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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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References

Act on Public Contracts (348/2007). Available at: http://www.finlex.fi/fi/laki/ajantasa/2007/20070348 [Accessed 11 December 2012]

Ahlgren, B. & Axelsson, R. 2007. Determinants of integrated health care development: chains of care in Sweden. *International Journal of Health Planning and Management*, 22(2), pp. 145–157.

Aho T. 2012. Hankinta- ja sopimuskäytännöt palvelujen ulkoistuksessa. In: M. Junnila et al., eds. *Sitä saa mitä tilaa. Tilaaja-tuottaja toimintatavan kehittyminen sosiaali- ja terveyspalveluissa*. Raportti 42/2012. Helsinki: Terveyden ja hyvinvoinninlaitos, pp. 118–135.

Alasuutari, P. 1996 Theorizing in Qualitative Research: A Cultural Studies Pespective. *Qualitative Inquiry*, 2(4), pp. 371–384.

Alasuutari, P. 1994. *Laadullinen tutkimus*. Jyväskylä: Vastapaino.

Alexander, M. & Young, D. 1996. Strategic Outsourcing. *Long Range Planning*, 29(1), pp. 116–119.

Allen, P. 2002. A socio-legal and economic analysis of contracting in the NHS internal market using a case study of contracting for district nursing. *Social Science & Medicine*, 54(2), pp. 255–266.

Allison, G. 1979. Public and Private Management: Are they Fundamentally Alike in All Unimportant Respects? In: J. Shafritz & A. Hyde, eds. *Classics of Public Administration*. Chicago: Dorsey Press, 1992.

Almqvist, R. & Högberg, O. 2005. Public-private partnerships in social services: the example of the City of Stockholm. In: G. Hodge & C. Greve, eds. The Challenge of Public-Private Partnerships. Learning from the experience. Cheltenham: Edward Elgar, pp. 231–256.

Amirkhanyan, A.A., Kim, H.J., & Lambright, K.T. 2008. Does the public sector outperform the nonprofit and for-profit sectors? Evidence from a national panel study on nursing home quality and access. *Journal of Policy Analysis and Management*, 27(2), pp. 326–353.

Antonsen, M. & Jørgensen, T.B. 1997. The 'Publicness' of public organizations. *Public Administration*, 75(2), pp. 337–357.

Arajärvi, E. & Väyrynen, R. 2011. Yksityinen palvelutuotanto sosiaali- ja terveyspalveluissa 2009. Available at: http://www.stakes.fi/tilastot/tilastotiedotteet/2011/Tr33_11.pdf [Accessed 3 September 2012]

Baldwin, J.N. 1987. Public versus Private: Not That Different, Not That Consequential. *Public Personnel Management*, 16(2), pp. 181–193.

Ball, R., Heafey M. & King D. 2007. The Private Finance Initiative in the UK. *Public Management Review*, 9(2), pp. 289–310.

Barr, D. A. 2007. Ethics in public health research: A research protocol to evaluate the effectiveness of public-private partnerships as a means to improve health and welfare systems worldwide. *American Journal of Public Health*, 97(1), pp. 19–25.

Billis, D. 2010. Towards a theory of hybrid organizations. In: D. Billis, ed. *Hybrid Organizations and the Third Sector. Challenges for Practice, Theory and Policy*. Basingstoke: Palgrave MacMillan, pp. 46–69.

Billis , D.& Glennester, H. 1998. Human Services and the Voluntary Sector: Towards a Theory of Comparative Advantage. *Journal of Social Policy*, 27(1), 79–98.

Björkgren, M., Häkkinen, U., Finne-Soveri, H., & Fries, B.E. 1999. Validity and Reliability of Resource Utilization Groups (RUG III) in Finnish Long-Term Care Facilities. *Scandinavian Journal Public Health*, 27(3), pp. 228–234.

Blomgren, M. & Lindberg, K. 2009. Mellan offentligt och privat i hälso- och sjukvården. In: K. Lindberg & M. Blomgren, eds. *Mellan offentligt och privat. Om styrning, praktik och intressen i hälso- ock sjukvården*. Stockholm: Santerus Academic Press Sweden, pp. 11–19.

Blomqvist, P. The Choice Revolution: Privatization of Swedish Welfare Services in the 1990s. *Social Policy and Administration*, 38(2), pp. 139–155.

Bovaird, T. 2010. A brief intellectual history of the public-private partnership movement. In: G.A. Hodge, C. Greve & A.E. Boardman, eds. *International Handbook of Public-Private Partnerships*. Northampton: Edward Elgar, pp. 43–67.

Bovaird, T. 2004. Public-private partnerships: From contested concepts to prevalent practice. *International Review of Administrative Sciences*, 70(2), pp. 199–214.

Boyne, G.A. 2002. Public and private management: what's the difference? *Journal of Management Studies*, 39(1), pp. 97–122.

Bozeman, B. 1987. *All Organizations Are Public. Bridging Public and Private Organizational Theories*. San Francisco: Jossey-Bass Publisher.

