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What are the consequences of outsourcing on organizational performance in municipal care services?

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Summary.

Research problem and background

Public sector in Norway experiences a rapid growth, which partly is explained by increased demand for public goods and services as a result of a higher level of welfare. Especially healthcare sector will experience such a pressure in years to come. If today's standard and care needs are maintained, a need for employment in the nursing and healthcare sector is expected to double from the current level by year 2050. At the same time, it is expected that the need for number of man-years will increase for nearly 200 percent for institutions and about 70 percent of home care services.¹ In case the growing service needs will not be met with a corresponding increase in employment, government should take measures to enhance productivity in services, at the same time preserve, and strengthen the competence of employees. An efficient and high qualitative service system with optimal resource utilization should be one of the most important governmental ambitions.

This paper discussed the growing trend in Norwegian public sector to outsource public services, which, however, is to a lesser degree common in healthcare and nursing sector. The paper has a following problem formulation:

What are the consequences of outsourcing on organizational performance in municipal care services?

Method

For the research, two organizations within the same municipality have been chosen for the analysis in order to find out whether form of ownership has an impact on organizational effectiveness and efficiency. The study is designed as a qualitative one, based on seven in-depth interviews with employees on different organizational levels. This helped to consider the question on several levels: on a level of municipal authority, on a management level in the organizations, and on a level of first line employees.

Several documents, such as FAFO-rapports and relevant legal acts were used as tertiary source of data in order to refute\confirm the findings.

Results

Effectiveness and efficiency of organizations operating in different sectors turned out to be challenging to measure and compare first and foremost due to the lack of common systems of

¹<http://www.med.uio.no/for-ansatte/aktuelt/horinger/dokumenter/utkast-stort-program-gode-og-effektive-tjenester.pdf>, p. 14, accessed on 31.05.2015

measurement indicators. Both organizations are occupied with efficiency and quality of their performance but they seem to use different work practices to achieve them.

The public organization uses instruments such as reinforced top-down control over work routines and time management tightening. The informants from the public sector experience that they are being more controlled and less trusted. This is quite an unfortunate development, since employees don't feel they have any freedom and decision authority over one's own work routines, which in worst case can lead to the feeling of disempowerment.

FAFO rapport (2013) detected that internal processes in private organization are typically characterized by more flexibility, and that "there is a shorter distance between an idea and action".

Our study revealed, that there is indeed more flexibility in the private organization, where employees feel free to come with suggestions about their own work practices and they have a feeling of being heard. The theoretical assumption about inherent flexibility of public sector proved true in the study, as there were much better prerequisites for dialogue, organizational learning and dialogue in the private organization than in the public. That is not to say that the public organization is less occupied with effectiveness, but it chooses to keep to old instruments of control and revealed less eagerness for innovation and change.

Conclusion

The study turned out to be partly consistent with the findings of previous researches that were revealed by the analysis of tertiary data, and partly discovered some patterns on its own. While FAFO-rapports didn't detect any particular variation among the organizations that could be traced to the form of ownership, our research revealed quite some differences when it comes to organizational performance and organizational behavior in the organizations across different sectors. Moreover, the reports draw a somewhat more negative picture of the consequences of outsourcing in Norwegian healthcare services, than what this study suggests.

However, we can not be sure that the detected differences can be explained by the change of ownership exclusively. We are careful with making a conclusion about what particular causes had a decisive impact on organizational performance; since most likely it was not a single, but rather a combination of different factors. However, we think that even though the current study didn't result into some unambiguous conclusion about consequences of outsourcing on organizational performance, it revealed some curious patterns on its own and can give a good starting point for more laborious research on this topic and a closer investigation of possibility for causality between organizational performance and a form of ownership.

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Chapter 1 – Introduction and theme formulation.

1.1 Background of the Problem.

This paper focuses on growing tendency in Norwegian municipalities to outsource municipal services to private contractors, which is done either by a simple process of contracting out or by putting services out to tender.

Different goals might be pursued when a municipality decides to outsource its services. First of all it can be connected to desire to cut cost through adopting innovative policies to achieve a better balance between foreseeable growth in citizen demand for services and ability of a government to provide these services. In other words, public sector meets some pressure for greater efficiency as the result of predicted demand growth. Second of all, it has been claimed that adapting polities of outsourcing will allow for a better quality level of the services, as state will lose its monopoly as a service provider, and competition will create a motivation to perform quality results among competitors. The next reason behind outsourcing might be that instead of building up its own competence, local governments want to borrow and use knowledge and experiences that already exist in private sector. That explains the active use of outsourcing in certain sectors – for example technical or financial sector. Last but not least, an idea to outsource might be not as much administrative as political initiative.

