servants responsible for purchasing health and social services and elected officials responsible for setting the annual budget for health and social care and for the political decisions on purchasing services from private providers. The analysis resulted in five analytical frames. The main emphasis in the frames was on the benefits for the municipality rather than on the good of the local people.

The article proceeds as follows: In the next section we briefly review the literature on contracting out of public services in different contexts. After that we describe the purpose of the study, methods, study context and the data in detail. Finally, we present the results of the analysis and discuss their significance. We conclude by summarising the main results of the study.

Why to contract out and why not?

Public, for-profit and not-for-profit have been assumed to pursue different societal goals [16,17] and potentially to possess certain qualities that make them superior to other sectors in certain societal fields. Vaillancourt Rosenau's [18] review of the literature suggests that private for-profit actors are creative and dynamic, innovative, able to adapt to rapid changes, good at replicating successful practices and at performing complex tasks, while public organisations are better in fields such as regulation and policy management as well as in ensuring equity, securing public interest and preventing discrimination or exploitation. Finally, it has been suggested that not-for-profit organisations are those who express compassion and commitment to individuals and are concerned with moral codes and individual responsibilities. Not-for-profit organisations have often been seen as a group of organisations, which base their actions on certain ideological or religious commitments [19] and which are able to meet the social need that the state and the market are unable or unwilling to satisfy [20]. Third sector organisations have been instrumental in developing the services that presently form the basis of the western welfare states e.g. [21] and provide a major part of health and social services especially in countries with social health insurance [20]. However, as to actual contracting out of health care and social services, the literature mainly discusses the relationship between the public sector and for-profit organisations.

The arguments for contracting out often include beliefs in improved cost-control and more flexible organisation [22], improved resource allocation and better management [2], cost-efficiency and better service quality [11] as well as willingness to concentrate on the 'core service' of the organisation e.g. [8,9,11,22-24]. It has often been suggested that in the public sector there is willingness to benefit from competencies and technologies applied by private providers, a desire to import additional resources in the public sector as well as a belief that private actors are able to operate more efficiently [2,6,9,25]. Furthermore, it has been reported that improvements in quality, increased user satisfaction, a way to motivate employees and a wish to reduce the scope of the state are the driving motivations for increasing the scope of private sector service delivery [6]. However, the literature also suggests that compared to their public or not-for-profit counterparts, private for-profit providers fare poorer in terms of e.g. service quality [26], staff density [27], psychosocial working conditions [28] and costs of care [29]. Contracting with the public sector is also suggested to undermine the terms and conditions of employment [30] as well as to create an unstable environment in which organisations are no longer able to offer secure long-term employment for their employees [19]. The research evidence on the performance of public and private providers is, however, controversial and reverse results have also been reported e.g. [27-29].

As to the state of democracy and citizen involvement, contracting with the private sector has raised several

concerns. Hodge and Coghill [3] state that privatization of service provision undermines political accountability but increases the importance of managerial and market accountability. In other words, through increased contracting, the power relations between societal actors may alter and the democratic state may incrementally change towards a more corporatist one [25]. Warner [29] goes so far as to argue that the movement from the public sector to the market diminishes the room for citizen involvement, which may be seen as a key to democracy. Flinders [31] sees privatization policies as a "Faustian Bargain" and suggests that while some short-term efficiency improvements and costs savings may be gained, the different privatization policies are likely to result in substantial political and democratic costs. Finally, it has been claimed that competition, which is often involved as services are contracted out, provides a poor foundation for equity between citizens [25,29].

As to the provision of health and social services in particular, Vining and Globerman ([32], 79) suggest that the criticisms of contracting out concern at least the following issues. Firstly, in the area of health care and social services the competition is often limited, leaving the purchasers fairly vulnerable to opportunistic behaviour, such as overcharging for services. Secondly, the complex nature of health and social services poses challenges for definitions of best quality as well as for monitoring provider performance. Finally, contracting involves a risk of poor performance but not necessarily a possibility to cancel the contract. In the empirical literature the reluctance has related especially to the special nature of health care and social services that often include regulatory tasks, prevention and ability to react in a case on a crisis [8,23].

Research context and methods

Municipalities are responsible for organising health care and social services for their residents in Finland. The municipalities have been free to contract with private providers since 1984 in social services and since 1993 in health care services. However, due to a deep recession in 1990s the issue of contracting did not become topical in the local health and social policy until the early 2000s. Since then the municipalities have expressed a growing interest in contracting out their services with private for-profit and not-for-profit providers.

Municipalities are currently in a process of reorganising the governance of their service structures in Finland [33]. One of the developments has been to reorganise their services by introducing a purchaser-provider split in the municipal organisation [34]. In addition, the new capacity needed to meet the growing demand of sheltered housing and home help for the older people is mostly purchased from the private sector.

A significant part of the housing services provided by private sector has traditionally been provided by private not-for-profit providers, with which the municipalities have already co-operated for decades. However, changes in the legislative environment (e.g. EU competition law) have made the contracting with private providers a process emphasising competition instead of co-operation. In addition, for-profit providers have been increasingly interested in the growing market of elderly care services. These developments have altered the positions of not-for-profit providers that now are forced to compete on the municipal contracts with for-profit providers. In 2009 the market shares in sheltered housing were at macro level 46%, 32% and 23% for the municipalities, for-profit providers and not-for-profit providers respectively [35]. However, the proportions vary locally.

In primary health care the volume provided by private providers is smaller compared to the care for the elderly [35]. However, the share of the private sector has been in increase since the mid 1990s. The total volume of primary health care services purchased from the private sector increased from 28 million Euros in 1995 to 154 million Euros in 2008. In 2009 there were 37 outsourced health centres in Finland, which served some 7% of the Finnish population [35]. In addition, especially the municipalities in rural areas have experienced difficulties in recruiting physicians to their health centres. This has opened a new market niche for private for-profit recruitment agencies that deliver physician and nursing workforce for health centres that struggle with recruitment problems. Also out-of hours A&E services are often purchased from private sector due to the recruitment problems. In primary health care the services purchased form private sector are mostly provided by for-profit providers.

Despite of the growing interest in contracting with private providers in Finland and elsewhere, only few studies have explored how policy makers ground their decisions. We try to fill in this gap by studying the framings the local authorities use as they talk about contracting out of health care and social services. In the analysis we used frame analysis, the method initially introduced by Goffman [13]. The way a certain policy problem is framed is important as framing creates rationales that authorize some policy solutions and not others [14]. Frame analysis provides a tool for revealing these rationales. It also enables us to uncover the underlying beliefs, perceptions and appreciations of the policy makers [15]. Finally, it provides a tool to depict and engage the array of arguments and their counter arguments that encircle complex and controversial policy issues that are characteristic of health care and social services [36].

We use interview data drawn from six municipalities in Finland. Of the participating cities, four are included among the ten largest cities in Finland and altogether they represent circa one-fifth of the Finnish population. The study is part of a larger research project exploring the separation of purchasing and provision functions in *primary health care and elderly care* services in Finland. The research plan has been written according to the guidelines of The National Advisory Board on Research Ethics. The selection criterion for municipalities was their administrative structure: the participating municipalities were selected from the municipalities that have separated purchasing and provision functions in their health care and social service organisations. The six municipalities participating in this study were selected because they represent different geographical areas in Finland [south, west, and north] and because they are in different stages in the process of separating purchasing and provision. All of these municipalities have also outsourced some of their services to for-profit and not-for-profit organisations.

The interviewees include civil servants and elected officials. Of the c*ivil servants* the researchers chose to interview those responsible for purchasing health and social services for the citizens. They play a crucial role when the political decisions are prepared for the city council. *Of the elected officials* the researcher chose to interview those who are responsible for setting the annual budget for health and social care and for the political decisions on purchasing services from private providers. The data were collected through group interviews (n = 13) with 2–6 participants. In addition, four interviews with only one participant were conducted. The interviews were organised separately for civil servants and elected officials. According to the principles of the National Advisory Board on Research Ethics in Finland a study like the one at hand is exempt from requiring ethics approval.

In all the interviews a thematic interview form concerning the purchasing practices of the municipality was applied. The interviewees were asked directly about their reasoning for purchasing services from the private sector. However, the interviewees referred to contracting issues also elsewhere in the interviews. The interviews were taped and transcribed by five research assistants. All the research assistants were asked to sign a written consent for professional secrecy.

The analysis was conducted in three phases (Table 1). The first author conducted the analysis and participated in the data collection with the two other authors. The final interpretations of the results were discussed among all the authors. In the analyses it was acknowledged that the interviewees could use several argumentation frames within a single interview. However, the purpose of the analyses was to explore the argumentation frames in general and not the argumentation of a single interviewee. The results are reported following this principle.

In the first phase of the analysis, all the references to contracting with the private sector were extracted inductively from the data and grouped according to their content. This resulted in eight contentually consistent ensembles, i.e. initial frames. In the second phase a "signature matrix" drawn from the work of Gamson and Lasch [37] was employed (see also [36]). In their work Gamson and Lasch ([37], 399–400) suggest that every frame has certain "signature elements" that help to reveal its core and position. These elements include *metaphors, exemplars, catchphrases, depictions, roots, consequences* and *appeals to principle*. These elements were employed in order to describe the eight ensembles established in the first phase. As a result of the second phase a signature matrix was completed (Table 2). Finally, analysing the signature elements of the initial frames, the eight initial frames were then aggregated into five final frames.

Results

In this section we present the results of the frame analysis, which resulted in five frames concerning the grounds for the decisions. Summaries of the frames and data extracts for each frame are provided in Table 3.

"Rational" reasoning

In this frame, the decisions to or not to contract out the services were represented as resulting from rational comprehensive decision-making processes. The decisions were represented as being based on strategic and rational planning and careful considerations that take into account the strategy of the municipality as a whole. The arguments for and against contracting were often something like *"we look at the big picture and then decide what is the most appropriate way to organise the services"*. Moreover, a fairly common viewpoint was that there are certain 'core services' that the municipality wants to preserve or which were even seen as compulsory for the public sector to carry out. This applies especially to health care. Contracting out was, thus, seen as a tool to organise services that are not included among these 'core services'. All in all, at first glance it seemed that were no ideological or personal preferences guiding the decision-making.

However, while the decisions were argued through objective, often financial or strategic measures, there were references suggesting that these arguments were partly used as rhetoric tools to convince the interviewers or in order to veil other potential arguments for the decision. Thus, while the initial grounds seemed to be fairly strategic and rational, the actual actions appeared to be

Table 1 Three phases of the analysis and their results (Adapted from Gamson&Lasch [37]: 399–400)

	First phase	Second phase	Third phase
Actions	Data reading and grouping of statements according to their content	Completion of"signature matrix"	Aggregation of the initial frames into five final frames
Results	Eight initial frames-*Strategic planning and rational decision-making- Irrational decision-making- Municipal economy- Market orientation- Citizens' best- Benchmarking- Fire fighting- Exogenous motivations*	Descriptions for each initial frame with the help of signature elements (Table 2).	The final frames*: Rational reasoning, Pragmatic realism, Promoting diversity among providers, Good for the municipality, Good for the local people*

influenced by several external factors. In the example below, for instance, the process is described as being rational while in actual practice it seems to be fairly incremental.

"Well as a matter of fact a lot has happened in different projects, they've produced quite a lot of the city's operations, some of them as permanent purchased services. We've had those, but I don't think it's going to work in actual practice [. . .] I mean we've always kind of started from the growth of service needs, or some other reason." Civil servant

Furthermore, several interviewees referred to a municipal strategy as a basis for their decisions. However, in some interviews it appeared that while the decisions were framed as strategic, in practice there was no actual strategy for the organisation of the services or it was potentially influenced by relative political strengths. The following quote is presented to illustrate the situation:

"I think it's better for us to buy strategic and clearer entities (. . .), it's sensible for both the client and municipal economy that the actor who is responsible does so as comprehensively as possible. And then again it may be that when contracting out a field, for instance, if we are speaking in a competitive sense, we need some leeway; while we would and surely will be taking specific owner alignment measures as to which of these are the strategic entities that we will hold on to." Politician T

In general, the interviewees positioned themselves as rational actors who try to defend the rationality of the

Table 2 Examples of a completed signature matrix for two initial frames: Citizens' best" and "Fire fighting"

	Citizens' best	Fire fighting
Metaphors	"Shopping around in the market place of health care and social services"; "Choosing services as one chooses the toppings for one's pizza"	A municipality as a "fire fighter" extinguishing fires here and there
Exemplars	***Municipality:*** Enabling choice and citizen involvement; taking care of citizens; creating continuity of care ***Private providers:*** Providing something more than the public sector; meeting diverse citizen needs; enabling choice and personalised services	***Municipality:*** Trying to ensure the availability of services; object rather than active subject ***Private providers:*** Able to meet the acute needs of the municipality e.g. delivering workforce.
Catchphrases	Citizens' right to choose their own provider and make their own decisions; representing the will of the citizens; individually tailor-made services; taking care of our citizens; continuity of care	Physician shortage; Shortage of facilities
Depictions	The decisions are based on the citizens' best. Privatizing provides citizens with better opportunities to choose their provider and with a more diverse selection of providers. On the other hand, the decision not to privatize is based on a notion that public sector needs to take care of citizens and that market forces endanger equity and equality.	The decision to privatize is argued with acute needs e.g. acute physician shortage. The decisions are made on a case-by-case basis.
Roots	Public choice; Paternalism; Individualism	Physician shortage; lack of monetary resources; service needs
Consequences	***Positive:*** Citizens get what they want; tailor-made services ***Negative:*** Failed monitoring may endanger the quality; patient safety may suffer if private providers employ staff that is not familiar with the area and local conditions	***Positive:*** Availability of services & better access ***Negative:*** Short-term improvements only, privatization as an emergency solution
Appeals to principle	The goal is to work for the best of the citizens: increased private provision enhances the ability to make choices	The goal is to ensure that the services are available even though there is a shortage of resources etc.

Table 3 How the justification to contract out/not to contract out is formulated and what is the interviewee position in each frame, description and data extracts

	"Rational" reasoning	Pragmatic realism	Promoting diversity of the providers	Benefits for the municipality	Good for the local people
Justification to contract out	The decision to contract out is a rational decision based on strategic planning and careful considerations taking into account the good of the municipality as a whole.	The decision makers are forced to choose an alternative, which from their point of view, is suboptimal or undesirable, but which is the only possible alternative in the present situation.	Outsourcing is a means to create provider diversity in order to improve quality and efficiency, gain cost-savings and create benchmark for public providers. In addition, diversity is seen as a source of flexibility and citizen choice.	Outsourcing is seen as a tool to boost municipal economy through job creation and increased tax revenue.	Outsourcing is seen as a means to ensure high quality, tailor-made services and to provide choice for the citizens.
Example	*"The planning takes into account the whole range of services, what there is available in the area and what we might possibly need more. Is it worthwhile to renovate the long-term hospitals that have been transferred to us and to what extent, how much we could preserve in the hospital area and how much it will cost or whether there's the option of abandoning the service and buying it. I mean we are planning all the time and this is one of the manifestations, we try to look at different areas of Helsinki for what the situation is."* (Civil servant)	*"We have this chronic problem that our older people are in completely wrong places, in wards in the regional hospital or health centres, and this will also lead to a fairly rapid institutionalisation of elderly patients. In a way the A&E department is a strategic key process used to direct older people with many illnesses into the orbit of specialized health care. And as we are dealing with people who do not know the services and as the municipality is 'saving', so to speak, and the A&E services are cheaper when contracted out. But we will get the bill through specialized health care and institutional care for older people."* (Civil servant)	*"Our model of multiple providers is a way of benchmarking our own provision against another provider to see whether there are new ways to provide services. I must admit though that this public system is pretty rigid in terms of reforms. In a way we must get some evidence that the work can surely be done in some other way."* (Civil servant)*"The more actors, the more there will be different ways of doing things. I have swallowed the idea that in the future the only possibility in the social services field is to increase productivity at work. Competition is the thing that increases it, especially if you have small units, they will do things differently and they all try to work towards more efficient solutions. But as I said earlier we should be able to create such quality indicators that we could look at it not only from a purely economic viewpoint."* (Politician)	*"And it started to appear right from the start as a local employment scheme, which it is to the greatest extent. And as we've got high unemployment numbers in the area and high structural unemployment, we've always had it, there's been very little discussion about it but it's the thing that's continuing to cause pressure in the background, that we should organise our operations in a way that would make visible our local employment and local need for jobs and to design systems that support local initiative."* (Civil servant)	*"It probably is this"ageing in place", the notion that the services somehow come closer to people, in the form of individualised solutions. The role of the municipality will become stronger in case management guidance, the role of the public sector as a promoter of solutions and as information and guidance services. And there will be countless ways to provide services and people will try to find solutions that suit them best and they will also pay for them."*(Civil servant)
Justification not to contract out	The decision not to contract out is based on the view that there are certain core services, which the municipality is willing to preserve. The costs of out-sourcing are seen excessive compared to the perceived benefits.	The decision makers are forced to choose an alternative, which from their point of view, is suboptimal or undesirable, but which is the only possible alternative in the current environment.	In relation to the aim of the diversity, a certain amount of public provision should also be preserved.If there is excessive diversity the chances are that the service system becomes too fragmented and the coordination of the system may become difficult resulting in inefficiencies and extra costs.	Not to contract out is seen as a tool to prevent multinational companies from obtaining a local monopoly and ruling the small local firms out of the market.Public sector wants to preserve its role as a good employer employing people in the area.	It is seen that citizens should be protected from the market forces. There is willingness to ensure the quality and continuity of care.
Example	*"Well certain official services should not be contracted out at the moment, at least not at the present moment, in the sense of responsibilities and other things. But we've seen some things, kind of strategic issues, too, that the city provides and operates. I don't think*	*"We had a situation in C., I believe, there was a health centre which could not get a doctor for two years. We wanted to buy them physician services so that K. would get a doctor. They turned it down for ideological reasons because they think it will lead to inequality. Or I don't know*	*"And in our elderly services, how much did E. say, it's quite preposterous what they've purchased. Fifty-four percent of the housing services. There actually is no room for further increase there. The municipality should have operations of its own to be able to benchmark."* (Politician)	*"It would be different if the actor in elderly services is a local business because we support local business activities. But the business in question that organises the physician services for the health center is a listed company and owned*	*"These are the resources that we are actually measuring. But you certainly need to have specific terms and conditions as the extreme horror scenario would be to return to the period of auctioned paupers, someone will make the lowest bid and the quality will start to suffer and our*