Brinkerhoff D.W. & Brinkerhoff J.M. 2011. Public-Private Partnerships: Perspectives on purposes, publicness, and good governance. *Public Administration and Development* 31(1), pp. 2–14.

Brooks, A.C. 2005. What Do Nonprofit Organizations Seek? (And Why Should Policymakers Care?). *Journal of Policy Analysis and Management*, 24(3), pp. 543–558.

Budhwar, P.S. & Boyne, G. 2004. Human resource management in the India public and private sectors: an empirical comparison. *International Journal of Human Resource Management*, 15(2), pp. 346–370.

Cappellaro, G. & Longo, F. 2011. Institutional public private partnerships for core health services: evidence from Italy. *BMC Health Services Research*, 11: 82.

Carroll, P. & Steane, P. 2000. Public-private partnerships: sectoral perspectives. In: S.P. Osborne, ed. *Public-Private Partnerships. Theory and practice in international perspective*. London: Routledge, pp. 36–56.

Castle, N.G. & Engberg, J. 2006. Organizational Characteristics Associated With Staff Turnover in Nursing Homes. *The Gerontologist*, 46(1), pp. 62–73.

Chandler, J.A. 1991. Public Administration and Private Management. Is There A Difference? *Public Administration*, 69(3), pp. 385–392.

Clarkeburn, H. & Mustajoki, A. 2008. *Tutkijan arkipäivän etiikka*. Tampere: Vastapaino.

Creed, W.E.D., Langstraat J.A. & Scully M.A. 2002. A Picture of the Frame: Frame Analysis as Technique and as Politics. *Organizational Research Methods*, 5(1), pp. 34–55.

Coburn, C.E. 2006. Framing the Problem of Reading Instruction: Using Frame Analysis to Uncover the Microprocesses of Policy Implementation. *American Educational Research Journal*, 43(3), pp. 343–379.

Coghill, K. & Woodward, D. 2005. Political issues of public-private partnerships. In: G. Hodge & C. Greve, eds. *The Challenge of Public-Private Partnerships. Learning from the experience*. Cheltenham: Edward Elgar, pp. 81–94

Colquitt, J.A. et al., 2001. Justice at the Millenium: A Meta-Analytic Review of 25 Years of organizational Justice Research. *Journal of Applied Psychology*, 86(3), pp. 425–445.

Comondore, V.R. et al., 2009. Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *British Medical Journal*, 339(4), p. b2732.

Creswell, J.W. & Plano Clark, V.L. 2007. *Designing and Conducting Mixed Methods Research*. Los Angeles: Sage.

Cunningham, I. 1999. Human Resource Management in the Voluntary Sector: Challenges and Opportunities. *Public Money & Management*, 19(2), pp. 19–25.

Cunningham, I. 2010. Drawing from a bottomless well? Exploring the resilience of value-based psychological contracts in voluntary organizations. *The International Journal of Human Resource Management*, 21(5), pp. 699–719.

Curtis, V. A., Garbrah-Aidoo, N., & Scott, B. 2007. Ethics in public health research: Masters of marketing: Bringing private sector skills to public health partnerships. *American Journal of Public Health*, 97(4), pp. 634–641.

Deveraux, P.J. et al., 2004. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *The Canadian Medical Association Journal*, 170(12), pp. 1817–1824.

DiMaggio, P.J., & Powell, W.W. 1983. The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. *American Sociological Review*, 48(2), pp. 147–160.

Domberg, S. & Fernandez, P. 1999. Public-Private Partnerships for Service Delivery. *Business Strategy Review*, 10(4), pp. 29–39.

Donahue, J.D. 1989. *The Privatization Decision. Public Ends, Private Means*. New York: Basic Books.

Donahue, J.D. & Zeckhauser, R.J. 2011. *Collaborative governance: private roles for public goals in turbulent times*. Princeton N.J.: Princeton University Press.

Donato, R. 2011. Extending Transaction cost economics: Towards a synthesized approach for analyzing contracting in health care markets with experience from Australian private sector. *Social Science & Medicine*, 71(11), pp. 1989–1996.

Dewan, P. K. et al., 2006. Improving tuberculosis control through public-private collaboration in India: Literature review. *British Medical Journal*, 332(11), pp. 574–578.

Edelenbos, J. & Klijn, E-H. 2009. Project Versus Process Management in Public-Private Partnership: Relation Between Management Style and Outcomes. I*nternational Public Management Journal*, 12(3), pp. 310–331.

Edwards, P., Shaoul, J., Stafford, A. & Arblaster, L. 2004. E*valuating the operation of PFI in roads and hospitals*. London: Certified Accountants Educational Trust.

Eggleston, K., Shen, Y-C., Lau, J., Schmid, C.H. & Chan, J. 2008. Hospital Ownership and Quality of Care: What Explains the Different Results? *Health economics*, 17(12), pp. 1345–62.

Ellonen, N. 2006. Monitasoanalyysit ja niiden soveltaminen sosiaalitieteissä. *Janus*, 4(2), pp. 127–138.