Table 3 How the justification to contract out/not to contract out is formulated and what is the interviewee position in each frame, description and data extracts *(Continued)*

	it's sensible to contract out all areas in our health care and social services field." (Politician)	*what the reason was but the plan fell through."* (Politician)		*by foreigners, I believe. The tax collected from our municipal residents is not meant to be used for this but the activities should benefit the whole region, the local businesses, and we do not have such health care businesses."*(Politician)	*elderly citizens will be left without food. It's just like wading through a quagmire you should have clear tools for measuring the quality. On no account should we leave them at the mercy of the market forces."* (Civil servant)
Interviewee position	A rational actor who tries to defend the rationality of the decisions and to promote a comprehensive decision-making process despite external pressures influencing the decisions.	Rational actor forced to adopt a pragmatic and realistic position towards the decisions as a means to adapt to prevailing environment	An actor who is willing to create diversity of providers and alternatives for citizens as long as it improves providers' operational measures and does not endanger public provision	An actor who does what is best for the municipality as a whole.	A actor who bases their decision on the notion of "the best of citizens"

decision-making processes in spite of several factors that actually influence the decisions or actual implementation of the policies.

Pragmatic realism

In this frame the decision to contract out or not was described as resulting from a situation in which the politicians or the civil servants implementing the policies are put "between a rock and a hard place". That is, they are forced to choose between two or more – from their point of view – unsatisfactory or suboptimal alternatives, such as choosing between contracting out to the private sector and compromising service availability. This applies especially to politicians that are responsible for the contracting out decisions.

Especially the civil servants described situations in which they had to choose an alternative, which – again from their point of view – is suboptimal or undesirable, but which is the only possible alternative in the current environment. For instance, there were situations in which an interviewee was reluctant to contract with a private provider but was forced to do so because of a lack of physicians, facilities or other resources and because the politicians saw contracting as the best policy option. Politicians, in turn, described situations in which they would have wanted to contract out a certain set of services, but "the political opposition they faced was so substantial that it was impossible".

In this frame the interviewees portrayed themselves as actors whose rational actions are restricted by the circumstances created by the political environment and by other exogenous factors influencing the policy decisions, such as a lack of resources, past decisions and legislation. The main undertone in the interviewees' talk was that they *"do what a man's got to do"*. That they act rationally in a less rational decision-making process and adapt reluctantly to the prevailing situation.

Promoting diversity among providers

In this frame contracting out was described as a means to increase the number of providers delivering heath care and social services and to create diversity among them. It was believed that diversity is beneficial as it creates competition between providers and enhances innovation, all of which are believed to result in improved quality, efficiency and cost-savings. Furthermore, the interviewees were willing to create a benchmark for public provision. It was thought that private providers possess certain qualities, which make them superior to public providers in terms of efficiency, cost-effectiveness and quality. Moreover, it was stated that cooperation with private providers is easier than with the municipality's own providers as the private providers "do what is agreed upon and do not show up in the middle of the contract period to beg for more money as the public providers might". It was also thought that increasing the number of providers would provide citizens with more opportunities to choose a provider and to receive personalised services. Finally, diversity was seen as a source of flexibility, which protects the service system against sudden changes potentially occurring in the future. Relating to this, there were references to the idea that diversity might enable the municipality to focus on its core tasks letting the private sector to take care of the services outside of this very core. A civil servant described the situation as follows:

> *"(. . .) perhaps there's the idea that the focus is on sheltered housing which is actually a sort of market-driven field nationally, but the city made a decision in the 2000s that the market is working pretty well, so we've basically making an effort to seek growth and to focus on our core operations." Civil servant*

However, several interviewees also stated that*"not everything should be contracted out"*. They felt that diversity also means the existence of a certain amount of public provision. This was seen crucial also from the benchmarking point of view, as the decision makers should be able to evaluate the performance of private providers against that of public providers. In addition, too much diversity could mean that the service system may become too fragmented and the coordination of the system as a whole might become difficult resulting in inefficiencies and extra costs.

Benefits for the whole municipality

In the fourth frame contracting out was described as a means to boost the economy and the employment rate of the municipality. On the one hand, purchasing services from local private providers was seen as a tool to create jobs and to support employment in the area. On the other hand, it was seen as a means to increase the municipal tax-revenue as the local firms are subject to a community tax collected by the municipalities. However, this argument was used mostly as a conditional one: Contracting out was seen as an option only if it was possible to purchase services from local providers. One of the interviewees described the matter as follows:

> *"It's a rather dominant opinion at the moment that we should try to attract business activities in this field and to make it more diverse. But since we know from bitter experience that if a purchasing decision is made, a multinational company owned by a foreign pension fund will come along and buy it and polish their operations to perfection while we are left practically empty-handed. We've had the same disappointments*

here as elsewhere in Finland. In effect, our economic development office is trying to figure out how to keep the people in the hands of businesses with a human face."Politician

In this frame, the decision not to contract out was also related to the quote above. The main argument against contracting with private providers was that there would be a danger that big multinational investment companies would come and attain a local monopoly in service delivery. This, in turn, would result in ruling the small local firms out of the market. In addition, the local authorities expressed their willingness to employ local people to preserve their image as a good employer. This all related especially to elderly care services.

In general, the interviewees portrayed themselves, as ones who make the decisions that they think are best for the municipality and its economy as a whole. In this sense the frame approaches the"rational" reasoning frame in which the good of the whole municipality was also considered. However, in this frame the arguments relate clearly to the municipal economy and employment of the area, while in the"rational" reasoning frame the descriptions of what is good for the municipality are focused more on health care and social services and described in a more abstract manner.

Good for the local people

The 'good for the local people' frame was the only frame in which citizens were considered as the first priority. Contracting out was seen as a means to ensure high quality services for the local people. On the one hand, contracting with private providers was seen as a means to ensure that citizens will get high quality services also in the future. A common argument was that *"we are not going to survive alone in the future, but need private providers to help us to meet the growing service needs"*. On the other hand, the argument was more qualitative: The local authorities saw contracting with private providers as a tool to ensure that citizens are able to choose among different service providers and acquire "high-quality" and "personalised" services. This argument was based on the idea that in the future the role of citizens will alter from a patient or client towards an active consumer who *"shops around in the service marketplace"*. This argument was also used to justify pure privatization or at least increasing co-payments for services through the introduction of vouchers.

"Well it's a question about money too and that's why we also try to make a conscious effort to reduce the city's expenses since the voucher is actually never fully commensurable with the cost of the service. So as to vouchers the city's share compared to a service provided by the city will be lower. Issues such as this are also at stake."Civil servant

The decision *not* to contract the services out was, in turn, based on the countering view. It was thought that it is the duty of the local authorities to *"protect citizens from market forces"*, especially when vulnerable patient groups and old people were concerned. It was also seen that contracting out would not guarantee continuity of care as staff turnover was considered higher among private providers that in the public sector. Finally, it was thought that as the measures to monitor the quality of care are fairly poor, the guarantee of care quality could be endangered if the services were contracted out.

Discussion

The analysis resulted in five frames, which the local politicians and civil servants interviewed in this study applied to describe their decisions on contracting out of health care and social services. The insights did not differ considerable between the civil servants and local politicians. There were arguments for and against contracting out in each stakeholder group and in each frame arguments from both civil servants and local politicians.

The decisions were framed in five ways. Firstly, the interviewees portrayed the decisions as rational and free from political, ideological or other exogenous influences. Occasionally, however, the use of rational descriptions rather resembled a rhetoric tool than the actual grounds for the decisions. This finding lends support to the study by Stold and Winbland [6] suggesting that while the decision-making process leading to contracting with the private sector seems to include e.g. economic arguments there are also ideological factors as well as elements form policy diffusion that guide the decisions. As a whole it seemed that the interviewees were aware that it might be more reasonable to argue the decisions on contracting with the private sector through strategic grounds rather than revealing personal preferences of the issue.

In the first frame several interviewees mentioned that there are certain 'core services' that the local authorities are not willing to contract out. Argumentation through 'core services' has also appeared in previous studies on outsourcing and contracting out but the consensus on the content of these services has remained elusive (e.g. [9,11,22,24,31]). Our data suggest that the 'core services' would include at least preventive and regulatory services (compare [8,23]). In general, however, the core services were rather vaguely defined also in this study and might be an interesting subject for further research.

In the second frame the interviewees described situations in which they were forced to choose an alternative which, from their point of view, was suboptimal or

undesirable but which was the only possible alternative in the present situation. In this frame, the interviewees admit that the decision-making process is not rational and that they try to adapt to it even though they were not supportive towards the final decisions. Thus, the actual decisions are trade-offs between different values and interests, and the decision makers are not always able to make decisions that would be accordance with their own values nor with the best of the local people. Several interviewees reported situations in which the decisions, potentially most beneficial for citizens, were not implemented, as there were other more important objectives that were pursued at the time. This leaves us to contemplate if contracting out really is a "Faustian Bargain" [31] through which the policy makers are able to gain short-term efficiency improvements and costs savings, but which long-term results in political and democratic costs, because the best of the local people is has not been the point of the departure as the decisions are made.

These decisions potentially suboptimal from the citizens' point of view are often influenced by the institutional settings and cultural contexts, as well as by individual beliefs and ideologies [11]. In our data probably the most influential factor affecting the decisions to contract out was the administrative structures of the municipalities. All the municipalities had adopted purchaser-providers split in their organisation, which had directed the municipalities already in the path involving the aim of increasing contracting out *per se*.

Thirdly, contracting out was justified through the willingness to promote service provider diversity, which was believed to result in improvements in public service provision and in increased opportunities for citizen choice. The improvements in public provision were seen especially resulting from increased competition and benchmarking opportunities with private providers. These, in turn, were believed to lead to improved quality of care and efficiency in service delivery in the public sector. This rationale seems to be in line with the arguments reported in previous studies on outsourcing and contracting out (e.g. [2,25]) as well as with the literature addressing the properties of different ownership types [18].

However, there are also studies that do not support these fairly stereotypical distinctions often presented in the literature. The findings of a recent study by Stolt and colleagues [27], for instance, did not support the notion of public providers learning from private providers. Rather, the quality of care in public units seemed to remain constant irrespective of the rate of competition between the providers in the area. In addition, studies by Warner [29] and by Comondore and colleagues [26] do not lend strong support to performance improvements of contracting in terms of quality and cost-savings (e.g. [26,29]). There have even been cases in which the evaluation of the performance of private providers has been significantly hindered, as the contract documents have not been available for the public [38]. The concerns of the transparency and the ability to monitor private providers' performance were expressed also in our interviewees (see also [32]).

The fourth frame was based on the aim to boost municipal economy through job creation and increased tax revenue. The interviewees were mainly willing to contract with the private sector only if it meant purchasing services from local, often third sector providers. Thus, the prevalent opinion was that the multinational for-profit companies would not be the most desirable partners due to their relative market strength compared to the small local providers. There seemed to be a real concern among the interviewees that they are not able to preserve local service provision due to the current competition law dictating that public procurement procedures be applied to purchases exceeding 100 000 Euros. Other scholars have also expressed their concerns about the effect of competitive tendering procedures on especially third sector organisations (e.g. [39]). Several interviewees also mentioned that they are willing to preserve jobs in the public sector and thus, preserve their reputation as a good and responsible employer. Similar arguments have also been reported elsewhere [9,24].

The fifth frame was the only frame in which citizens' best was applied as a point of departure. In the other frames the arguments for and against contracting out were mainly related to the benefits the municipality would potentially gain trough contracting. It could be argued that the improvements in the municipal economy and the cost-savings gained through competition, for instance, would in the end also benefit the local people. Potentially this is the case. However, the reasoning for the existence of the public organisations and the legitimacy of the decision-making authorities are based on the notion of them serving the local people. The public provision and the monopoly status given to the public sector in certain service fields have been justified through the importance of the product and the protection of vulnerable client groups (e.g. [18]). The needs of patients in the context of primary care and elderly care are inherently complex and require cooperation between several societal sectors and promotion of integrated care. Successful integration of health care and social services especially in the care of elderly patients would potentially result in benefits for the patients [40] as well as in reduction of costly hospital admissions [41]. However, the interviewees expressed very little concerns about the consistency of care chains or continuity of care. In the cases these were discussed, the interviewees described

situations in which there were other factors that tip the scales in favour of other values than the best of citizens in terms of comprehensive care.

Throughout the interviews it appeared that the orientation towards the role of citizens is changing. This applies especially to elderly care services. Several interviewees saw that the senior citizens are becoming active consumers willing to "shop around" in the market place of health care and social services (compare [29]). In addition, there was also a fairly strong belief that citizens are willing to invest in their services and purchase them also out of pocket. The argumentation focusing on citizens' best interests was indeed also applied to justify the increasing co-payments that would result from the introduction of vouchers and from restrictions on the eligibility criteria for receipt of services. These developments seem to be somewhat similar than those reported in Sweden [42].

The municipalities included in this study represent large or medium sized cities in Finland and thus, the results cannot be extrapolated to small and rural municipalities. In smaller municipalities the argumentations are potentially fairly different as the provider market is often non-existent, which undermines the feasibility of contracting with the private sector as a policy tool. In addition, small municipalities, often located in rural areas, potentially use contracting for different purposes that do the larger cities. The rural areas in Finland have experienced major difficulties in recruiting physicians in their health centres. Those municipalities have mostly used contracting as a tool to ensure physician services by contracting with recruitment agencies that deliver physician and nursing workforce for health centres that struggle with recruitment problems. The large cities, in turn, have often interest to seek also for benchmarking opportunities and provide the citizens with opportunities to choose among several service providers. The municipalities participating in this study are potentially among the municipalities with the most positive position towards contracting with private providers, because they have adopted market-oriented administrative model also in their own organisation. Thus, the results do not potentially reflect the opinions overall in the country.

The data were collected through group interviews that may influence the way the interviewees talk about contracting with the private sector. However, an effort was made to reduce the barriers to talk about contracting out by organising separate interviews with the civil servants and the politicians. In addition, we have focused only on primary care and elderly care services and thus questions related to secondary care and for instance to elective surgery have not been addressed here. These services are potentially very different from the services discussed here and thus deserve study in their own right. Finally, the cross-sectional study design results in fairly static analysis and results. However, we acknowledge that the frames used to argue different contracting strategies potentially vary over time and a contracting strategy can be argued through several frames even by one interviewee. The results of the study provide the reader with the variety of the argumentation frames which are potentially used to argue different contracting strategies over time.

Conclusions

This study suggests that the policy makers use a number of grounds to justify their decisions on contracting out. To some extent, the argumentation frames concerning contracting out were also consistent with the findings of earlier studies on contracting out and outsourcing decisions. Most of the arguments were related to the benefits of the municipality rather than on what is best for the local people. The interviewees saw contracting with the private sector as a means to improve the performance of public providers, to improve service quality and efficiency and to boost the local economy. While there were lots of references on the interviewees' willingness to make decisions that benefit citizens, it seemed that in practice there are other factors that become more important in the actual decision-making situation. This is potentially due to the complex decision-making environment involving several political and ideological viewpoints and different value bases. Indeed, the interviewees described several situations in which they were forced to make a decision they saw suboptimal or non-beneficial for citizens, as it appeared to be the only possible alternative in the contemporary environment.

It seems that the interviewees believe that citizens are willing to become active consumers who will shop around for services and also purchase them out of pocket. The increasing choice of a provider involves many promises but also a number of threats. As the choice increases there is also a danger that the status of citizens not able to make their choices properly deteriorates and their potential to receive services becomes less likely. Thus, if the choice is increased there should also be proper counseling services for citizens in order to ensure their access to services. Moreover, there were some references to the increasing willingness to transfer the costs of care to citizens. If contracting with the private sector also involves introducing novel financing mechanisms such as vouchers, there is a true danger that the co-payments of citizens will increase. This, in turn, could severely endanger the affordability of the services and lead to even more substantial undermining of the welfare state, which already now is coming apart at the seams.

Competing interests
The authors declare that they have no competing interests.

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Authors' contributions
LKT, JL and SM have contributed to the planning and date collection. LKT was responsible for drafting the data analysis that was developed in cooperation of JL and SM. LKT was also responsible for drafting the article and developing it after comments by the other authors. All authors read and approved the final manuscript.

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A study on purchaser-provider co-operation in the local welfare regimes in Finland

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Abstract

The paper presents a baseline picture of the co-operation between service purchasers and private elderly care and primary health care providers both at the national level and at the level of local welfare regimes in Finland. Data from two national surveys and from interviews conducted in six municipalities are analysed. The perceptions of the co-operation during the contractual period differed substantially between the private providers and the municipalities. The differences occurred especially between the for-profit providers and the municipalities. In general the private providers would be willing to work together with the municipalities, but to them it seems that the municipalities lack interest in this. The municipalities, in turn, considered that contracting is mostly a tool to reduce administrative responsibilities. However, in order to be able to gain benefits from contracting, to avoid excessive transaction costs and to co-ordinate the network of different service providers, the municipalities should invest in contract management and also be active during the contractual period.

Keywords: *public-private partnership, contracting out, contract management, public sector reform, mixed methods*

Introduction

The paper explores the co-operation between service purchasers (i.e. municipalities) and private for-profit and not-for-profit elderly care and primary health care providers in the context of the local welfare regimes in Finland. In recent years these local welfare regimes have experienced several structural changes as the municipalities have been reorganising their service structures. Thus the paper presents a general baseline picture of the co-operation in this changing environment.

We use the term co-operation to refer to a concept that might also be labelled public-private partnership. However, due to its ambiguous character (e.g. Weihe, 2008) we prefer the term co-operation. At the operational level we have divided co-operation into four dimensions: information sharing, trust, evaluation of the contract and its implementation and co-development of services. These particular aspects are among the most commonly discussed issues in the literature and can also be easily identified from our data.

The arguments for closer co-operation between a purchaser and a provider can be drawn from several branches of the literature. One approach is provided in the literature that defines the relationship between a purchaser and a provider as a principal-agent relationship and describes its potential problems such as information asymmetry and transaction costs (Rees, 1985). Drawning on this, Transaction Cost Economics proposes that a contractual relationship always involves a certain amount of uncertainty and costs, depending on the characteristics of the service in question (Williamson, 1975).

Uncertainty may relate to several aspects (Geyskens et al., 2006). *Volume uncertainty* relates to difficulty to accurately predict the volume requirements of the relationship. *Technological uncertainty* refers to inability to accurately forecast the technical requirements of the contractual relationship. *Behavioural uncertainty* relates to the degree of difficulty in verifying whether the other party to the contract complies with what has been agreed upon. Especially in health care and social services drafting a comprehensive or complete contract taking all the uncertainties in to account is often impossible (Petsoulas, 2011; Enthoven, 1993; Arrow, 1963).

Health care and social services have a number of features which often cause high transaction costs and incomplete contracts (Allen, 2002). In elderly care the outcomes are often intangible and complexity in the measurement of outcomes makes this field of services prone to transaction costs (Feiock & Jang, 2009). Thus there are potentially many informal arrangements that communicate the information missing in formal contracts between the individuals (Ouchi, 1979) and organizations. In the absence of full knowledge either of the future circumstances or of the actual performance of the contracting parties, trust and cooperation are crucial for effective contracting because they sustain the informal aspects related to contracting (Allen, 2002; Geyskens et al., 2006). One way of supporting the informal

aspects of contracting is integration through informal networks or partnerships (Allen, 2002). The idea is that contracts may remain incomplete as contingencies can be dealt with as they arise (Donato, 2010; 6, 2004).

The literature on Public-Private Partnerships (PPP) emphasises the idea that closer co-operation between a purchaser and a provider would help to tackle uncertainty and also complexities in the environment or the services provided. Klijn and Teisman (2000, 86) have suggested that PPP is a process in which the partners are "involved in joint decision making and production" rather than in a pure principal-agent relationship. Due to their flexible structures PPPs have been suggested to be beneficial forms of collaboration in complex and changing environmental settings such as health care and social service systems (Pierre & Painter, 2010). PPPs moreover include an idea that public and private sectors have different properties which, if put together, could result in synergy gains and benefit to both parties involved in a partnership (McQuaid, 2000).

The call for closer co-operation can also be argued for through growing and complex client needs which require services from more than one provider or professional (e.g. Mur-Veeman et al., 2003). This applies especially to the elderly, who often need both health care and social services. It is necessary that a multitude of professionals and provider units, public and private organisations, health care and social service sectors as well as service purchasers and providers work together in order to provide adequate services for clients with several needs. In this context the service purchaser should foster cooperation especially between the different providers. This in turn is possible only if the purchaser co-operates closely with the providers.

This study draws on data collected in Finland, a service system in which municipalities are responsible for funding, coordinating and commissioning the services for their residents. The municipalities also run most of the provider organisations. In recent years these local welfare regimes have experienced several structural changes as the municipalities have been reorganising their service structures (Vuorenkoski et al., 2008). One major development has been the marketization of health care and social service policies. This means the institutionalization of market-like mechanisms in the public sector in the forms of purchaser-provider models, vouchers and contracting out the services (Anttonen & Häikiö, 2011). Another change in the local service delivery structures has been the increase in the volume of services contracted out to the private sector (Ministry of Social Affairs and Health, 2012). The new capacity for reacting to the growing need for sheltered housing and home help for the elderly in particular are typical examples of services purchased from the private sector.

The local market structures have also changed. Traditionally a major part of the housing and home help services in Finland have been provided by not-for-profit providers. However, changes in the legislation (e.g. EU competition law) as well as the increased interest of the private providers in the growing market of elderly care services have changed the market structures. The entry of big, multinational, for-

profit companies in the health care and social services market in Finland has directed the development towards a more consolidated market as the large companies purchase and merge the operations of smaller providers. This has undermined the traditional much less competitive purchaser-provider relations between the municipalities and not-for-profit organisations.

Contracting between the municipalities and private providers may take various forms. The most common types of contracts are direct contracts paid by capitation or fee for service basis and framework contracts. In direct contracting a certain set of services is purchased from a private provider for a certain period of time. In elderly care the provider is usually paid on capitation bases. Certain procedures (e.g. physiotherapy, cataract surgery, eye examinations) and emergency services are paid for by fee for service basis. Framework contract is a type of contracting in which the characteristics and unit prices of the services are defined, but the volume of the service use and thus the income of the providers vary according to the number of clients actually referred to the provider during the contractual period.

The study is a part of larger research project exploring the separation of purchasing and provision functions in *primary health care and elderly care* services in Finland. In this study we use data collected in this project. The analysis is conducted in two parts. First we apply quantitative survey data to describe the general macro level situation in the cooperation and to compare the perceptions of the purchasers, for-profit and not-for-profit providers. The quantitative analysis is complemented by an analysis of qualitative interview data to explore how purchasers and private providers describe the collaboration during the contractual period at the micro level. The two analyses are summarized in the discussion section of the paper.

Aspects of co-operation and research questions

The literature provides a number of factors that contribute to the success of co-operation. One of the most commonly mentioned is *trust* between the parties entering into a contractual relationship (e.g. Donato, 2010; Klijn & Teisman, 2003 & 2000; Sullivan & Skelcher, 2002). Trust has been suggested to be an important factor in supporting the informal aspects of contracting (Geyskens et al., 2006). Moreover, trust helps the parties involved in a contractual relationship to create a more stable environment in uncertain conditions by creating opportunities to make predictions of the future (6, 2004) and in that way to manage complexity. Trust also has a potential to reduce transaction costs due to reduced need for monitoring (Gilson, 2003). Trust may relate to contract compliance (Geyskens et al., 2006), which means that the parties can trust that the other party will operate as agreed in the contract (e.g. Lewis et al., 2008; Klijn & Teisman, 2003 & 2000). However, trust can also relate to the trustworthiness of the information the other party provides when the contracts are negotiated and when the duration of the contractual period has begun.

Information sharing between the parties is an important aspect of co-operation, especially in the context of health care and social services, in which purchasing of the services involves substantial uncertainty due to the complex needs of the clients (Faulkner, 2004; Goodwin, 2004; Grimshaw et.al., 2002; Allen, 2002; Sullivan & Skelcher, 2002; Linder, 2000). The information shared between the parties may relate to patient records or other relevant information concerning the care of the customers. Information sharing may also refer to informing the other party about future plans and expectations or to a clear articulation of the expectations about the co-operation and its outcomes, especially as the contracts are negotiated. In the context of health care and social services flexible flow of information concerning the care of clients can support the continuity of the care processes.

Based on the literature on trust and information sharing we formulate the following research questions:

1. *Do purchasers/private providers trust that their partners will operate as agreed in the contract?*
2. *Do purchasers/private providers perceive that their partners provide them with adequate information they can trust regarding the service delivery?*

Close co-operation enables parties entering into a contractual relationship to gain an access to a pool of resources that include a greater variability than those resources contained in the domain of any single organisation (Donato, 2010; Vranbaek, 2008; Klijn & Teisman, 2003 & 2000; McQuaid, 2000). Collaboration during the contractual period has been suggested to serve as a mechanism for transmitting information, ideas and knowledge and for developing the skills and capabilities for experimenting with alternative approaches to service delivery (Donato, 2010). Development often refers to the development of the municipal service provision in a certain service field as a whole. In the public sector there is a willingness to benefit from private providers' competencies and technology, an urge to import additional resources into the public sector and a belief that private actors are able to operate more efficiently (Stolt & Winblad, 2009; Almqvist & Högberg, 2005; Coghill & Woodward, 2005; Entwistle, 2005). Thus co-development of the service would be assumed to be a special interest of the municipalities. In light of the literature we ask:

3. *Do purchasers/private providers find that the services are appropriately developed in co-operation with their partners?*

In the context of health care and social services to draft a comprehensive or complete contract taking account of all uncertainties is often impossible (e.g. Petsoulas 2011). This being so it might be beneficial to evaluate the contract itself and its implementation during the contractual period. This allows the parties to address potential problems arising during the contract implementation and act reactively if there are issues that have not been taken into account when the contracts were negotiated (Donato 2010; 6, 2004; Klijn & Teisman 2003 & 2000; Vaillancourt Rosenau 1999). Moreover, evaluation allows parties to discuss

potential changes in the client needs and changes in the volume of the services. Hence we ask:

4. *Do purchasers/private providers perceive that the contract and its implementation are evaluated with their partners and does this have relevance to the interpretation of the contract?*

Data and methods

Survey data and statistical analysis

Survey data was collected with two separate surveys: one to municipalities and another to private social service providers. The survey directed to municipalities was sent to those Finnish municipalities that organise services only for their own residents. That is, they do not belong to collaborative areas in which municipalities organise the services joitnly (see Vuorenkoski, 2008). The survey was sent to 124 municipal organisations of which 80 responded (65%). The median size of the municipalities was 8734 inhabitants (min=1936; max=588 549). The survey to private providers was sent to 443 private for-profit and not-for profit providers of which 94 for-profit and 78 not-for-profit providers responded resulting in a response rate of 39% for the whole sample. The providers were contacted through the Association of Social Services Employers and Businesses and the Private Health Care Association, which are member associations of the Confederation of Finnish Industries (EK). The median number of the organisations full-time employees was 10 (min=1; max=1863) in the for-profit organisations and 29 (min=1; max=500) in the not-for-profit organisations.

In both surveys there was the same set of questions concerning co-operation between service purchasers and providers (Table 1). The questions were formulated in the form of statements and they concerned the four aforementioned aspects of co-operation. Responses to the statements were rated on a Likert-scale ranging from 1 (“Always”) to 5 (“Never”). Due to small number of responses in the categories “Always” and “Never” the answers were re-categorised into three: 1 (“Always or Mostly”), 2 (“Sometimes”), 3 (“Rarely or Never”).

Table 1 Survey statements on the different aspects of the co-operation

Trust	-	I completely trust the information our partners provide us concerning service provision
	-	I can trust that our partners operate as agreed in the contract
Information sharing	-	As to success in service delivery our partners provide us with adequate information
Co-development	-	Services are developed in cooperation with our partners
Evaluation of the contract and its implementation	-	The contract and its implementation are evaluated with our partners during the contract period

The responses were compared across the municipalities, for-profit and not-for-profit providers, using cross-tabulation and Chi-square-test for statistical significance. Analyses using Kruskal-Wallis one-way analyses of variance by ranks support the findings of the cross-tabulations but are not reported due to the similarity of the results. The analysis was run using Statistical Package for the Social Sciences (SPSS) 19.0. The level of statistical significance was set at 0.05.

Interview data and content analysis

The interview data were collected in six municipalities. The selection criterion for the municipalities was their administrative structure: the municipalities were selected among those municipalities that have separated purchasing and provision functions in their health care and social service organisations. The six municipalities represent different geographical areas in Finland and have all adopted the purchaser-provider split in their administration fairly recently. All these municipalities have also contracted out their services to for-profit and not-for-profit organisations.

The public sector interviewees include c*ivil servants* responsible for purchasing health and social services. Private sector interviewees include the management level in for-profit and not-for-profit primary health care or elderly care provider organisations. The selection of the providers was conducted with the help of the study municipalities. Representatives of the municipalities were asked to name one primary care and one elderly care provider they would consider to be among their most important private service providers. With two exceptions the elderly care service providers were not-for-profit organisations. All the primary care providers were for-profit organisations. The data from civil servants was collected through six group interviews with 2-6 participants each. The data from private providers was collected through 11 interviews with 1-2 participants each.

All the interviews were conducted using a thematic interview format. The interviewees were asked directly about their perceptions of co-operation, but they also referred to this elsewhere in the interviews. The interviews were taped and transcribed by five research assistants who were asked to sign a written consent to maintain professional secrecy. All the researchers pledged their commitment to the guidelines of good research practice by The National Advisory Board on Research Ethics.

The main aim of the qualitative analysis was to gain a perspective and clarification for the macro level analysis with the survey data. The analysis did not aim to provide a comprehensive view of the perceptions of an individual interviewee. Rather it was assumed that the interviewees might articulate contradictory statements within the interviews. The interview data was analysed by theory driven content analysis. The focus was on the interviewees' descriptions of trust, information sharing, contract evaluation and co-development of the service. All statements concerning those aspects of collaboration were collected and grouped.

After that the descriptions of the purchasers, for-profit and not-for-profit providers were analysed separately. This was intended to achieve a more general perception of a particular stakeholder group. As the different aspects of co-operation were related to each other in the interviewees' speech, the results are also reported so as to reflect the way the interviewees discussed the issues in the data. The discussion with the results and the theory is presented in the discussion section.

Results

Survey

The perceptions of the different aspects of co-operation differed between the purchasers and for-profit and not-for-profit providers (Table 2). In all the aspects the differences were statistically significant. The differences occurred especially between the municipalities and the for-profit providers. Compared to the for-profit providers, the not-for-profit providers were more positive regarding the state of co-operation. There was also more variation in the responses of the not-for-profit providers than in those of municipalities and for-profit providers, which formed more likeminded stakeholder groups.

As to contract compliance, the municipalities expressed more trust in their partners than did the private providers. The municipalities were also more likely to respond that their partners provided them with adequate information. The majority of the municipalities reported that they were able to trust the information provided by their partners, whereas the for-profit providers especially reported that they could rarely or never trust the information provided by the municipalities. The municipalities and not-for-profit providers reported that they did develop the services in co-operation with their partners while the for-profit providers perceived pretty much the opposite. The vast majority of the municipalities reported that the contracts were appraised with their partners while especially the for-profit providers again reported the opposite.