Elo, S. & Kyngäs, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), pp. 107–115.

Elshtain, J.B. 1997. The Displacement of Politics. In: J. Weintraub & K. Kumar, eds. *Public and Private in Thought and Practice*. Chicago: The University of Chicago Press, pp. 166–181.

Entwistle, T. 2005. Why are local authorities reluctant to externalise (and do they have good reason)? *Government and Policy*, 23(2), pp. 191–206.

Eskola, J. & Suoranta, J. 1998. *Johdatus laadulliseen tutkimukseen*. Tampere: Vastapaino.

European Commission. 2004. Green paper on public-private partnerships and community law on public contracts and concessions. Brussels 30.4.2004.

Faulkner, K. 2004. Public-Private Partnerships. In: A. Ghobadian, D. Gallear, N. O'Regan & H. Viney, eds. *Public-Private Partnerships. Policy and Experience*. Hampshire: Palgrave Macmillan, pp. 65–70.

Feiock, R.C. & Jang, H.S. 2009. Nonprofits as Local Government Service Contractors. *Public Administration Review*, 69(4), pp. 668–680.

Finne-Soveri, H., Björkgren, M., Vähäkangas, P. & Noro, A. 2006. *Kotihoidon asiakasrakenne ja hoidon laatu – Rai järjestelmä vertailukehittämisessä*. Helsinki: National Research and Development Centre for Welfare and Health.

Flinders, M. 2005. The Politics of Public–Private Partnerships. *British Journal of Political and International Relations*, 7(2), 215–239.

Fredriksson, S. Hyvärinen, O., Mattila, M. & Wass H. 2009. *Kilpailuttaminen poliittisena päätöksenä*. Vammala: Kunnallisalan kehittämissäätiö.

Fredriksson, S. & Martikainen, T. eds. 2006. *Kilpailuttamisen kokemukset*. Vammala: Kunnallisalan kehittämissäätiö.

Forma, P., Niemelä, M., Saarinen, A. eds. 2008. *Hyvinvointivaltion kilpailuttaminen*. Vammala: Kunnallisalan kehittämissäätiö.

Gamson, W.A. & Lasch, K.E. 1983. The political culture of social welfare policy. In: S.E. Spiro & E. Yuchtman-Yaar, eds. *Evaluating the welfare state: Social and political perspectives*. New York: Academic Press, pp. 397–415.

Garcia Prado, A. & Lao Pena, C. 2010. *Contracting and Providing Basic Health Care Services in Honduras: A Comparison of Traditional and Alternative Service Delivery Models*. Washington: The World Bank.

Geyskens, I., Steenkamp, J-A. & Kumar, N. 2006. Make, buy, or ally: a transaction cost theory meta-analysis. *Academy of Management Journal*, 49(3), pp. 519–543.

Ghobadian, A., Gallear, D., Viney, H. & O'Regan, N. .2004. Future of Public-private Partnership. In: A. Ghobadian, D. Gallear, N. O'Regan & H. Viney, eds. *Public-Private Partnerships. Policy and Experience*. Hampshire: Palgrave Macmillan, pp. 271–302.

Giskens, K. et al., 2008. Household and food shopping environments: do they play a role in socioeconomic inequalities in fruit and vegetable consumption? A multilevel study among Dutch adults. *Journal of Epidemiology and Community Health*, 63(2), pp. 113–120.

Goffman, E. 1974. *Frame analysis: An essay on the organization of experience*. Boston: Northeastern University Press.

Goulet, L.R. & Frank, M.L. 2002. Organizational Commitment Across Three Sectors: Public, Non-Profit, and For-Profit. *Public Personnel Management*, 31(2), pp. 201–210.

Green-Pedersen, C. 2002. New Public Management Reforms of the Danish and Swedish Welfare States: The Role of Different Social Democratic Responses. *International Journal of Policy, Administration, and Institutions*, 15(2), pp. 271–294.

Grimshaw, D., Vincent, S., & Willmott, H. 2002. Going privately: Partnership and outsourcing in UK public services. *Public Administration*, 80(3), pp. 475–502.

Haley-Lock, A., & Kruzick, J. 2008. Serving Workers in the Human Services: The Roles of Organizational Ownership, Chain Affiliation, and Professional Leadership in Frontline Job Benefits. *Nonprofit and Voluntary Sector Quarterly*, 37(3), pp. 443–467.

Hansen, N., Sverke, M. & Näswall, K. 2008. Predicting nurse burnout from demands and resources in three acute care hospitals under different forms of ownership: A cross-sectional questionnaire study. *International Journal of Nursing Studies*, 46(1), pp. 96–107.

Harris, M. 2010. Third sector organizations in a contradictory policy environment. In: D. Billis, ed. *Hybrid Organizations and the Third Sector. Challenges for Practice, Theory and Policy*. Basingstoke: Palgrave MacMillan, pp. 25–45.

Hefetz, A. & Warner, M. 2004. Privatization and Its Reverse: Explaining the Dynamics of the Government Contracting Process. *Journal of Public Administration Research and Theory*, 14(2), pp. 171–190.