Table 2 Cross-tabulation results (%) and test results chi-square test for significance

I COMPLETELY TRUST THE INFORMATION OUR PARTNERS PROVIDE US CONCERNING SERVICE PROVISION					
	For-profit	*Not-for-profit*	*Municipality*	*Pearson chi-square*	
Always or mostly	26.6	32.8	39.2	*Value*	*29.473*
Sometimes	22.8	29.5	50.0	*Df*	*4*
Rarely or never	50.6	37.7	10.8	*Asymp. sig (2-sided)*	*0.000****

I CAN TRUST THAT OUR PARTNERS OPERATE AS AGREED IN THE CONTRACT					
	For-profit	*Not-for-profit*	*Municipality*	*Pearson chi-square*	
Always or mostly	56.0	56.9	68.4	*Value*	*12.691*
Sometimes	20.0	24.1	27.6	*Df*	*4*
Rarely or never	24.0	19.0	3.9	*Asymp. sig (2-sided)*	*0.013**

AS TO SUCCESS IN SERVICE DELIVERY OUR PARTNERS PROVIDE US WITH ADEQUATE INFORMATION					
	For-profit	*Not-for-profit*	*Municipality*	*Pearson chi-square*	
Always or mostly	19.2	38.3	50.0	*Value*	*32.288*
Sometimes	34.6	36.7	42.1	*Df*	*4*
Rarely or never	46.2	25.0	7.9	*Asymp. sig (2-sided)*	*0.000****

SERVICES ARE DEVELOPED IN CO-OPERATION WITH OUR PARTNERS					
	For-profit	*Not-for-profit*	*Municipality*	*Pearson chi-square*	
Always or mostly	36.4	57.6	55.3	*Value*	*18.329*
Sometimes	32.5	25.4	38.2	*Df*	*4*
Rarely or never	31.2	16.9	6.6	*Asymp. sig (2-sided)*	*0.001***

THE CONTRACT AND ITS IMPLEMENTATION ARE EVALUATED WITH OUR PARTNERS DURING THE CONTRACT PERIOD					
	For-profit	*Not-for-profit*	*Municipality*	*Pearson chi-square*	
Always or mostly	31.6	42.6	71.1	*Value*	*38.049*
Sometimes	27.6	32.8	26.3	*Df*	*4*
Rarely or never	40.8	24.6	2.6	*Asymp. sig (2-sided)*	*0.000****

*** p<00.1, ** p<0.01, * p<0.05

Interview

The service purchasers seemed to be fairly content with the way the providers complied with the contracts and provided them with information. A couple of purchasers mentioned how they were very satisfied with the co-operation with private providers and how they were truly able to trust that the private providers would do as agreed. The co-operation with private providers was seen to be even easier than co-operation with the municipalities' own providers because in the latter relationship the contracts were not perceived to be binding or something that really should be complied with.

In turn, almost all of the providers perceived that municipalities did not inform them sufficiently about their needs and plans concerning service purchasing in the future. A lack of such information created uncertainty, especially with regard to the time after the present contractual period. A representative of a for-profit provider described the situation like this:

> *"One cannot see clearly what the municipalities' plans are in the long run. At first they say we don't need your services and the next day they call and ask if we can provide beds for two clients."* (For-profit provider)

In addition to the future plans, several private providers mentioned that the municipalities did not provide sufficient information about the clients they refer to private providers. A provider described their experiences as follows:

> *"Well it was possible that some granny just popped in and we had no information on her and her conditions. We barely knew her name."* (Not-for-profit provider)

While the inadequate information potentially affects the providers' ability to meet the needs of the patient, it also has a potential to influence the general perception of the municipalities' referral practices. Especially in the case of framework contracts the providers seemed to be fairly suspicious. The providers contemplated that the municipalities' case managers might not be very well disposed towards the private providers or that they might refer only very demanding clients to private providers.

Due to the perceived problems in the information flow, several providers called for meetings in which the municipalities could inform the providers about topical issues and also about their future plans. In some municipalities these were already organised. However, these discussion forums were often accessible only for the municipalities' own provider units, even though the issues discussed there were likely also to be important for the private providers.

Comments about the joint meetings and discussions were often related to the descriptions of trust which in turn were mostly related to contractual issues and especially to the municipalities' compliance with the present contract. Several providers reported that during the contractual period the municipalities might have imposed additional conditions on providers even though these were neither agreed

upon in the contract nor discussed with the providers beforehand. A common view that emerged in the data is aptly condensed in the following quote:

> *"Well it seems that in the municipality the emphasis is on developing the content of matters already agreed on. At least all sort of new instructions keep coming our way. Just think of the content of residential services and what the clients are entitled to. In a way it feels as if for the price already agreed bit by bit there comes all sorts of extra demands without our having any chance to exert influence on it. So that at the same price we do keep on doing a bit more and a bit more." (Not-for-profit provider)*

The discussion was similar when the interviewees talked about the information the purchasers provided to them during the bidding process. It was claimed that the contents of the services were not adequately defined. This, in turn, had often led to the aforementioned situations in which the providers felt that the purchasers had imposed on the providers additional conditions not agreed upon in the contract. Several providers found that situations like these might be prevented if the purchasers and providers discussed the contract and its contents during the bidding process. The providers called for more informal discussions before and during the bidding process. This suggestion, however, did not gain major support among the purchasers. Many of them considered that informal discussions during the bidding process might favour some providers at the expense of the others. Purchasers perceived that they needed to comply with the legislation to the letter, which made them very cautious in everything they did during the bidding process. The providers in turn perceived this as inflexibility on the part of the purchasers.

The not-for-profit providers especially were interested in developing the services in co-operation with the municipalities. However, the perceptions of their ability to do so were variable. Some of the providers claimed that the municipalities did not include them in their development projects. The purchasers admitted this. Some purchasers mentioned that one of the reasons for the lack of co-development and closer partnership was the lack of adequate resources. However, there were also several providers who mentioned doing development work together and that the municipalities were much better in this respect than their reputation suggested.

The interviewees mentioned that they had organised joint training opportunities, exchange of good practises and establishment of common guidelines and standards of services. The development work, however, was done mainly at the micro level in the organisations. In other words, the inclusion of goals for co-development was not yet actualised at the level of contracts.

The experiences of the contract evaluation were twofold. One half of the interviewees described how they had regular evaluation meetings at least bi-annually; another half perceived that the contract and its implementation were not regularly evaluated. Interestingly, it was the providers who mentioned the evaluation being fairly regular and frequent. In the municipalities several interviewees mentioned that once the contract had been signed the purchasers and

providers did not communicate unless a major problem occurred. A reason for this was the municipalities' lack of adequate resources to take care of contractual relations with the private providers. This applied especially to situations with multiple private contractors. A purchaser described the matter as follows:

> "*But on the other hand one can state with stark realism that we have few resources to really take care of the partnerships. So that if we think, for example, if there were like 60 providers, how many times a year can we meet them. That they are quite often official inspection visits or the equivalent." (Service purchaser)*

The analysis suggests that the perceptions of the purchasers and providers regarding trust and information sharing are rather opposite. The private providers' views of co-development of services and of contract evaluation were ambiguous, while the purchasers were more likely to point out that they did not have many joint activities with private providers during the contractual period. Interestingly, it was the providers who mentioned that the appraisal of the contracts with the purchasers was regular and frequent while the purchasers often reported that they did not have adequate resources to take care of the contracts after they had been signed.

Discussion

In this paper we focused on the co-operation between purchasers and private for-profit and not-for profit providers. The results provide a fairly ambiguous picture of the state of the collaboration. Consequently we did not obtain univocal answers to our research questions. The data provides us with a picture in which the perceptions of the co-operation differ substantially between the private providers and the municipalities. In the survey, the differences occurred notably between the for-profit providers and the municipalities, while the not-for-profit providers were more content with the co-operation. The interview data, for its part, paints a picture in which the private providers form a more unanimous stakeholder group.

The historical background provides a partial explanation for the differences in the perceptions between the for-profit and not-for-profit providers. Not-for-profit providers have a long tradition as elderly care providers in Finland and elsewhere in Europe. They have been instrumental in developing the services that form the basis of the contemporary western welfare states (e.g. Sullivan & Skelcher, 2002: 89). Not-for-profit providers have also been a source of innovations and development in the service provision patterns. However, it seems that the demarcation between the not-for-profit and for-profit provider sectors is becoming increasingly blurred because the not-for-profit providers have to compete with the for-profit providers under the same expectations of effectiveness and efficiency (Anttonen & Häikiö, 2011; Karsio, 2011).

A more general explanation for the differences can be drawn from the literature on the characteristics of different types of organisations, i.e. organisations with

different ownership status. The public agencies are mainly owned collectively by the members of a political community, whereas private for-profit firms are usually under the ownership of entrepreneurs or shareholders (Budhwar & Boyne, 2004). For-profit organisations are traditionally assumed to follow a profit-maximization objective in order to yield benefit for their owners by serving those who are willing and able pay for the services (Brooks, 2005). The public organisations have mainly been seen to be serving the general public (Perry & Rainey, 1988) and, in a service system based on the idea of universalism, all those in a need of the services. Not-for-profit organisations may be seen to complement the public sector by serving the public with particular illness, disability, occupation etc., as the not-for-profits are often guided by a certain ideology (Haley-Lock & Kruzich, 2008). They have been described as the actors that are able to meet the social needs that the state and the market are unable or unwilling to satisfy (Amendola et al., 2011) as well as correcting the market failures (Koning et al., 2007).

It can be assumed that the operating principles are different in different types of organisations (Nutt, 1999) and thus, interests to embark on contracting as well as the expectations towards the co-operative relationship may differ widely between municipalities, for-profit and not-for-profit providers. The municipalities embark on contracting because they want to ensure the services for their residents, while for the for-profit providers a contractual relationship means things such as profits, security or insecurity and eventually a basis for their existence. The interest of not-for-profit providers in turn draws partly on the willingness to serve the interest of the community and partly from the need to maintain their existence via municipal contracting. Thus the not-for-profit and for-profit providers have potentially only partly similar expectations and needs regarding the contractual relationship. This proposition is supported by the survey data applied in this study.

Contracting out services to the private sector often includes aims such as improved cost control and more flexible organization, improved resource allocation and better management, cost-efficiency and better service quality (e.g. Laamanen, 2008; Almqvist & Högberg, 2005; Entwistle, 2005; Sørensen & Bay, 2002). The public sector is also often willing to benefit from private providers' competencies and technology as well as to import additional resources in the public sector (Stolt & Winblad, 2009; Almqvist & Högberg, 2005; Coghill & Woodward, 2005; Entwistle, 2005). However, if the municipalities were to benefit from the private sector resources and know-how, the purchasers and providers would also have to co-operate during the contractual period.

The results suggest that the private providers would be willing to work together with the municipalities for better services, but it seems that it is the municipalities that lack an interest in such co-operation. This is fairly surprising, because the co-development activities would presumably specifically benefit the municipalities. Moreover, the private providers perceived that the municipalities did not provide them with sufficient information either on their future plans or during the bidding process. Several providers reported that the municipalities had imposed additional

conditions on providers even though these were neither agreed upon in the contract nor discussed with the providers beforehand.

The perception that the municipalities are not interested in co-operating with the private providers may be a consequence of the municipalities' and private providers' different attitudes towards contracting. The municipalities may view contracting not as a function that should be managed after the bidding process but more as a means to reduce their overall management responsibilities (Brown & Potovski, 2003). However, in order to be able to derive benefits from contracting, to avoid excessive transaction costs and co-ordinate the network of different service providers, the municipalities should manage the contracts and also be active during the contractual period. Thus contracting out cannot be applied as a means to reduce the municipalities' administrative responsibilities.

This is likely an issue that is not acknowledged in the municipalities as they contract the services out to the private sector. Our analysis suggests that the municipalities have not fully acknowledged the needs and wishes of the private providers. While some of the needs relate to the providers' interest to secure their profits and operations (e.g. information sharing on municipalities' future plans) there are also certain issues the municipalities should take into account and invest in. In light of our qualitative analysis these would include joint meetings with the municipality and other service providers in order to share information on practical matters, regular contract appraisal and negotiations on potential needs to revisit the contracts as well as the establishment of platforms for co-development of the services. This would benefit the contracting parties, but especially the clients through potentially improved chains of care (e.g. Mur-Veeman et al., 2003).

The municipalities included in this study represent large or medium-sized cities which have adopted a market-oriented administrative model in their administrations. Due to their size and administrative structures, the municipalities in this study differ to some extent from the majority of the small municipalities in Finland. In absolute numbers, the study municipalities have more private contractors, which potentially makes close co-operation with private providers more difficult compared to a situation with only a few private partners. The issue was also raised in the interviews. In addition, the market in small municipalities consists of only a few providers. Thus it may be that in the larger cities with more providers operating in the market competition becomes emphasised at the expense of co-operation. The perceptions of co-operation would be rather different if we had studied the perceptions of the purchasers and the providers in the context of small municipalities.

This cross-sectional study provides a baseline picture of the co-operation between the service purchasers and private providers in Finland. However, we believe that the nature of the co-operation between the purchasers and providers is fairly dynamic and dependent on several factors that we were not able to control in this study. Our analysis suggests that e.g. the duration and other characteristics of the

contract, the characteristics of the services purchased and whether the municipality has a long history of contracting out to the private sector might influence the collaborative practices during the contractual period. In order to be able to capture the dynamic nature of the phenomenon and to see in which direction the co-operation is developing at the macro level, we would need follow-up data. Moreover, it would be beneficial to examine more closely the micro level factors that enable or impede closer co-operation during the contractual period.

Conclusions

The analysis suggests that the providers and the municipalities have different expectations of cooperation. The private providers would be willing to work together with the municipalities for better services, but for them it seems that the municipalities lack interest in this. The municipalities, in turn, consider that contracting is a means to reduce administrative responsibilities. There are certain issues it might benefit the municipalities to take into account and invest in. In light of our analysis these may include e.g. joint meetings with the municipality and other service providers in order to share information on practical matters that potentially affect the operations of the providers, regular contract appraisal and negotiations on potential needs to revisit the contract with the providers as well as the establishment of platforms for the co-development of the services. It would be important for the municipalities to understand that moving towards closer co-operation requires a willingness to invest in contract management.

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Health Research Policy and Systems

Research

An analysis of ophthalmology services in Finland - has the time come for a Public-Private Partnership?

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Abstract

Background: We studied the prerequisites for Public-Private Partnership (PPP) in the context of the Finnish health care system and more specifically in the field of ophthalmology. PPP can be defined as a more or less permanent cooperation between public and private actors, through which the joint products or services are developed and in which the risks, costs and profits are shared.

The Finnish eye care services system is heterogeneous with several different providers and can be regarded as sub-optimal in terms of overall resource use. What is more, the public sector is suffering from a shortage of ophthalmologists, which further decreases its possibilities to meet the present needs. As ophthalmology has traditionally been a medical specialty with a substantial private sector involvement in service provision, PPP could be a feasible policy to be used in the field. We thus ask the following research question: Is there, and to what extent, an open window of opportunity for PPP?

Methods: In addition to the previously published literature, the research data consisted of 17 thematic interviews with public and private experts in the field of ophthalmology. The analysis was conducted in two stages. First, a literature-based content analysis was used to explore the prerequisites for PPP. Second, Kingdon's (1995) multiple streams theory was used to study the opening of the window of opportunity for PPP.

Results: Public and private parties reported similar problems in the current situation but defined them differently. Also, there is no consensus on policy alternatives. Public opinion seems to be somewhat uncertain as to the attitudes towards private service providers. The analysis thus showed that although there are prerequisites for PPP, the time has not yet come for a Public-Private Partnership.

Conclusion: Should the window open fully, the emergence of policy entrepreneurs and an opportunity for a win-win situation between public and private organizations are required.

Background

Since the emergence of the New Public Management (NPM) in the 1970s [1], redefining the boundaries between public and private sectors has drawn increasing interest. Along with the NPM, the public sector began to adopt a more market-oriented approach to arranging welfare services, and the view on the public sector as an irreplaceable actor in correcting the welfare differences and

inequalities in society, was questioned. Among the policies that emerged as a consequence of the NPM was also the concept of Public-Private Partnership (PPP) [2]. The concept of PPP first appeared in the health care literature in the 1990s, and the term has gained popularity over the past decade [3]. In this article we define PPP as a more or less permanent cooperation between public and private actors, through which the joint products or services are developed and in which the risks, costs and profits are shared [2].

This study is situated in the context of the Finnish health care system and more specifically in that of ophthalmology, which is a part of specialized medical care in Finland. The Finnish health care system comprises three different levels, i.e. municipal health care, occupational health care and private health care, all of which receive public funding to some degree. Municipal health care is mainly funded through taxation, whereas private health care and occupational health care are funded by compulsory National Health Insurance (NHI) and by out-of-pocket payments. The municipalities (i.e. local authorities) are obliged by law to arrange primary and secondary care services for their citizens. Each municipality must belong to a hospital district, altogether 20 in Finland, that provides specialized health care for the population of their member municipalities[4] Furthermore, each hospital district belongs to one of the five university hospital responsibility areas that are accountable for providing the most specialized medical care, specialist training and research. In order to access public specialist medical care, i.e. public specialists and public hospitals, a referral from a licensed physician, either public or private, is needed [4]. No referral is needed to visit a private specialist.

As for the relationship between public and private sectors in Finnish health care, it can be said that the present situation is perhaps best characterized by the co-existence of the two sectors. While the private and public actors are operating in parallel, the sectors are not related as systems. Lately, some marginal cooperation between the two sectors has developed as the public sector has for instance purchased some surgical services from private enterprises. All in all there has not been, however, much room for partnership arrangements in the Finnish health care system. Hence, in most cases the public sector has been the dominant actor in terms of organizing, providing and funding health care services. However, there are a few fields where the private sector has traditionally played a major role, one of them being ophthalmology.

In Finland, ophthalmology has traditionally been a specialty in which the use and provision of private services have been more common than in health care on average. Other specialties with a relatively large share in private service provision in Finland are dental care [5] and gynecology [6]. Together with gynecology, ophthalmology accounted for over one-third of all private specialists visits in 2006 [4]. Moreover, as many as two out of three ophthalmology patients are currently managed by the private sector [7]. Eye care services are provided mainly by public and private specialists in outpatient clinics or hospitals and by optometrists in optical stores but also by general practitioners (GP) in occupational health care (OCH) and health centers, albeit it is rare for health centers to have ophthalmologists of their own. As a whole, the actors operating in the ophthalmology service system are multiple, and there are many different ways to access care (Figure 1).

The majority of Finnish ophthalmologists operate part-time within both the public and private sectors, which has contributed to the shortage of ophthalmologists in the public sector [8]. As the specialists' work is divided into two sectors, this kind of dual practice may lead to a wasteful use of health care resources. What is more, as far as service provision is concerned as a whole, the heterogeneous service system may take the aggregate resource allocation even more under the ideal level. Finally, the ageing of the population, new technologies and new forms of care further increase the challenges facing ophthalmology.

In this study we examine the prerequisites for Public-Private Partnership (PPP) in the context of Finnish ophthalmology services. As the private sector's share in the ophthalmology services is relatively considerable, we believe that PPP could be an adequate policy for solving the current problems discussed above. We adopted an organizational viewpoint, as is common within PPP theories. Ophthalmologists have traditionally been sole practitioners in Finland, usually having a contractual relationship with the optical stores. Recently, however, large chains of health care companies have gained ground in ophthalmology and a multitude of ophthalmologists is employed by them. Consequently, the decisions are no longer made at the level of single practitioners but higher up in the organizations. Hence, an organizational approach can be deemed reasonable.

Methods

Theory

In order to study the prerequisites for PPP, we formulated an analysis framework based on the theoretical and empirical literature on PPP. It is not clear what different authors eventually mean by PPP [9]. Consequently, the concept of PPP is not a fixed policy concept but an umbrella term covering a variety concepts [10,11]. It was possible, however, to identify certain factors common to different PPP arrangements. As we were interested in the preconditions of PPP, we identified the factors found to

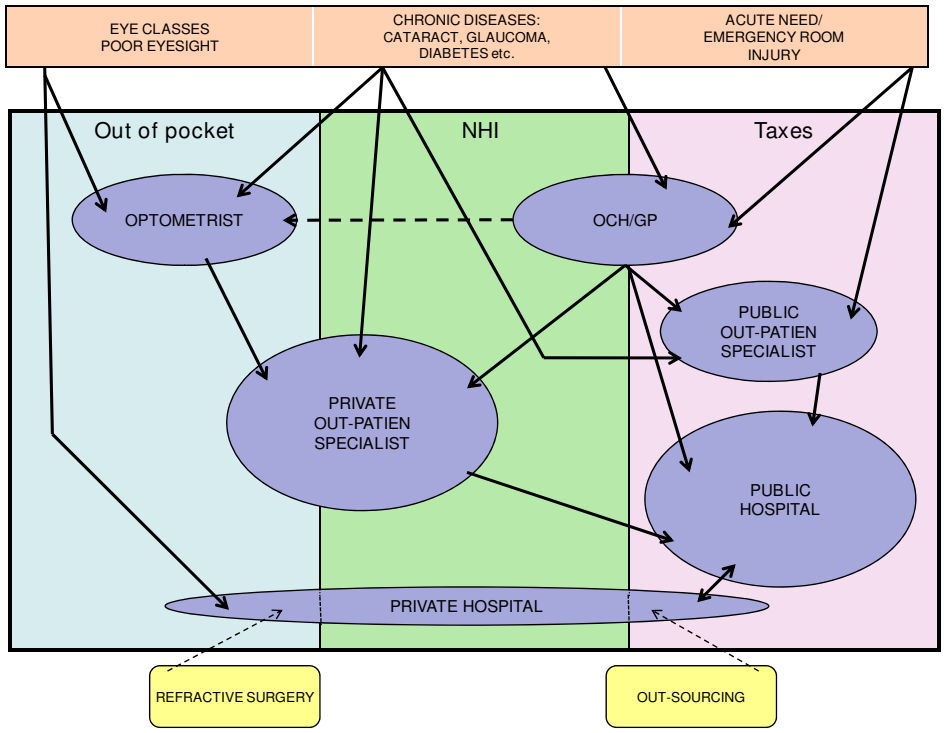

Figure 1
Finnish eye care services system by funding channels and service providers.

affect the formulation of PPP from the literature. The findings were classified into three categories labeled as "mutual disadvantage and mutual benefit", "mutual values and mutual relationship" and "the wider societal context". We define PPP as a policy concept that is related to a shared goal or a shared problem, which the actors cannot meet or solve alone (e.g. actors have complementary resources). On the other hand, the prerequisites are related to the compatibility of the actors' organizational values and cultures, and to the context in which the partnership is planned.

In addition, PPP can be seen as an example of a policy change. As the changes in public policies take place through multiple processes affected by multiple actors and a wider societal context, we complemented the analysis with Kingdon's (1995) theoretical framework drawn from the social and political sciences [12]. The theory has been used also in previous studies on health care [13,14]. Kingdon (1995) argues that the current policies may change through three independent streams called the problem stream, the policy stream and the political stream. First, the change requires that the actors are able to find a common problem and are willing to solve it (an open window of opportunity in the problem stream). Second, to solve the problem, a feasible solution, of which sufficient mutual understanding prevails, must be found (an open window of opportunity in the policy stream). Finally, attention must be paid to the political atmosphere which dominates in society and to the environment in which the actors operate (an open window of opportunity in the political stream). According to the theory, a simultaneous opening of the window of opportunity in all the streams will make agenda change possible. In other words, the streams come together at critical times and when coupled together, a window of opportunity for agenda change will open [12].

We addressed the following research question: Is there, and to what extent, an open window of opportunity for PPP in ophthalmologic services in Finland?

Data

The present study is part of a research project designed to explore new innovative ways to arrange ophthalmology services. At the beginning of the project in Summer 2007, a literature reviewed was conducted and altogether 17 experts were interviewed. Our informants represented the main public and private actors in ophthalmology in the responsibility area of Tampere University Hospital (TAUH). The group of private actors (n = 5) consisted of the representatives of three national chains of private

health care, each of which has a substantial market share in ophthalmology services. The group of public sector actors consisted of the representatives of the responsibility area of TAUH. They came from public secondary health care, i.e. specialized medical care (n = 10), and from a large primary health centre (n = 1). The interview group consisted mainly of the management personnel of these organizations, but also included ophthalmologists (n = 4) and nursing staff (n = 1). The selection of the interviewees was based on identifying different viewpoints and ensuring saturation of the data.

Thematic interviews were conducted between Autumn 2007 and Spring 2008, and they were based on the interview frame developed by the researchers of the project. The purpose of the interviews was to explore the prerequisites of systemic health care innovations in health care, one of the aspects being the relationship between public and private sectors. Several themes were discussed in the interviews, e.g. the present problems of the ophthalmology service system, the current relationship between the public and private sectors and the actors' views on the possible new operational policies. The data used can be considered sufficient as it is compatible with the view of ophthalmology given by official documents and research literature.

In order to describe current public opinion concerning private service providers, we employed a study published by The Foundation for Municipal Development (FMD) in 2006. The study used a postal survey to explore the attitudes of citizens (n = 1 039) and municipal managers (n = 190) towards local government [15]. The study addressed two questions about the attitudes towards the involvement of the private sector in service provision. We used these questions to analyze current public opinion concerning the private sector.

Analysis

The analysis was conducted in two stages using theory-based content analysis. We first analyzed whether the prerequisites for PPP were dealt with in the interviews. This was done by using the literature-based theoretical approach discussed above. The informants' factual statements were used as the unit of analysis. We did not aim at providing a comprehensive view of a single informant's way of thinking. Rather, we assumed and accepted that an interviewee may express even contradictory statements within a single interview. All the statements that discussed the relationship between public and private sectors, the problems in the current situation or possible policy proposals were understood as relevant for our analytical purpose. The statements were interpreted as views expressed by the actors in the policy arenas in question.

To conduct the second stage of the analysis we employed Kingdon's (1995) multiple streams theory of policy change. We aggregated the results from the first stage of the analysis following Kingdon's framework and drew on the study by FMD to examine whether there is an open window of opportunity for PPP in the field of ophthalmology.

Results

Analysis of the prerequisites for PPP

Mutual disadvantage and mutual benefit

Before starting the analysis we assumed that the current state of affairs appears disadvantageous for both the public and private service providers mainly due to the facts mentioned above. Furthermore, we assumed that both sectors could benefit from improvements in the present situation. Hence, we begin the analysis by examining whether the contemporary situation in the field of ophthalmology appears disadvantageous for the actors and whether future benefit could be gained with the help of PPP.

Awareness of the fact that the objectives set for an organization cannot be met alone may impede the initiation of PPP [9,16-18]. References to this were found in the data when the demand conditions were discussed. The actors of the public sector perceived the public sector's own resources to be inadequate with respect to demand, making it impossible to provide care to all patients in the current situation.

"The biggest problem at the moment is that the patient load has increased enormously and there is no chance that we could take care of them all" (Head Nurse, Pub)

The private actors, in turn, referred to problems that were mainly related to the perceived instability of demand. They felt that there was a lack of infrastructure and know-how needed to treat all the patients. The instable demand conditions, however, make it risky to acquire the devices and equipment necessary for the treatment of patients.

"Purchasing devices requires substantial monetary investments, but will the number of incoming patients cover the expenses?" (Ophthalmologist1, Priv)

Moreover, the private actors seemed to be afraid of the possible strengthening of the public sector, as the improvements in the public sector's scope of action would probably change the market position and the number of public sector service contracts. This, in turn, could make the competitive stance of private producers even more uncertain.

"The biggest specter here, in the private sector, is that the public sector is able to do all the things we do in the private side at the moment" (Manager1, Priv)

Recognition of the interdependency between public and private organizations was found to be another factor that may affect the initiation of PPP [9,16-18]. The issue emerged when discussing the division of labor.

"My conclusion was that we have a structure that perpetuates the shortage of ophthalmologists and the waiting lines. When the majority of ophthalmologists are working in both the public and private sectors, the system is a two-way street, which then creates the current structure." (Chief ophthalmologist1, Pub)

Thus the ophthalmologists' dual practice seems to cause a disadvantageous situation in terms of aggregate resource allocation. The current structure also seemed to blur the market conditions and cause conflicts of interest for individual practitioners. Finally, in addition to the dual practice, the specialists' monopoly on the supply of labor was said to increase health care costs, partly because specialists are in high demand.

"The cost of ophthalmology care has already risen in both sectors because the experts' charges are going through the roof" (Manager1, Priv)

The current situation appears to be disadvantageous especially from the point of view of the employers. The employees, i.e. ophthalmologists, for their part, are likely to regard the current situation as beneficial, as they possess strong negotiation power on the conditions of their work. Should the initiation of PPP succeed, it is crucial that the professionals working for the organizations are motivated to change the current situation [19]. Without internal legitimacy given to the formulation of PPP, there are no prerequisites for PPP [20]. According to our analysis, the possible change was considered both positive and negative by the ophthalmologists. However, resistance by the profession was mentioned frequently when a particular interest group possibly opposing PPP was named.

"The ophthalmologists are most probably the biggest single group of opponents"

(Manager1, Pub)

When multiple actors operate in the same field without a mutual agreement on the terms of cooperation, the division of labor and the responsibilities between the parties may appear unclear [19]. This may result in wasteful resource use and overlap in service supply. In the data, the vague roles in service provision were indeed seen suboptimal in aggregate.

"I'm totally convinced that more health could be produced if the use of the resources, currently allocated in ophthalmology, was better planned. Now the system is fragmented, divided into public and private and it isn't necessarily known what the private sector is doing. Our effectiveness falls short of optimal levels."

(Chief ophthalmologist1, Pub)

However, the PPP could increase the possibility for better resource allocation [17] and it could also be seen as a tool to understand a complex service system [21].

More effective resource allocation and service supply requires, however, that the actors are able to find clear roles in service provision [22]. It is also required that supplementary resources exist between the public and private sectors [16,23,24]. The distribution of labor was mentioned in the context of sight examinations and optical prescriptions, which were almost unanimously seen as tasks belonging to the private sector. Instead, more contradictory views between the sectors were connected to the management of cataract surgery:

"The university hospitals and the central hospitals should particularly invest in operations that cannot be carried out in the private sector."

(Ophthalmologist1, Priv)

A common private sector view was that the public sector should concentrate on the most difficult operations, specialist training and research, while routine operations, such as cataract surgery, could be undertaken by the private sector. The public sector actors did not share this view, as they wanted to retain the routine operations in the public sector. Both sides were unanimous in asserting that the most demanding tasks must be undertaken in the public sector, mainly because the private sector is lacking adequate equipment. At the same time, however, the refractive surgery procedures depend almost entirely on private supply, as they are not performed in public hospitals.

In the end, the formulation of PPP provides experience of its necessity and sensibility [23]. PPP could be a beneficial solution for the private sector because "*it would improve the profile value of the private sector in a totally different way*" as one of the interviewees described the matter. Demand in the public sector is fairly constant [25], partly due to the obligations arising from law, and the private sector might want to confirm its market position under uncertain demand conditions. In the public sector, in turn, the benefits were seen in the form of the technologies, and new

types of services and practices that would diffuse from private to public sector if the PPP was formed.

"The line between the public and private sectors can possibly be crossed so that treating private patients in the public sector becomes possible. I would find it necessary. Effective practices from the private sector would be better integrated into public health care as they are in the same building anyway."

(Chief ophthalmologist2, Pub)

In addition, the public sector could acquire additional resources through the partnership and thus improve its capacity to provide services. However, we also identified negative attitudes, and it seemed that especially the public actors had a strong desire to operate independently without any external help.

All in all the attitudes towards the possible cooperation arrangements seemed to be contradictory. It may be that the need for PPP is realized but the ethos of the public sector talks against it. In the private sector the negative attitudes were mainly connected with the fact that the PPP was not considered a policy proposal capable of bringing any surplus value to the private organization. The discussion finally boils down to the values of the actors, which are discussed in the next section.

Mutual values and mutual relationship

The initiation of PPP may fail if the values and objectives of the parties differ considerably [18]. We found that the operating principles in the public and the private sectors were differently perceived.

"If we consider this clearly as a systemic matter, the private sector should be involved. However, the profit seeking interests of the private sector create a problem." (Manager2, Pub)

The quotation reflects a situation in which the profit seeking interests of the private sector seem to be clashing with the values of the public sector. In turn, private actors may be afraid that a PPP agreement between former competitors could endanger market competition [26]. This was brought up also by some of our informants. In addition, the political nature of public sector decision-making was found problematic by the private actors and this kind of obstacle to PPP has also been identified in the literature [27].

The values held by the specialist also direct the operations that are carried out within the sectors. The public and private sectors seem to offer different kinds of incentives for specialists. As one of the informants put it:

"Those who work for the private sector do it for money. In the public sector one can, in turn, best maintain ones professional skills." (Administrative nurse, Pub)

It seems that more demanding tasks make ophthalmologists willing to work for the public sector. One interviewee even reported that the possibility to operate was "*the spice of work*". In addition, also the possibility to receive training must be included as an incentive to work for the public sector. By contrast, the private sector was considered a more pleasant working environment with its "*convenient working hours and comfortable posts*" as one of the interviewees reported.

The above-mentioned differences between the sectors also reverberate to differences between the patients treated and to the know-how needed in the public and private sectors [28].

"We have specific criteria for surgery and patients not meeting them are not operated on -- more ripe cataracts are sent here from the public sector but we have agreements to determine what is done here." (Manager2, Priv)

As this quotation shows, the present situation seems to make "cream skimming" possible for private actors. However, the public sector seems to practice similar kind of sub-optimizing, as it regards contracts with the private sector only as a last resort. This kind of "public sector cream skimming" as an obstacle to the PPP has been reported by other studies as well [10].