Hellowell, M. 2010. The UK's Private Finance Initiative: history, evaluation, prospects. In: G. Hodge & C. Greve, eds. T*he Challenge of Public-Private Partnerships. Learning from the experience*. Cheltenham: Edward Elgar, pp. 307–332.

Heponiemi, T. et al., 2012. Ownership type and team climate in elderly care facilities: the moderating effect of stress factors. *Journal of Advanced Nursing*, 68(3), pp. 647–657.

Hillmer, M.P. et al., 2005. Nursing Home Profit Status and Quality of Care: Is There Any Evidence of an Association. *Medical Care Research and Review*, 62(2), pp. 139–166.

Hirsjärvi, S., Remes, P. & Sajavaara, P. 2007. *Tutki ja kirjoita*. Helsinki: Tammi.

Hodge, G. & Coghill, K. 2007. Accountability in the Privatized State. *Governance*, 20(4), pp. 675–702.

Hodge, G. & Greve, C. 2010. Public-Private Partnerships: Governance Scheme or Language Game? *The Australian Journal of Public Administration*, 69(S1), pp. S8–S22.

Hodge, G.A., Greve C. & Boardman A.E. 2010. Introduction: the PPP phenomenon and its evaluation. In: G.A. Hodge, C. Greve & A.E. Boardman, eds. *International Handbook of Public-Private Partnerships*. Northampton: Edward Elgar, pp. 3–16.

Hsiu-Fang, H. & Shannon, S.E. 2005. Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, 15(9), pp. 1277–1288.

Jacobs J. 1992. *Systems of Survival*. London: Random House.

Jokinen, K. 2008. Miten laadullinen tutkimus vakuuttaa? In: K. Lempiäinen, O. Löytty, M. Kinnunen, eds. *Tutkijan kirja*. Tampere: Vastapaino, pp. 243–250.

Julkunen, R. 2000. Social background of the rise of the third sector. In: M. Siisiäinen, P. Kinnunen & E. Hietanen, eds. T*he third sector in Finland. Review to research of the Finnish third sector.* Helsinki: The Finnish Federation for Social Welfare and Health, pp. 52–69.

Junnila, M. et al. 2012. *Sitä saa mitä tilaa. Tilaaja-tuottaja toimintatavan kehittyminen sosiaali- ja terveyspalveluissa*. Helsinki: Terveyden ja hyvinvoinninlaitos.

Jussila, H. 2012. *Päätöksenteon tukena vai hyllyssä pölyttymässä? Sosiaalipoliittisen tutkimustiedon käyttö eduskuntatyössä*. Sosiaali- ja terveysturvan tutkimuksia. Helsinki: Kelan tutkimusosasto.

Kantonen, J., Aronkytö, T., Palmunen, J. & Keinänen, M. 2012. Terveyskeskuspäivystyksen ulkoistus ja uudistus toivat säästöjä Vantaalle. *Suomen lääkärilehti*, 67(32), pp. 2147–2152.

Karasek, R.A., & Theorell, T. 1990. *Healthy work. Stress, productivity, and the reconstruction of working life*. New York: Basic Books.

Karasek, R.A. 1979. Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly*, 24(2), pp. 285–308.

Keane, C., Marx, J. & Ricci, E. 2002. Services Privatized in Local Health Departments: A National Survey of Practices and Perspectives. *American Journal of Public Health*, 92(8), pp. 1250–1253.

Keane, C., Marx, J. & Ricci, E. 2001. Privatization and the Scope of Public Health: A National Survey of Local Health Department Directors. *American Journal of Public Health*, 91(4), pp. 611–617.

Keskimäki, I., Tynkkynen, L-K., Miettinen, S. & Lehto, J. 2012. Kansainvälisiä kokemuksia tilaaja-tuottaja-toimintatavoista: Englanti, Uusi-Seelanti ja Ruotsi. In: M. Junnila et al., eds. *Sitä saa mitä tilaa. Tilaaja-tuottaja toimintatavan kehittyminen sosiaali- ja terveyspalveluissa*. Terveyden ja hyvinvoinninlaitos: Helsinki, pp. 56–74.

Kingdon, J.W. 1995. *Agendas, alternatives, and public policies*. New York: Addison, Wesley, Longman.

Kivisaari, S., Kokkinen, L., Lehto, J. & Saari, E. 2009. *Sosiaali- ja terveydenhuollon systeemisen innovaation johtaminen*. Kahden tapaustutkimuksen opetuksia. Helsinki: VTT.

Klijn, E-H. 2010. Public-private partnerships: deciphering meaning, message and phenomenon. In: G.A. Hodge, C. Greve & A.E. Boardman, eds. I*nternational Handbook of Public-Private Partnerships*. Northampton: Edward Elgar, pp. 68–80.