"Out of necessity, we have lately purchased a substantial amount of services from the private sector, but if we had an adequate capacity to render treatment, I don't see any reason to cooperate." (Manager2, Pub)

It was also evident that the private actors were mistrustful of the public sector as a service contractor. As one interviewee commented:

"In extreme cases of distress the cavalry is called in, but otherwise people are left to fend for themselves. The university hospital will not sign a contract until it is forced to render treatment" (Manager3, Priv)

Thus it is possible to conclude that while both sectors are willing to undertake only the operations optimal for them their activities are also underpinned by different values.

These differences comprise neither a constraint on nor an impetus for PPP per se. Rather, the way the differences are identified and taken into consideration is important [18]. This finally boils down to the good mutual relationship and confidence between the parties, which, when lacking,

may impose potential constraints on any kind of relationship [20]. The analysis suggests that the relationship between the public and private sectors cannot be described as good. In the public sector the comments were associated with more general ideas about the private sector, whereas the private sector informants reported their own experiences from the field in more detail.

"If I have to send a patient with a complication to TAUH, I find it embarrassing. When that patient goes there they will ask if that private sector sad sack with huge earnings has again taken care of the business." (Ophthalmologist1, Priv)

In addition, the lack of mutual appreciation also emerged from the interviews. This is evidenced by the previous quotation, as well as by the fact that in the private sector it was felt that the communication between the sectors was not working. This has been identified as an obstacle to PPP in the literature as well [28]. While it seems that there are communication problems between the organizations, many of our informants stressed that the ophthalmologists in both sectors are part of a rather cohesive professional community with much lower barriers to communication.

Finally, certain public sector tasks and responsibilities, imposed by law, possibly impede the formulation of PPP [29]. The public sector actors may be afraid that, because of PPP, it may not be possible to fulfill all the public duties, e.g. training and research [18,30]. Also the questions of equal and sufficient supply of services, the efficient use of resources, the social responsibility and the safety of services may come up when the PPP is considered [9,16]. Some public sector informants also referred to social responsibility. In addition, the fear of endangering the specialist training and research, which mainly belong to the public sector, emerged in the interviews.

"How the research and training could be included bothers me" (Ophthalmologist1, Pub)

Finally, the political nature of the public sector's decision-making may be problematic from the private sector's point of view [27]; this was also what our analysis showed.

Wider societal context

The discussion about the possibilities of PPP must be considered inherently political, as the PPP is, in the end, a matter of allocation and redistribution of the scarce societal resources [31]. The public sector policy makers are dependent, at least in theory, on public opinion, and in order to consider the prerequisites for PPP, it is important to analyze whether public opinion supports private sector involvement in service provision [19]. To estimate public opinion on enhancing the role of the private service producers, we drew on the study conducted by The Foundation for Municipal Development (FMD 2006) (Table 1).

Citizens' attitudes towards private service providers were fairly negative. An examination of the trend from the year 1990 to 2006 showed that the attitudes have grown increasingly negative over the past one and a half decades [15]. The municipal managers' opinions were less skeptical, but the increasing involvement of the private sector did not gain full support from them either. In both groups, most respondents reported that they "somewhat agreed/disagreed" with the statements of the study. Thus it seems that, in the end, public opinion on the matter remains uncertain.

The health care system must be regarded as part of a wider system, which determines the practices that are allowed in the health sector [32]. The acts and statutes resulting from the political process must be taken into account when PPP is planned, as legislation may forbid the formation of a partnership. The legislative constraint may emerge especially if changes to current legislation must be made. [9,22] References to the legislative constraints on the PPP also emerged from the data.

"What about legislation and health insurance fees? And whose premises will be used? And what about the charges; when will the hospital charges be used and when those of the private practices?" (Administrative nurse, Pub)

Under current Finnish legislation, it is not possible to execute all the forms of PPP, as the health insurance act rules out the reimbursement of private services in public premises [33]. There are, however, examples of arrangements that make it possible to bypass the legislation [4].

Interpretation: how open is the window?

Problem stream

We define "a problem" as a state of affairs which is in conflict with the actors' appreciations and attitudes and to which a change is hoped for [12]. Thus the problem is not objectively determined but a question of the actors' subjective interpretations of the situation. In the analysis above we identified several problems that were shared by both sectors. However, even if the problems were common in the end, they were defined and described differently by public and private actors (Table 2).

The first two problems seem to concern more clearly the public sector alone. The majority of public sector informants saw that the growth in demand had surpassed the existing resources that were considered inadequate. The matter was discussed both generally and in the context of TAUH. However, the situation was problematic also from

Table 1: Attitudes of citizens and local authority executive directors towards private service providers

	Outsourcing of municipal services would increase inequality and insecurity among citizens (%)				
	Agree	**Somewhat agree**	**Cannot say**	**Somewhat disagree**	**Disagree**
Citizens	23	43	4	26	3
Manager	2	32	4	44	17
	Outsourcing of municipal services would result in better services and cost-savings (%)				
	Agree	**Somewhat agree**	**Cannot say**	**Somewhat disagree**	**Disagree**
Citizens	7	41	5	33	14
Manager	12	46	5	32	4

Source: FMD 2006: 16-23, 62-64, 66-67, 69

the private sector's point of view. Some private sector informants referred to problems related to the perceived uncertainty of demand for private ophthalmology services. Some others described their concerns about the possible strengthening of the public sector, which could change the market positions, i.e. possibly create a public monopoly in service supply.

The latter two problems, instead, seemed to concern both sectors similarly. When the division of labor was discussed, the actors of the public sector expressed it in the form of vague roles in service provision. The private actors, by contrast, felt that the public sector's willingness to hold on to the less demanding operations was the main problem. Finally, the fourth problem was defined similarly by both sectors. The ophthalmologists' dual practice was seen as a structure resulting in sub-optimal resource use. In the public sector this was embodied especially in structures which led to a shortage of ophthalmologists. In the private sector the problem was more about the ophthalmologists' high charges that increase the cost of service supply. In both sectors the resource use was problematic especially from the point of view of the employers.

In the end the problem seems to be, however, as follows:

"It is one of those 'every man wants to have his own thresher' things. Everybody wants to hold on to everything and manage by themselves." (Manager2, Priv)

In conclusion, the problems identified are mostly common, but as the interests to solve the problems differ, the window of opportunity in the problem stream opens only partially.

Policy stream

When the informants were asked about the possible future changes in the ophthalmology field, not many concrete policy proposals were brought up. The two policy concepts mentioned were the out-sourcing of the services and a model of a public company used in TAUH for hip replacement surgery. However, the first is not a permanent policy alternative as the public sector employs private service providers only in situations of excessive demand. The latter is more a PPP model applied within the public sector and does not represent the concept of PPP as we understand it in this study.

Table 2: Perceived problems in the public and private sectors

PROBLEM	PUBLIC	PRIVATE
Demand	Excessive growth in demand	Perceived uncertainty of demand
Public sector position	Inadequate resources	Possible strengthening of the public sector
Division of labor	Vague roles	Public sector wants to retain the low-risk surgeries as well
Ophthalmologists' dual practice	Sub-optimal resource use	Sub-optimal resource use

Albeit the PPP did not emerge strongly as a policy proposal, several informants spoke for the cooperation between the public and private sectors, and a clearly negative attitude towards more intense cooperation was expressed only by one of the private sector representatives. Taking this and the literature-based analysis into account it can be said that there are, however, prerequisites for PPP. Through PPP it could be possible to meet the needs of the present in several respects, e.g. the need to solve the disadvantageous situation concerning the suboptimal resource use. Also the structure of dual practice could be challenged as the employers' negotiation power might increase and the dissolution of the specialists' monopoly could become possible.

It must be noticed, however, that the resistance from the employee side may comprise a constraint on PPP. It also seems that the values between the sectors are not shared. Within the public sector a shared ideal of how the services should be produced, i.e. through public provision, prevails, and the actors in this sector are reluctant to turn to the private service providers. At the same time, the big private chain organizations strive for profit and do not regard any change in service production as a fundamental question, unless it has an effect on their market positions.

In conclusion, while there is a lack of proposals for PPP, several prerequisites for it can be found. However, as long as a concrete policy alternative is absent, the window of opportunity cannot be opened fully and probably not even partially. Should the window open fully for PPP, there is a need for a policy entrepreneur to introduce PPP as a solution to the problems. It seems that such an actor is absent at the moment. Hence presently the opportunity window in the policy stream is at least half shut.

Political stream

Public opinion is neither strictly for nor against the increasing involvement of private providers in public service provision. Consequently, public opinion and its impact on the possibilities of PPP remain uncertain. Furthermore, the legislation and the public sector's responsibilities also comprise apparent constraints on PPP. However, these constraints do not appear impenetrable, as some solutions to bypass them already exist [4]. In conclusion, the window of opportunity in the political stream opens partially for PPP.

Discussion

The data set used in this study was relatively small. In a country such as Finland the number of actors relevant to a change as the one discussed in this study is, however, limited. Furthermore, ophthalmology must be regarded as a rather small field of medical expertise. Taking these points into account the data used here represent quite well the relevant scope of actors in the TAUH responsibility area and with some reservations also in the whole of Finland as far as ophthalmology is concerned. In addition to the small data set, it is also crucial to note that the data were primarily collected for use in an innovation management research project mentioned above and hence, PPP was not the original focus of the interviews. It is also possible to identify exogenous factors, such as the current global financial crisis, that may bring some changes to the context of the opportunity window.

As for the study of The Foundation for Municipal Development (2006), we find that it reflects public opinion fairly well also in 2009, three years after the completion of the study, as the changes in the political mood tend to happen slowly. It must be noted, however, that the private sector has traditionally had a relatively large market share in the eye care services compared to the health care services as a whole. Thus, if the views specifically towards private eye care services were asked, public opinion might appear slightly different, i.e. more positive towards the private sector.

The literature-based analysis made it possible to provide a view of the different parties' viewpoints and thus, as an analytical tool, the international literature worked well. Even though the literature concerned different kinds of PPP arrangements in different kinds of contexts, it seems that there might also be some universal factors that affect the initiation of PPP. However, as the analysis was based on the literature, we may have failed to perceive some factors that have an effect on the initiation of PPP in the context of our study.

In the context of PPP it seems that Kingdon's (1995) theory works well when analyzing the stream of problems. The common problems seem to be the most crucial factors when initiating PPP, as without them it is likely that PPP does not appear as a sensible policy solution. Kingdon's (1995) theory was, however, a useful tool when interpreting the results and in the end its role in the study was critical as it made it possible to answer our research question. Even though the theory was originally developed in the context of the US political system, its level of abstraction may be considered universal enough for Western Europe as well. Kingdon's (1995) theory, as well as other theories based on institutionalism, has been used to analyze different kinds of health care reforms in different kinds of health care systems [34]. Taking these considerations into account we thus find the theory suitable for the purpose of the present study. However, research on the applicability of the theory in analyzing health care reforms is called for.

The authors had different roles during the course of the present study. The first author performed the analysis based on the interviews but did not contribute to data collection as did the second author. The interpretation of the analysis was formulated through a dialogue between the authors. Thus, when the reliability of the analysis is concerned, we see the authors' different roles in the study process as complementing each other and hence the analysis as reliable.

Conclusion

The analysis allows us to conclude that the window of opportunity for PPP opens partially in the field of ophthalmology. However, the question remains: To what extend is the window open, i.e. is the window half-open or half-shut? If we look at the current situation, assuming that in any case some improvements must be made, we find three possible alternatives to solve the situation. On the one hand, the situation can be settled by forming a PPP agreement. On the other hand, the possibilities are either a public monopoly or a fully privatized service system. Even though we found some references to better coordination of work within the public sector, i.e. between primary and secondary health care, a public monopoly does not seem a feasible alternative to solve the situation. This is mainly because the private sector has traditionally been a strong actor in eye health services and because the resources of the public sector are seriously lacking. As for the latter alternative, the informants mentioned that in the future ophthalmology might be a fully privatized specialty of medicine. However, this does not seem likely either, mainly because of the public sector's responsibilities for specialist training and research as well as due to the fact that for the most demanding operations, the necessary resources are available only in the public sector.

If, however, we assume that improvements are not essential, it may be possible that the current situation remains constant. The situation would then appear as path dependent [35]. As shown by our analysis, the situation seems to be disadvantageous for both sectors. Hence, it is likely that both sectors would benefit from a change in the current situation. It is not clear, however, whether the actors fully recognize this fact. It seems that there is a need for a policy entrepreneur, i.e. an actor who is willing to invest his or her time, money and reputation to couple the three streams discussed above [12]. The situation calls for an actor capable of making all the parties see the disadvantages of the current situation as well as the advantages of the policy alternative in question.

There is no doubt that an exogenous pressure, e.g. population ageing, changes in a global or national financial situation or in the market, did not affect the initiation of PPP. However, Kingdon (1995) argues that the absence of a policy entrepreneur leaves the window of opportunity shut, as coupling of the streams may not take place without one. In a situation where prerequisites exist but a concrete policy proposal is missing, a policy entrepreneur may be an even more crucial actor than in a situation with a clear policy alternative. If the policy entrepreneur does appear, the window of opportunity may open fully.

In addition to a policy entrepreneur, the full opening of the window of opportunity calls for the existence of a win-win situation, where both parties gain benefit of some kind. As for the case addressed in this study, the win-win situation must exist particularly at the level of organizational management as in this study we have adopted an organizational viewpoint on PPP. This, however, does not mean that all the actors in the field find PPP favorable. As for the profession of ophthalmologists, recognition of the problem and the interest to solve it seem to be lacking. It may be said that there is a problem, even though differently defined, among all the others but the ophthalmologists. If we studied the same matter from the ophthalmologists' point of view it is likely that any change in the current situation would strike them as negative, as the profession can be seen as one that gains if the current state of affairs prevails. Hence, it is worth noting that the interpretation of the situation discussed here will also depend on the viewpoint adopted.

As the changes in society such as population ageing and technological developments have weakened the possibility of the public sector to meet the needs of the present, there is an increasing need for new health care policies (e.g. PPP) and cooperation between different societal actors in all developed countries. Even though Finnish municipalities and hospital districts can procure services from private service providers, the opportunity is not used to a very large extent [4]. This may be due to the fact that the Nordic countries have had a fairly negative attitude towards the growth of the private health care sector. This can be inferred from the tradition of the Nordic welfare state according to which the responsibility for production of welfare services rests with the public sector. [36] These kinds of ideological dispositions towards the private sector have partly hindered the private sector's involvement in health service provision. However, if considered in the context of ophthalmology, the case is somewhat different, as the services are often produced by private providers. That is to say that in ophthalmology PPP would not necessarily mean a greater market share for the private sector but better possibilities to coordinate service provision as a whole. Thus, the ideological argument against PPP is not necessarily well grounded with regard to ophthalmology.

In conclusion, the time has not yet come for PPP in the context of Finnish ophthalmology services. What the study did reveal, however, was that the discussion on the relationship between the public and private sectors in the context of health care has been put on the agenda. It seems that the previously mentioned co-existence of the public and private sectors seems to be altering towards greater recognition of the other actors operating in the field. Hence, although the time may not be ripe for a partnership at the moment, it seems likely that it might be some time in the future.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

LKT conducted the analysis and most of the literature search. JL contributed to data collection and provided supervision for the first author. Both authors contributed to the methodology, interpretation and concluding remarks.

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Employees' Perceptions on Organisational Justice, Job Control and Job Demands:
Do Ownership and Human Resource Management Practices Matter?

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ABSTRACT

The issue to be addressed in this study is whether ownership and HRM practices are associated with employees' perceptions of organisational justice, job control and job demands. The study focuses on care personnel working in sheltered housing facilities for elderly people. Multi-level linear regression is applied to analyse the data. The results support the argument that an increased similarity between public, not-for-profit and for-profit organisations is emerging in HRM issues. HRM practices were found to associate with positive outcomes in organisational justice and job control. However, to be successful in the implementation of HRM, it is crucial that employees understand the justification for each procedure as well as find it a useful resource in terms of their own job.

Keywords: *Elderly Care, Experience, Institutional Isomorphism, Job Control, Job Demands, Nursing Staff, Organizational Justice, Public and Private*

INTRODUCTION

The increasing proportion of old people and especially those over 90 has been suggested to result in an increasing demand for the care services and also an increasing need for workforce. The new capacity for the services is often purchased from private sector. Consequently

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private services providers are increasingly involved in the delivery of the publicly funded health care and social services. Moreover, while employers compete on young skilful employees they also need to sustain the working ability of the ageing workforce. To be successful in both of these quests employers need to understand the importance of appropriate and fair Human Resource Management (HRM) practices.

Public, not-for-profit and for-profit organisations have often been assumed to pursue different societal goals (Haley-Lock & Kruzich, 2008; Schmid & Nirel, 2004). It is, however, not evident whether this has to do with the organisations management practices or the wellbeing of the employees. The question of ownership and for-profit ownership is a highly debated subject. The arguments for and against public or private delivery of public services are, however, rarely based on valid research evidence (Øvretveit, 2003). In this paper we try to put some light on this matter.