Klijn, E-H., Edelenbos, J. & Hughes, M. 2007. Public-Private Partnership: Two-Headed Reform. A Comparison of PPP in England and the Netherlands. In: C. Pollitt, S. van Thiel & V. Homburg, eds. *New Public Management in Europe. Adaptation and Alternatives*. Hampshire: Palgrave Macmillan, pp. 71–89.

Klijn, E-H. & Teisman, G.T. 2000. Governing public-private partnerships: analysing and managing the process and institutional characteristics of public-private partnerships. In: S.P. Osborne, ed. *Public-Private Partnerships. Theory and practice in international perspective*. London: Routledge, pp. 84–102.

Klijn, E-H., & Teisman, G.R. 2003. Institutional and Strategic Barriers to Public-Private Partnership: An Analysis of Dutch Cases. *Public Money and Management*, 23(3), pp. 137–146.

Kokkinen, L. & Lehto, J. 2011. Changing Health Care from Inside Out: Policy Entrepreneur Questioning Ophthalmology Service Production in Finland. *International Journal of Public and private Healthcare Management and Economics*, 1(1), pp. 16–27.

Kokko, S. et al. Kunta- ja palvelurakenneuudistuksen toteutuminen. Kuntakysely sosiaali- ja terveyspalvelujen järjestämisestä ja tuottamisesta. Helsinki: Terveyden ja hyvinvoinnin laitos.

Konetzka, R.T. et al., 2005. Personal Care Aid Turnover in Residental Care Settings: An Assessment of Ownership, Economic, and Environmental Factors. *The Journal of Applied Gerontology,* 24(2), pp. 87–107.

Koning, P., Noailly, J., & Visser, S. (2007). Do not-for-profits make a difference in social services? A survey study. *De Economist*, 155(3), pp. 251–270.

Konu, A.I., Lintonen, T.P., Autio, V.J. 2002. Evaluation of WellBeing in Schools – A Multilevel Analysis of General Subjective Well-Being. *School Effectiveness and School Improvement*, 13(2), pp. 187–200.

Kovalainen, A., Simonen, L. & Österberg, J. 1996. S*osiaalipalveluyrittäjän muotokuva. Tutkimus sosiaali- ja terveysalan uusyrittäjistä ja vaihtoehtoisista palveluntuottajista*. Helsinki: Stakes.

Laamanen, R. et al., 2008. Outsourcing primary health care services – How politicians explain the grounds for their decisions. *Health Policy*, 88(2–3), pp. 294–307.

Lagomarsino, G., Nachuk, S. & Singh, Kundra S. 2009. *Public Stewardship of Private Providers in Mixed Health Systems: Synthesis report from the Rockefeller Foundation – sponsored initiative on the role of the private sector in health systems*. Washington DC: Results for Development Institute.

Lehto, J., Anttonen, A., Haveri, A. & Palukka, H. 2012. Julkisen palvelun muutos tutkimuskohteena. In: A. Anttonen, A. Haveri, J. Lehto, H. Palukka, eds. *Julkisen ja yksityisen rajalla*. Tampere: Tampere University Press, pp. 11–16.

Leyland, A.H. & Goldstein, H. 2001. *Multilevel Modelling of Health Statistics*. Chichester: Wiley.

Leyland, A.H. & Groenewegen, P.P. 2003. Multilevel modelling and public health policy. *Scandinavian Journal of Public Health*, 31(4), pp. 267–274.

Lewis, J.M., Baeza, J.I. & Alexander, D. 2008. Partnerships in primary care in Australia: Network structure, dynamics and sustainability. *Social Science & Medicine*, 67(2), pp. 280–291.

Linder, S.H. 2000. Coming to terms With the Public-Private Partnership. In: P. Vaillancourt Rosenau, ed. *Public-Private Policy Partnerships*. Massachusetts: MIT Press, pp. 19–36.

Linder, S.H. 1999. Coming to Terms With the Public-Private Partnership. A Grammar of Multiple Meanings. *American behavioral scientist*, 43(1), pp. 35–51.

Lonnroth, K. et al. 2004. Public-private mix for DOTS implementation: What makes it work?. *Bulletin of the World Health Organization*, 82(8), pp. 580–586.

Lowndes, V. & Skelcher, C. 1998. The Dynamics of Multi-Organizational Partnerships: An Analysis of Changing Modes of Governance. *Public Administration*, 76(2), pp. 313–333.

Maarse, H. 2006. The Privatization of Health Care in Europe: An Eight-Country Analysis. *Journal of Health Politics, Policy and Law*, 31(5), pp. 981–1014.

MacFarlane, A. & O'Reilly-de Brun, M. 2012. Using Theory-Driven Conceptual Framework in Qualitative Health Research. *Qualitative health Research*, 22(5), pp. 607–618.

Mache, S. et al. 2009. Physicians' working conditions and job satisfaction: does hospital ownership in Germany make a difference? *BMC Health Services Research*, 9, 148.

McKee, M., Edwards, N., & Atun, R. (2006). Public-private partnerships for hospitals. *Bulletin of the World Health Organization*, 84(11), pp. 890–896.

McQuaid, R.W. 2000. Theory of partnership: why have partnerships? In: S.P. Osborne, ed. *Public-Private Partnerships. Theory and practice in international perspective*. London: Routledge, pp. 9–35.

Meriläinen, R. 2008. Tutkimukset poliittisessa päätöksenteossa. In: K. Lempiäinen, O. Löytty, M. Kinnunen, eds. *Tutkijan kirja*. Tampere: Vastapaino, pp. 125–138.

Middtun, L. & Haagen, T.P. 2006. The private–public mix of healthcare: evidence from a decentralised NHS country. *Health Economics, Policy and Law*, 1(3), pp. 277–298.

Mikkola, H. 2009. *Toimiiko kilpailu lääkäripalveluissa?* Sastamala: Kunnallisalan kehittämissäätiö.

Milestapping, C. 1992. Caring for profit: alienation and work stress in nursing assistants in Canada. *Work & Stress*, 6(1), 3–12.

Ministry of Social Affairs and Health. 2012. *Sosiaali- ja terveyspalveluiden kilpailuttamisen toimivuus*. Helsinki: Ministry of Social Affairs and Health.

Mur-Veeman, I., Hardy, B., Steenbergen, M. & Wistow, G. 2003. Development of integrated care in England and the Netherlands: Managing across public-private boundaries. *Health Policy*, 65(3), pp. 227–241.

Myllymäki, K. Elonheimo, O. Linna, M. 2011. Oman ja ulkoistetun terveysaseman palveluntuotannossa eroa Kouvolassa. *Suomen Lääkärilehti*, 66(13), pp. 1103–1111.

Nelson, J.C. et al., 1999. Public/private partners. Key factors in creating a strategic alliance for community health. ***American Journal of Preventive Medicine***, 16(3 Suppl), pp. 94–102.

Newell, J. N. et al., 2004. Control of tuberculosis in an urban setting in Nepal: Public-private partnership. *Bulletin of the World Health Organization*, 82(2), pp. 92–98.

Niiranen, V. 2003. Kunnallisten sosiaalipalvelujen kilpailuttamisen sosiaalipoliittinen näkökulma. In: E. Ollila, M. Ilva & M. Koivusalo, eds. *Kilpailuttaminen sosiaali- ja terveyspolitiikan näkökulmasta*. Helsinki: National Research and Development Centre for Welfare and Health, pp. 69–78.

Noelker, L.S., Ejaz, F.K., Menne, H.L. & Bagaka's, J.G. 2009. Factors affecting frontline workers' satisfaction with supervision. *Journal of Aging & Health*, 21(1), pp. 85–101.

Noro, A., Finne-Soveri, H., Björkgren, M., Vähäkangas, P. 2005. I*kääntyneiden laitoshoidon laatu ja tuottavuus – RAI-järjestelmä vertailukehittämisessä*. Helsinki: National Research and Development Centre for Welfare and Health.

Nutt, P.C. 1999. Public-Private Differences and the Assessment of Alternatives for Decision Making. *Journal of Public Administration Research and Theory*, 9(2), pp. 305–349.

Ogbu, U.C. et al., 2010. Hospital Stroke Volume and Case-Fatality Revisited. *Medical Care*, 48(2), pp. 149–156.

Okko, P. et al., 2007. *Terveyspalveluiden hierarkiat ja markkinat*. Vammala: Kunnallisalan kehittämissäätiö.

Ollila, E., Ilva, M., Koivusalo, M., eds. 2003. *Kilpailuttaminen sosiaali- ja terveyspolitiikan näkökulmasta*. Helsinki: National Research and Development Centre for Welfare and Health.

O'Neill, C., Harrington, C., Kitchener, M. & Saliba, D. 2003. Quality of Care in Nursing Homes. An Analysis of Relationship Among Profit, Quality, and Ownership. *Medical Care*, 41(12), pp. 1318–1330.

Ouchi, W.G. 1979. A Conceptual Framework for the Design of Organizational Control Mechanisms. *Management Science*, 25(9), pp. 833–848.

Øvretveit, J. 2003. Nordic privatization and private healthcare. *International Journal of Health Planning and Management*, 18(3), pp. 233–246.

Øvretveit, J. 1996. Beyond the public private debate: the mixed economy of health. *Health Policy*, 35(1), pp. 75–93.

Pallesen, T. 2004. A political perspective on contracting out: the politics of good times. Experiences from Danish local governments. *Governance*, 17(4), pp. 573–587.

Parry, E., Kelliher, C. 2009. Voluntary sector responses to increased resourcing challenges. *Employee Relations*, 31(1), pp. 9–24.

Parry, E., Kelliher, C., Mills, T. & Tyson, S. 2005. Comparing HRM in the voluntary and public sectors. *Personnel Review*, 34(5), pp. 588–602.

Pekkarinen, L. 2007. The Relationship Between Work Stressors and Organizational Performance in Long-Term Care for Elderly Residents. Helsinki: National Research and Development Centre for Welfare and Health.