The issue to be addressed in this paper is whether ownership and HRM practices are associated with employees' perceptions of organisational justice (Colquitt, 2001), job control and job demand (Karasek & Theorell, 1990). These factors reflect general leadership and management practices as well as psychosocial working conditions in an organisation. These have suggested resulting in positive outcomes for both the employees, but also for the organization (e.g., Laschinger, 2004). The focus of the paper is on the personnel working in sheltered homes for elderly people, which is the most rapidly extending segment in the field of elderly care in Finland. The term "sheltered housing facility" refers to care facilities offering accommodation and a certain set of services (e.g., care, meals, and cleaning) for elderly people. Eligible for sheltered housing are the elderly citizens who are not capable of living on their own and are in need of regular help. Residents pay rent as well as for the services they use. A cross-sectional survey data were used in the study and multi-level modelling was applied as a statistical method.

REVIEW OF LITERATURE AND STUDY HYPOTHESES

Organisational Justice, Job Control and Job Demand

Perceived organisational justice may be seen as a determinant of effective leadership (van Knippenberg & De Cremer, 2008). A perception of fairness of the procedures may be used as a means to evaluate leadership and its legitimacy in general (van Knippenberg et al., 2007; Konovsky, 2000). Furthermore, justice can be seen as one of the basic requirements for the organisation's effective functioning and employee satisfaction (e.g., Colquitt et al., 2001; Greenberg, 1990). It has been claimed that if employees perceive just treatment they will potentially be well disposed to their work, work outcomes, their superiors and the decisions made by the superiors (Barling & Phillips, 1992; Greenberg, 1990; Laschinger, 2004). Moreover, organisational justice has been shown to be associated with employee health and wellbeing (e.g., Elovainio et al., 2005; Elovainio et al., 2002; Kivimäki et al., 2003), productivity (Heponiemi et al., 2007) organisational behaviour (Moorman, 1991), job satisfaction and turnover intensions (Cohe-Charash & Spector, 2001). The perception of organisational justice has also been shown to have an effect also on the quality of care (Pekkarinen, 2007).

To define organisational justice we adopt Colquitt's conceptualization (2001) and divide the perceived organisational justice into four dimensions: distributive, procedural, interpersonal, and informational justice. Procedural justice refers to the perceived justice of the organisation's decision-making procedures. Interpersonal justice is related to the interpersonal treatment that employees receive when decisions are implemented in the organisation. Informational justice refers to the explanations on decisions and other information provided by employers. Distributive justice deals with the rewards the employees receive for their job (Colquitt, 2001; Colquitt et al., 2001).

Perceived job control and job demands describe employees' psychosocial working conditions. These have been suggested relating to sickness leaves, psychological distress, cardiovascular diseases, musculoskeletal disorders (Höckerting & Herenstam, 2006) and the quality of care (Pekkarinen, 2007). In this paper we adopt the Job Demand-Control model (Karasek, 1979; Karasek & Theorell, 1990). The model is based on the assumption that mental strain results from the joint effects of job demands and the freedom of decision-making to meet these demands (Karasek, 1979). Job demands can be defined as the work demands placed on the employee in their work, whereas job control is defined as the authority permitted to an employee to decide how to meet those demands (Karasek, 1979).

Career and skills development, participation in supplementary education (Meyer & Smith, 2000; Paré & Tremblay, 2007; Parry & Kelliher, 2009; Rodwell & Teo, 2007) and developmental performance reviews (Boswell & Boudreau, 2002; Rodwell & Teo, 2007; Tremblay et al., 2010) have been suggested to associate with different dimensions of organisational justice. Thus, perceived organisational justice, but also perceptions on job control and job demands may be seen partly as results of effective leadership (e.g., van Knippenberg & De Cremer, 2008). Thus, we conclude that organisational justice as well as job control, and job demands, are potentially influenced through HRM practices. Based on this assumption we state our first hypothesis accordingly:

- Hypothesis 1: HRM practices, such as receipt of mentoring, participation in supplementary education and participation in the developmental performance review are positively associated with perceived organisational justice and job control as well as negatively associated with perceived job demands.

Ownership Status and Human Resource Management

In the field of health and social care, comparisons between organisations under different ownership have mainly focused on *access* (e.g., Amirkhanyan et al., 2008), *quality of care* (e.g., Comondore et al., 2009; Hillmer et al., 2005; O'Neill at al., 2003), *costs* (e.g., Deveraux et al., 2004) and *performance* (e.g., Rosenau & Linder, 2003). Human resource issues have, in turn, not been addressed to any large extent (see however e.g., Hansen et al., 2009). However, in a more general body of the leadership and management literature a number of public-private comparisons exist (e.g., Boyne, 2002; Budhwar & Boyne, 2004; Nutt, 1999; Perry & Rainey, 1988). The studies present rather controversial results leaving the question of the importance of the ownership open for further research. Moreover, most of these existing studies have focused on comparisons between public and private or between not-for-profit and for-profit organisations (e.g., Amirkhanyan et al., 2008). The studies acknowledging all of the three ownership types suggest that public not-for-profit and for-profit organizations are potentially different in respect to their management and leadership practices (Boyne, 2002; Budhward & Boyne, 2004; Höckerting & Härenstam, 2006; Nutt, 1999; Parry et al., 2005). It has also suggested that ownership has an influence on perceived job demands and job control (e.g., Höckerting & Härenstam, 2006; Härenstam, 2008).

Public sector is increasingly turning to not-for-profit and for-profit organisations for the delivery of health and social services. It has been suggested that increasing contracting with public sector creates isomorphism between different ownership types making the traditional organisational boundaries blurry and changing (Cunningham, 2008). Public sector organisations have indeed started to increasingly emulate the HRM practices and strate-

gies of for-profit organisations (e.g., Rodwell & Teo, 2007). Not-for-profit organisations, in turn, have been forced to make their operations more transparent and to professionalise their management practices in order to survive in the competition on contracts (Parry & Kelliher, 2009). Moreover, in the field of health and social care factors such as professional culture, education, and strict regulation, are likely to produce similarities and affect the processes taking place in the workplace (DiMaggio & Powell, 1983; Rodwell & Teo, 2007).

Some scholars have even argued that all organisations are public to some extent. Some are just more exposed to public control than others (Bozeman, 1987). This dimensional approach understands the public-private distinction moving along a continuum where pure private or public organisations are rarely found (Goulet & Frank, 2002). Drawing from this, it may be suggested that contracting with public sector increases the private organisations' degree of 'publicness' as they become more dependent on the funding coming from the public pocket. At the same time contracting increases the private nature of the public organisations as part of their operations are moved to the hands of private actors. Moreover, increased market orientation may undermine the special characteristics of not-for-profit organisations, while promoting the culture adopted from the business sector. Based on all the arguments above we state our second hypothesis accordingly:

As to the not-for-profit sector in turn, contracting with public sector has suggested to undermine employees' terms and conditions due to external cost pressures (Cunningham, 2008) as well as to create more unstable environment in which organisations are no longer able to offer secure long-term employment for their employees (Parry & Kelliher, 2009). Furthermore, it has been argued that contracting threatens the possibilities of not-for-profit organisations to maintain their traditional objectives and ideals, which, in turn, further interferes the employees' commitment to the organisation (Cunningham, 2010). Finally, there are scholars suggesting that increasing involvement in provision of public services has required not-for-profit organisations. This, for its part, has potential to develop the organisational culture and organisation of work towards the ones originating from organisation driven by pro-market ideology (Baines, 2004).

Based on the arguments above, we formulate our second hypothesis accordingly:

- Hypothesis 2: The perceptions of organisational justice, job demands and job control are not determined by the ownership as such, but mediated through HRM practices.

METHODS AND DATA

Measures

Dependent Variables

The dependent variables describing organisational justice, i.e., procedural, interpersonal, informational and distributional justice, were drawn from the work of Colquitt (2001), while the variables addressing job control and job demand were adopted from the work of Karasek and Theorell (1990) and Karasek (1979). The values of the scale variables were calculated as the means of the values of single items. Responses to these items were rated on a Likert-scale ranging from 1 ("totally agree") to 5 ("totally disagree"). The justice variable measuring procedural justice consisted of five items (e.g., 'We have influence over the decisions made in the workplace'). The three other justice variables consisted of four items. For interpersonal justice the respondents considered variables such as 'My supervisor treats us with respect'. To measure informational justice the respondents we asked to consider items such as 'My supervisor communicated the decision in a timely manner'. For distributional justice the respondents we asked to express their opinion on variables such as 'My salary and the respect I receive reflect the effort I have put into my work'. The job control variable consisted of

Table 1. Dependent variables used in the analysis

	Number of items	Cronbach's alpha	Source
Procedural justice	5	0.86	Colquitt 2001
Interpersonal justice	4	0.92	Colquitt 2001
Informational justice	4	0.89	Colquitt 2001
Distributional justice	4	0.96	Colquitt 2001
Job control	9	0.63	Karasek & Theorell 1990
Job demand	3	0.78	Karasek & Theorell 1990

nine items, such as 'I have a say in my tasks'. In the job demands variable three items, such as 'My work requires excessive work load' were included. Cronbach's alphas were calculated for each of the dependent variables to indicate consistency of each variable (Table 1).

Explanatory Variables

The detailed information of all the explanatory variables is provided in Table 2. Ownership status was coded into three categories. For-profits were defined as either independent private companies or as part of a larger private corporation. Not-for-profits meant units that were owned by associations or foundations. The public units were those that were run and owned by municipalities. In the analysis for-profit units were used as a reference group as they had the smallest number of respondents.

Perceived organisational justice, but also perceptions on job control and job demands may be seen as results of effective leadership (e.g., van Knippenberg & De Cremer, 2008). Career and skills development, participation in supplementary education and participation in developmental performance reviews have been suggested to associate with different dimensions of organisational justice (Boswell & Boudreau, 2002; Meyer & Smith, 2000; Paré & Tremblay, 2007; Parry & Kelliher, 2009; Rodwell & Teo, 2007;). Thus, participation in supplementary education and participation in the developmental performance review were chosen to describe HRM practices of a unit. As it has been suggested (Brown et al., 2010) that employees' experiences of performance review may play an important role as to employees' attitudes towards their job in general, perceived utility of the review was also included in the performance review variable. Finally also receipt of mentoring was included among the HRM variables, as the practice was considered important for the employees working in health and social services.

Of the individual characteristics, age, education, employment status, employment contract and job tenure were included among the explanatory variables. This choice was based on the literature addressing the determinants of perceived organisational justice, job demands and control (e.g., Ban et al., 2003; Cohen-Charash, 2001; Härestam et al., 2004; Höckerting & Härenstam, 2006; Manville, 2008; Mirvis, 1992; Titrek, 2009). In addition Mirvis (1992) has suggested that the three sectors differ at least as to their employees' level of education as well as to the proportions of part- and full-time workers. The structure and size of the overall organisation, as well as the size of the work unit, has been suggested to affect employees' perceptions on their psychosocial working conditions (e.g., Härestam et al., 2004; Höckerting & Härenstam, 2006).

The size of an organisation may indicate the organisations' resources allocated to HRM operations (Ban, Drahnak-Faller, & Towers, 2003; Rodwell & Teo, 2004). Units' inpatient days per year were used to reflect the size of the work unit. The size of the overall organisation was addressed employing a categorical variable grouping small, medium and large organisa-

Table 2. Explanations and coding criteria for the explanatory variables applied in the multilevel linear regression models

UNIT CHARACTERISTICS		
Variable	**Explanation**	**Coding or explanation**
Ownership status	Whether the unit was owned by a private for-profit, a private not-for profit or a public agency	0=public 1=private not-for-profit 2=private for-profit (reference category)
Organizational structure	The size of the parent organization the unit belongs to	0=Small: private single-unit enterprise 1=Medium: 2-5 units in the same region/small municipality 2=Large: more than 5 units/large municipality (reference category)
Staffing level	The number of nursing staff / The number of residents	
In-patient days	The number of inpatient days in a unit / year	
Case-mix	Describes the need for staff time based on care needs of the client	Scale: 1 = average client <1 needs less care than average client >1 needs more care than average client
HRM CHARACTERISTICS		
Variable	**Explanation**	**Coding or explanation**
Developmental performance review	Whether the respondent had participated in a developmental performance review within a year and how they perceived it	1=Yes, useful 2=Yes, neutral 3=Yes, not useful 4=No (reference category)
Supplementary education	Whether the respondent had participated in supplementary education within a year	0=Yes 1=No (reference category)
Mentoring	Whether the respondent had received mentoring within a year	0=Yes 1=No (reference category)
INDIVIDUAL CHARACTERISTICS		
Variable	**Explanation**	**Coding or explanation**
Age	Self-reported age in years	
Job tenure	Years worked in the current position	
Education	The respondent's level of education	1= degree (i.e., polytechnic/ university) 2=secondary level (i.e., practical nurse) 3= no education (reference category)
Employment status	Whether the employee worked full-time or part-time	0=full-time 1=part-time (reference category)
Employment contract	Whether the employee had a permanent of fixed-term contract	0=permanent 1=fixed-term (reference category)

Table 3. Means (sd) for justice measures and continuous explanatory variables, proportions for categorical explanatory variables in the whole data and according to ownership status

	For-profit	Not-for-profit	Public	Total
	N=190	N=335	N=404	N=929
RESPONSE VARIABLES				
Procedural	3.60 (0.77)	3.66 (0.76)	3.62 (0.72)	3.63 (0.74)
Interpersonal	3.70 (1.03)	4.03 (0.84)	3.87 (0.89)	3.89 (0.91)
Informational	3.53 (0.97)	3.67 (0.87)	3.66 (0.86)	3.64 (0.89)
Distributional	2.55 (1.03)	2.73 (1.10)	2.46 (1.04)	2.57 (1.07)
Job control	3.45 (0.59)	3.65 (0.56)	3.61 (0.54)	3.59 (0.56)
Job demand	3.08 (0.87)	3.31 (0.92)	3.41 (0.91)	3.31 (0.92)
UNIT CHARACTERISTICS				
Respondents from large organizations, %	53.3	34.7	77.2	56.9
Staffing level	0.65 (0.10)	0.70 (0.14)	0.51 (0.13)	0.60 (0.15)
Inpatient days	7 897 (2 760)	6 359 (3 535)	11 680 (7 713)	8 983 (6 6142)
Case-mix	0.87 (0.11)	0.88 (0.11)	0.81 (0.13)	0.84 (0.12)
HRM CHARACTERISTICS				
Participation in performance review/useful, % respondents	33.5	36.1	38.9	36.8
Participation in performance review/neutral, % respondents	18.8	17.3	17.5	17.7
Participation in performance review/not useful, % respondents	9.1	8.7	7.5	8.2
Participation in supplementary education, % respondents	53.3	64.2	70.9	64.9
Receipt of mentoring, % respondents	46.2	50.9	28.1	40.0
INDIVIDUAL CHARACTERISTICS				
Age	42.1 (12.0)	42.2 (11.3)	44.0 (11.3)	43.0 (11.5)
Job tenure	5.2 (7.1)	5.5 (4.9)	6.6 (6.7)	6.0 (5.7)
Education: secondary level, % respondents	86.3	82.4	84.1	83.9

continued on following page

Table 3. continued

Education: degree level, % respondents	11.2	12.4	9.6	10.9
Full-time employees, % respondents	82.7	91.3	94.7	91.0
Permanent employees, % respondents	83.2	83.5	81.5	82.6

tions. Staffing level and residents' case-mix were used to describe employee workload, which has also suggested affecting perceptions of psychosocial working conditions (Höckerting & Härenstam, 2006; Pekkarinen, 2007).

Data

This study is a part of a research project exploring whether organisational ownership has an impact on the quality of care, cost of care and employee wellbeing in the context of elderly care in Finland. As part of the project a cross-sectional postal survey to assess employees' working conditions and job characteristics was conducted in 2008. Questions concerning perceptions of organisational justice, job demand and job control as well as questions on units' HRM practices and employees' socio-demographic status were included in the survey. Data on the units' modified case-mix were based on the RUG (Resource Utilisation Group) classification system for long-term care (Björkgren et al., 1999) and home care (Poss et al., 2009). The case-mix index reflects the relative resources needed to the care for different patient groups. The index is based on measurement of staff time. These data were obtained from the Finnish RAI benchmarking database (Finne-Soveri et al., 2006; Noro, 2005; THL RAI database, 2010). RAI (Resident Assessment Instrument) benchmarking database is a system for benchmarking elderly care in Finland. It aims to improve quality of long-term care for elderly, to integrate services and information flow over care providers, to improve national registers that follow use of health and social services, and to plan and develop financial and payment systems in long-term care (Noro, 2005).