Perry, J.L., & Rainey, H.G. 1988. The Public-Private Distinction in Organizational Theory. A critique and research Strategy. *The Academy of Management Review*, 13(2), pp. 182–201.

Pierre, J. & Painter, M. 2010. Why legality cannot be contracted out: exploring the limits of New Public Management. In: M. Ramesh, E. Araral & X. Wu, eds. *Reasserting the Public in Public Services. New Public Management Reforms*. London: Routledge, pp. 49–62.

Pollitt, C., van Thiel, S. & Homburg, V., eds. 2000. *New Public Management in Europe. Adaptation and Alternatives*. Hampshire: Palgrave Macmillan.

Pollock, A.M. 2004. *NHS plc: the privatization of our health care*. London: Verso.

Poór, J., Karoliny, Z.S., Musztyné Bártfai, B.V., Pótó, Z.S. & Farkas, F. 2009. Similarities and differences of human resource management in private and public sector organizations in the light of new public management in international comparison. *Acta Oeconomica*, 59(2), pp. 179–206.

Poss, J.W., Hirdes, J.P., Fries, B.E., McKillop, I. & Chase, M. 2009. Validation of Resource Utilization Groups version III for home care (RUGIII/HC): Evidence from a Canadian home care jurisdiction. *Medical Care*, 46(4), pp. 380–387.

Rajala, T. Tammi, J. & Mecklin, P. 2008. *Kilpailuttamisen näkyvät ja näkymättömät kustannukset*. Vammala: Kunnallisalan kehittämissäätiö.

Rees, R. 1985. The Theory of Principal and Agent — Part I. *Bulletin of Economic Research*, 37(1), pp. 3–26.

Reich, M.R. 2002. Public-private partnerships for Public Health. In: M.R. Reich, ed. *Public-Private Partnerships for Public Health. Harvard Series on Population and International Health*. Cambridge: Harvard University Press.

Rein, M. & Schön, D. 1994. Frame-Critical Policy Analysis and Frame-Reflective Policy Practice. *The International Journal of Knowledge Transfer and Utilization*, 9(1), 85–104.

Ring, P.S. & Perry, J.L. 1985. Strategic Management in Public and private Organizations: Implications of Distinctive Contexts and Constraints. *Academy of Management Review*, 10(2), pp. 276–286.

Rissanen, S., Hujala, A. & Helisten, M. 2010. The state and future of social service enterprises – a Finnish case. *European Journal of Social Work*, 13(3), pp. 319–337.

Rushefsky, M.E. & Patel, K. 1998. *Politics, Power & Policy Making. The Case of health Care reform in the 1990s*. New York: M.E. Sharpe.

Rushton, S. and Williams, O.D., eds. 2011. *Partnerships and Foundations in Global Health Governance*. Basingstoke: Palgrave Macmillan.

Saltman, R.B., Calltorp, J. & de Roo, A. 2011. *Health sector innovation and partnership: policy responses to the new economic context. Background paper. OECD 50th Anniversary Conference on Health Reform: Meeting the challenge of ageing and multiple morbidities*. Paris 22.6.2011.

Saltman, R.B. 2003. Melting public-private boundaries in European health systems. *European Journal of Public Health*, 13(1), pp. 24–29.

Schwartz, J.B., & Bhushan, I. 2004. Improving immunization equity through a public-private partnership in Cambodia. *Bulletin of the World Health Organization*, 82(9), pp. 661–667.

Schmid, H., & Nirel, R. 2004. Ownership and Age in Nonprofit and For-Profit Home Care Organizations: What Makes the Difference? *Administration in Social Work*, 28(3-4), pp. 183–200.

Scott, P.G. & Falcone, S. 1998. Comparing Public and Private Organizations. An Exploratory Analysis of Three Frameworks. *American review of public administration*, 28(2), pp. 126–145.

Schön, D.A. & Rein, M. 1994. *Frame reflection. Towards the resolution of intractable policy controversies*. New York: Basic Books.

Sievänen, N., Rissanen, S. & Kaarakainen, M. 2010. *Lopettaneiden hoivayritysten teema-haastattelujen tutkimusraportti*. Kuopio: Itä-Suomen yliopisto.

Simon, P.A., & Fielding, J.E. 2006. Public health and business: A partnership that makes cents. *Health Affairs*, 25(4), pp. 1029–1039.

Sinervo, T. et al., 2010. *Yksityinen vai kunnallinen palveluasuminen? Kustannukset, asiakas-rakenne, hoidon laatu ja henkilöstön hyvinvointi*. Helsinki: Terveyden ja hyvinvoinnin laitos.

Sørensen, R. & Bay, A-H. 2002. Competitive Tendering in the Welfare State: Perceptions and Preferences among Local Politicians. *Scandinavian Political Studies*, 25(4), pp. 357–384.

Steinberg, P.J. 1999. Public and Private. *Political Studies*, XLVII, pp. 292–313.

Steijn, B., Klijn, E-H. & Edelenbos, J. 2011. Public-private partnerships: added value by organizational form or management? *Public Administration*, 89(4), pp. 1235–1252.