The data were drawn from 128 sheltered home units in Finland, mainly comprising large cities in Southern Finland. The selection of the units was based on the invitation sent to all the sheltered home units that already participated in the RAI - quality-benchmarking project (Finne-Soveri et al., 2006; Noro et al., 2005; THL RAI database, 2010). The invitation was accepted by nearly all of the units, which then delivered the survey to their employees. In addition, for-profit units were recruited from the capital area and from the second largest cities in Finland in order to attain a sufficient number of for-profit units. The units were invited to participate in RAI – quality benchmarking as well as to answer the survey.

Altogether 959 employees completed the survey resulting in a response rate of 66.6%. The response rate did not differ between ownership types. Due to the small number of male respondents (n=25) only female respondents were included in the analysis. Responses with missing values for gender (n=5) were also excluded from the analysis. Finally the units (n=2) with missing values for all unit level factors were excluded. The final sample comprised 929 participants of which 20.5% worked in for-profit units and 36.1% in not-for-profit units. The units belonged to 62 different organizations ranging from large private organizations or large municipalities to small private single-unit enterprises. Of the units, 18% were for-profit and 39.8% not-for-profit. The median number of the respondents per unit was 9 (min=2; max=28). Descriptive statistics are reported in Table 3.

Table 4. Multilevel linear regression models for all the response variables, models 1 and 2

	PROCEDURAL		**INTERPERSONAL**		**INFORMATIONAL**		**DISTRIBUTIONAL**		**CONTROL**		**DEMAND**	
	Estimate	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***
Intercept	3.590	<0.0001	3.640	<0.0001	3.486	<0.0001	2.541	<0.0001	3.432	<0.0001	3.052	<0.0001
Unit characteristics												
Ownership												
Public	0.033	0.690	**0.246**	**0.046**	0.191	0.120	-0.082	0.490	**0.192**	**0.001**	**0.395**	**0.002**
Nor-for-profit	0.064	0.443	**0.399**	**0.002**	0.186	0.139	0.198	0.105	**0.218**	**0.0003**	**0.255**	**0.051**
For-profit (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
	PROCEDURAL		**INTERPERSONAL**		**INFORMATIONAL**		**DISTRIBUTIONAL**		**CONTROL**		**DEMAND**	
	Estimate	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***
Intercept	4.001	<0.0001	4.539	<0.0001	4.297	<0.0001	2.106	<0.0001	2.674	<0.0001	1.222	<0.0001
Unit characteristics												
Ownership												
Public	0.015	0.875	0.160	0.238	0.085	0.523	-0.034	0.797	**0.1761**	**0.006**	**0.331**	**0.011**
Nor-for-profit	0.067	0.445	**0.442**	**0.001**	0.2334	0.063	0.169	0.173	**0.228**	**<0.0001**	**0.265**	**0.027**
For-profit (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Level of hierarchy												
Small	-0.0893	0.383	-0.279	0.065	-0.398	0.007	-0.094	0.521	-0.088	0.218	0.044	0.753
Medium	0.060	0.421	-0.006	0.956	-0.081	0.447	0.037	0.729	-0.086	0.099	-0.034	0.743
Large (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Staffing level	0.116	0.691	-0.150	0.725	0.046	0.912	0.942	0.024	0.185	0.366	**-0.799**	**0.045**
Inpatient days	<0.0001	0.889	<0.0001	0.816	<0.0001	0.646	<0.0001	0.768	<0.0001	0.517	**<0.0001**	**0.044**
Case-mix	-0.334	0.249	-0.494	0.787	-0.762	0.065	-0.297	0.470	-0.019	0.924	**1.894**	**<0.0001**
Individual characteristics												
Age	0.001	0.803	-0.001	0.787	0.002	0.474	**0.009**	**0.007**	**0.007**	**<0.0001**	**0.006**	**0.026**

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Table 4. continued

	PROCEDURAL		INTERPERSONAL		INFORMATIONAL		DISTRIBUTIONAL		CONTROL		DEMAND	
	Estimate	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*
Education												
Degree	-0.181	0.168	-0.173	0.253	-0.154	0.298	-0.212	0.254	**0.364**	**<0.0001**	**0.349**	**0.020**
Secondary	-0.193	0.087	-0.135	0.297	-0.096	0.450	-0.284	0.075	**0.212**	**0.011**	**0.295**	**0.022**
Other (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Employment status												
Full-time	0.007	0.935	-0.242	0.813	0.069	0.490	0.028	0.824	0.068	0.3012	-0.086	0.394
Part-time (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Employment contract												
Permanent	-0.031	0.649	-0.147	0.059	-0.113	0.137	-0.078	0.416	**0.098**	**0.049**	0.033	0.671
Fixed-term (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Job tenure	-0.002	0.674	-0.001	0.976	<0.001	0.998	0.001	0.905	0.001	0.814	**0.015**	**0.007**

Table 5. Final multilevel linear regression models for all the response variables

	PROCEDURAL		INTERPERSONAL		INFORMATIONAL		DISTRIBUTIONAL		CONTROL		DEMAND	
	Estimate	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***	***Estimate***	***P***
Intercept	3.980	<0.0001	4.593	<0.0001	4.351	<0.0001	2.091	<0.0001	2.718	<0.0001	1.242	0.0095
Unit characteristics												
Ownership												
Public	0.031	0.662	0.149	0.241	0.078	0.515	-0.028	0.832	**0.144**	**0.017**	**0.328**	**0.001**
Not-for-profit	0.020	0.816	**0.364**	**0.002**	0.150	0.182	0.120	0.328	**0.181**	**0.001**	**0.250**	**0.035**
For-profit (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Level of hierarchy												
Small	-0.011	0.909	-0.198	0.157	**-0.310**	**0.019**	-0.016	0.909	-0.063	0.339	0.0286	0.838
Medium	0.113	0.123	0.043	0.673	-0.029	0.761	0.086	0.422	-0.062	0.201	-0.0321	0.753
Large (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Staffing level	0.159	0.574	-0.086	0.828	0.121	0.746	**1.012**	**0.014**	0.213	0.256	**-0.861**	**0.029**
Inpatient days	-4.41E-6	0.512	-7.61E-6	0.432	-0.00001	0.256	-5.91E-7	0.952	-2.17E-7	0.960	**0.000019**	**0.054**
Case-mix	-0.3627	0.1941	-0.5584	0.1531	**-0.8262**	**0.0255**	-0.329	0.419	-0.078	0.673	**1.8721**	**<0.0001**
HRM characteristics												
Performance review												
Yes, useful	**0.060**	**<0.0001**	**0.432**	**<0.0001**	**0.463**	**<0.0001**	**0.420**	**<0.0001**	**0.2255**	**<0.0001**	-0.1373	0.0543
Yes, neutral	0.345	0.865	-0.028	0.724	-0.116	0.131	0.010	0.316	**0.115**	**0.023**	-0.008	0.918
Yes, not useful	**0.093**	**0.018**	**-0.383**	**0.0004**	**-0.415**	**<0.0001**	**-0.274**	**0.040**	**-0.155**	**0.022**	0.096	0.383
No (ref.)	0	-	0	-	0	-	0	-	0	-	0	-

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Table 5. continued

	PROCEDURAL		INTERPERSONAL		INFORMATIONAL		DISTRIBUTIONAL		CONTROL		DEMAND	
	Estimate	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*	*Estimate*	*P*
Supplementary education												
Yes	0.027	0.612	**0.136**	**0.024**	**0.129**	**0.027**	0.036	0.630	**0.194**	**<0.0001**	0.160	0.066
No (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Mentoring												
Yes	**0.054**	**0.022**	0.105	0.103	**0.125**	**0.044**	0.041	0.602	0.019	0.632	**0.121**	**0.010**
No (ref)	0	-	0	-	0	-	0	-	0	-	0	-
Individual characteristics												
Age	0.002	0.366	-0.005	0.073	-0.002	0.360	0.006	0.070	**0.005**	**0.002**	**0.006**	**0.028**
Education												
Degree	-0.176	0.173	-0.207	0.156	-0.184	0.192	-0.204	0.268	**0.307**	**0.001**	0.282	0.062
Secondary	-0.165	0.135	-0.131	0.297	-0.082	0.499	-0.256	0.105	**0.184**	**0.022**	0.245	0.058
Other (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Employment status												
Full-time	-0.019	0.827	-0.576	0.554	0.036	0.703	0.005	0.997	0.057	0.369	-0.088	0.387
Part-time (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Employment contract												
Permanent	-0.073	0.276	**-0.222**	**0.004**	**-0.187**	**0.012**	-0.141	0.144	0.024	0.620	0.027	0.775
Fixed-term (ref.)	0	-	0	-	0	-	0	-	0	-	0	-
Job tenure	0.0002	0.960	0.003	0.507	0.004	0.455	0.003	0.631	0.003	0.449	**0.015**	**0.006**

Statistical Analysis

Descriptive statistics (means, standard deviations) were used to describe the data. The relationships between the explanatory variables were tested applying Pearson's correlation. The Pearson correlation coefficients between explanatory variables ranged between -0.01 and 0.64. In the case of missing values for the explanatory variables the method of multiple imputation was used (e.g., Rubin, 1996; SPSS, 2007). The imputations were repeated five times for each individual case. The mean value of the imputations was then used to replace the missing value for each individual case. For the unit level variables the procedure was implemented at the unit level. As the analysis was done without imputed values the result did not differed statistically from those attained with the imputed data.

Multilevel linear regression was applied in the exploratory analysis, as it was assumed that the employees' responses might depend on both the unit they were working for and their individual characteristics (Colquitt et al., 2002; Leyland & Goldstein, 2001). Multilevel modelling was performed using SAS (Statistical Analysis System) version 9.1. The model was fitted applying the MIXED procedure (Singer, 1998). In all the analyses the level of statistical significance was set at 0.05. Interaction between HRM and ownership was tested but not found statistically significantly associate with any of the dependent variables.

The analysis was built in three parts. In the first model ownership variable was put in the model alone. In the second model ownership and all the variables except for HRM variables were added. In the final model HRM variables were added in the model.

RESULTS

Comprehensive regression statistics are reported in Tables 4 and 5. Participation in performance review was found to be a significant explanatory factor for all the dependent variables except for job demands. The respondents who had participated in the performance review and experienced it useful perceived more organizational justice in general and had a higher perception of job control. They also perceived lower job demands compared to those who had not participated in the performance review, even though the effect was slightly insignificant. By contrast, those who had participated in a performance review but found it not useful perceived lower levels of organisational justice as well as lower job control compared to those who had not participated at all. In addition, a neutral view on performance review was positively associated with the perception of job control. Participation in supplementary education was positively associated with the perception of interpersonal and informational justice as well as with job control. Receipt of mentoring had a positive effect on procedural and informational justice as well as on job demands. Thus, rather strong support was gained for Hypothesis 1.

Ownership was not statistically significantly associated with procedural, informational and distributional justice. For interpersonal justice, job demands and job control the effect ownership was statistically significant in all models and the effect did not change to any large extent in the models two and three. Employees in not-for-profit and public units perceived more job control compared to the for-profit units. At the same time, however, perceived job demands were also higher compared to for-profit units. Employees in not-for-profit units also perceived more interpersonal justice compared to the employees in for-profit units. Public ownership was positively associated with the perception of interpersonal justice in the first model, but the effect turned out to be insignificant after adding other variables in the model. Thus, Hypothesis 2 was not entirely supported.

Staffing level, case-mix and inpatient days were associated with perceived job demands. The more the residents needed care (i.e., the bigger the value of case-mix), the less there was personnel working in the unit and the bigger the unit was, the more the employees perceived

job demands. Staffing level also had a positive effect on the perception of distributional justice, while case-mix was negatively associated also with the perception of informational justice. The level of hierarchy influenced perceived informational justice: employees working in single-unit private enterprises perceived lower levels of organisational justice compared to large organisations.

Age, education, job tenure and employment status were found to be significant explanatory factors for one or more dependent variables. Age was positively associated with job control but also with the perceptions of job demands. Education was positively associated with perceived job control: the higher the education, the more the employee felt control over their jobs. Job tenure, for its part, had a positive effect on job demands: the longer the employees had worked in their current jobs, the more demanding the job was perceived. Employment status also played a role: a permanent employment contract had a negative effect on perceived interpersonal and informational justice.

DISCUSSION

In this study we have tested two hypotheses concerning the importance of HRM practices and ownership as to employees' perceptions of organisational justice, job demands and job control. The results support the hypothesis that HRM practices are positively associated with perceived organisational justice and job control as well as negatively associated with perceived job demands. However, job demands seemed to be the less affected by HRM practices in this study.

The results for ownership confirm the complexity of the issue of ownership reported already by several scholars. The results support Hypothesis 2 to the extent that ownership was associated with interpersonal justice, job demands and job control, but it is not the only determinant behind the perceptions. However, its effect remained significant also after the HRM variables were added in the model. Thus, it may not be said that the effect of ownership is purely mediated by HRM practices applied in this study. It might be important to explore the issue in more detail also with other HRM practice variables as well.

Of HRM practices especially performance review seemed to play a highly significant role in all the dependent variables except for job demands. However, it appeared that solely introducing a performance review in the unit does not guarantee better outcomes in terms of employee perceptions of the organisation and their own job, but that the quality of the performance review is an important factor. Similar suggestions can be found in the work of Brown and colleagues (2010). As to perceived organisational justice and job control, it seems that participation in the performance review is worthwhile only if the employees find the procedure a useful resource in terms of their own job. If the experience is negative (i.e., not useful) or neutral, the performance review may even have negative implications for the perceptions of the organisation and work in general.

The proportion of those who had not found the performance review useful was highest in the for-profit units, which scored lowest also in most of the response variables examined. We did not find interaction between performance review and ownership in this study and thus, we are not allowed to draw any conclusions about that in this paper. However, it might be interesting to examine the issue in more detail, as the results of our study somewhat contradict non-empirical suppositions of private, for-profit organisations' personnel policies, but also previous research on leadership in private for-profit organisations (e.g., Boyne, 2002; Walsh, 1995).

As to organisational justice, the results quite strongly support the literature suggesting increasing similarity and isomorphism between public, not-for-profit and for-profit organisations as to HRM issues (e.g., Antonsen & Jørgensen, 1997; Cunningham, 2010, 2008; DiMaggio & Powell, 1983; Koning et al., 2007; Rodwell & Teo, 2007). This has potentially to do with current developments of increased public sector contracting and tendering pro-

cedures (e.g., Cunningham, 2010, 2008). On the other hand that might have to do with the nature of health care and social service sector in which factors such as professional culture, similar educational background as well as strict regulation are likely to produce similarities and affect the processes taking place in the workplace (DiMaggio & Powell, 1983; Rodwell & Teo, 2007).

Ownership was, however, associated with job control and job demands. Employees in for-profit units perceived lower job demands, which may be explained, among other things, by staffing levels and the case-mix of residents: in the for-profit units the case-mix was rather heavy but also the staffing level was reasonable. As to job control the for-profit units compared lowest. This is somewhat against the preliminary assumptions of better leadership and higher job control in private organisations (Walsh, 1995.) However, it has also been suggested that working with the demand of profit may have a negative effect on perceived control as the valuation of the daily work may be more based on results or work outcomes (Höckerting & Härenstam, 2006).

The highest demands were perceived in the public units in which also the average staffing level was lowest but the number of inpatient days was highest. Perceived job control in public units was similar to the not-for-profit units, in which, however, the staffing level was comparatively higher. This does not allow us to draw any far-reaching conclusions, but it may be possible to assume that employees in public units may perceive more job strain than their counterparts in not-for-profit and possibly also in for-profit units (Karasek & Theorell, 1990).

In this study we have been able to compare public, not-for-profit and for-profit organisations, which has not been that common in the existing body of literature. However, the cross-sectional study design does not offer possibilities to compare stability of the differences or the changes in time. Collecting follow-up data is, however, something that will be done within next years. The organisations participating in the study represent mainly the large cities in Finland. However, the data may be said to present quite well the elderly care service structure in Finland, but also in other western countries with rather similar service structure (e.g., Nordic Countries, Canada, New Zealand). Public and not-for-profit organisations still play a major role, but for-profit organisations are increasing their proportions of the total volume of the services. Of HRM practices we were able to investigate only three specific activities. To gain more comprehensive knowledge also other HRM activities like career management, rewards and other training activities should be included. Also the perceptions of the usefulness of HRM activities should be included, as it seems to matter as the successful of the activities are considered.

CONCLUSIONS AND PRACTICAL IMPLICATIONS

This study lends support to an argument about increased similarity between public, not-for-profit and for-profit organisations in HRM issues. Based on the results it may be assumed that it is the organisational procedures that potentially play a significant role as to employees' perceptions towards their work and superiors. This increases the importance of adequate HRM practices, which also in this study were found to associate with positive outcomes in organisational justice and job control. However, to be successful in the implementation of HRM, it is crucial that employees understand the justification for each procedure as well as find it a useful resource in terms of their own job. The results also suggest that for job demands structural factors, such as staffing level and case mix might be more important that HRM practices and thus, it is important to pay attention to these aspects of work as well.

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