Stolt, R., Blomqvist, P. & Winblad, U. 2011. Privatization of social services: Quality differences in Swedish elderly care. *Social Science & Medicine*, 72(4), pp. 560–567.

Sullivan, H. & Skelcher, C. 2002. *Working across boundaries: collaboration in public services*. Hampshire: Palgrave Macmillan.

Tashakkori, A. & Teddlie, C. 1998. M*ixed Methodology. Combining Qualitative and Quantitative Approaches*. Thousand Oaks: Sage.

Tomlinson, F. 2005. Idealistic and Pragmatic Versions of the Discourse of Partnership. *Organization Studies*, 26(8), pp. 1169–1188.

Tynkkynen, L-K. et al., 2012. Integrating public and private home care services: the Kotitori model in Tampere, Finland. *Journal of Integrated Care*, 20(5), pp. 284–295.

United Nations. 2010. *United Nations Global Compact Annual Review – Anniversary edition*. New York: United Nations Global Compact Office.

Vaara, A. & Mikkola, H. 2012. Terveysaseman ulkoistamisen haasteet ja riskien hallinta. *Suomen Lääkärilehti*, 67(32), pp. 2143–2146.

Vaillancourt Rosenau, P.V., & Linder, S.H. 2003. Two Decades of Research Comparing For-Profit and Nonprofit Health Provider Performance in the United States. *Social Science Quarterly*, 84(2), pp. 219–241.

Vaillancourt Rosenau 2000. *Public-Private Policy Partnerships*. Massachusetts: MIT Press.

Vaillancourt Rosenau, P. 1999. The Strengths and Weaknesses of Public-Private Policy Partnerships. *American Behavioral Scientist*, 43(1), pp. 10–34.

Vining, A.R. & Globerman, S. 1999. Contracting-out health care services: a conceptual framework. *Health Policy*, 46(2), pp. 77–96.

Vohlonen, I. Komulainen, M. & Vehviläinen, A. 2010. Ulkoistetun avosairaanhoidon toimivuus ja tulokset Kouvolassa. *Suomen Lääkärilehti*, 65(9), pp. 817–827.

Vrangbaek, K. 2008. Public-private partnerships in the health sector: The Danish experience. *Health Economics, Policy, & Law*, 3(Pt 2), pp. 141–163.

Warner, M.E. Reversing privatization, rebalancing government reform: Market, deliberation and planning. *Policy and Society*, 27(2), pp. 163–174.

Weihe, G. 2010. Towards a process perspective on public-private partnerships. In: G.A. Hodge, C. Greve & A.E. Boardman, eds. I*nternational Handbook of Public-Private Partnerships*. Northampton: Edward Elgar, pp. 510–525.

Weihe, G. 2008. Public-Private Partnerships and Public-Private Value Trade-Offs. *Public Money and Management*, 28(3), pp. 153–158.

Weihe, G. 2005. *Public-Private Partnerships: Addressing a nebulous Concept*. Working Paper no. 16. Copenhagen: International Centre for Business and Politics, Copenhagen Business School.

Weintraub, J. 1997. The Theory and Politics of the Public/private Distinction. In: J. Weintraub & K. Kumar, eds. *Public and Private in Thought and Practice*. Chicago: The University of Chicago Press, pp. 1–42.

Wettenhall R. 2010. Mixes and partnerships through time. In: G.A. Hodge, C. Greve & A.E. Boardman, eds. *International Handbook of Public-Private Partnerships*. Northampton: Edward Elgar, pp. 17–42.

Wettenhall, R. 2003a. The rhetoric and reality of public-private partnerships. *Public Organization Review*, 3(1), pp. 77–107.

Wettenhall, R. 2003b. Three-Way Categorisations, Hybrids and Intersectorsal Mixes in the Governance Equation. *Asian Journal of Public Administration*, 25(1), pp. 57–86.

Widdus, R. 2001. Public-private partnerships for health: Their main targets, their diversity, and their future directions. *Bulletin of the World Health Organization*, 79(8), pp. 713–720.

Williamson, O. 1975. *Markets and hierarchies: Analysis and anti trust implications*. New York: The Free Press.

Wolfe, A. 1997. Public and Private in Theory and Practice: Some Implications of an Uncertain Boundary. In: J. Weintraub & K. Kumar, eds. *Public and Private in Thought and Practice*. Chicago: The University of Chicago Press, pp. 1–42.

Yung, A. et al., 2005. Public and private psychiatry: can they work together and is it worth an effort? *Australian and New Zealand Journal of Psychiatry* 39(1–2), pp. 67–73.

Yung, A. & Grigg, M. 2000. Developing partnerhips between public and private psychiatry. *Australasian Psychiatry*, 8(4), pp. 332–335.

6, P. 1994. Introduction. In: P. 6 & I. Vidal, eds. *Delivering welfare, Repositioning non-profit and co-operative action in western European welfare states*. Barcelona: Centre d'Iniciatives de l'Economia Social (CIES), pp. 1–17.

Original publications