The number of municipalities in Norway that choose outsourcing has grown rapidly from 2004 when the number was 50 % to comprising eight out of ten municipalities in 2012.² However, it doesn't apply for all range of municipal services. Typical services to outsource are: renovation, cleaning, road-building, maintenance and other technical services. Moreover, surveys indicate an expected considerable further growth in the number of municipalities that expose tasks and services to competition or introduce various marked based mechanisms in order to outsource.³

²Arbeidslivet.no. «Konkurranseutsetting vil trolig øke i omfang». <http://www.arbeidslivet.no/Velferd/Konkurranseutsetting/Konkurranseutsetting-vil-trolig-oke-i-omfang/>, accessed on 03.03.2015

³NIBR-rapport 2012:21. https://www.regjeringen.no/globalassets/upload/krd/rapporter/rapporter_2012/2012-21.pdf, accessed on 03.03.2015

Apparent rapid growth in municipal privatization indicates that the experiences are mostly positive. Indeed, privatization might work well as an instrument to address some issues in it was supposed to resolve in the first place (see previous paragraph).

The number of different municipal services that during last years have been privatized is big and they are so essentially different, that it is not possible to make general conclusions and sum up experience of organizations that are placed in different sectors and provide different types of services.

It seems that out of all there is one type of organizations that stand apart – those that provide services within health and care sector. We see a striking difference when it comes to outsourcing of healthcare services. According to FAFO-rapport “Konkurransetsetting vil trolig øke i omfang”, while the percentage of privatized organizations grows in most sectors, only 15 % of all municipalities (numbers for 2013) outsource services which are grouped under the category “nursery schools, institutional health care of home based health care”⁴. Health and care services had been subject to privatization to much lesser extent than other types of municipal services. This can be explained by several facts – among other things a particular place health and care takes in public sectors activities (this topic will be elaborated on in chapter 2).

The choice of research topic of this paper can be explained by the fact that we think privatization of municipal health and care services and impact it might have on organizational performance deserves a separate and independent research. One of the latest big analyses was performed by FAFO in 2013, and it groups health and care together with nursery schools. It states: «Kun 15 prosent av kommunene hadde konkurranseutsatt barnehager, institusjonsbasert pleie og omsorg og pleie og bistand i hjemmet». Two conclusions can be drawn from such formulation used in the rapport:

- 1) for some reasons it was considered that health and care services are comparable with preschool services,

and if not, then
- 2) the actual amount of outsourced healthcare services is even lower than 15%.

⁴Arbeidslivet.no. «Konkurransetsetting vil trolig øke i omfang».
<http://www.arbeidslivet.no/Velferd/Konkurransetsetting/Konkurransetsetting-vil-trolig-oke-i-omfang/>,
accessed on 03.03.2015

1.2 Statement of the Problem

Outsourcing (privatization) of municipal services was intended first and foremost to achieve better cost efficiency as well as quality improvement of performed services. This paper tries to find out what transformations take place in organizations that perform municipal health and care services after they have been outsourced. At the same time it seeks to fill an existing gap in knowledge when it comes to outsourcing within health and care services and the consequences of such outsourcing.

The research was further limited to home based care and nursing services.

Extensive provision of home based health care services is a form of welfare good that traditionally distinguishes Nordic countries from the rest of the Europe (Kautto: 2000).

Home based health care as a statutory service attained rapid development from being a quite small element to taking quite a central position in public health care. This role is expected to remain growing because of predicted aging of population. Home-based care is only one of many sub components of broad range of existing governmental public health services. A sub component that has particular characteristics because of its intermediate position – home care is typically provided for groups of population who presumably after some time will become users of different kind of services - *residential* care - that is nursing homes, rest home, care home. Residential care is separated and is provided by different organizations in public sector, which puts home based care organizations in position of dependency. In case public residential care institutions are to experience some challenges in future, a consequence would be an increased pressure on home based care services and its capacities (that is if hypothetically government will not be able to provide a sufficient number of spots in institutional care institutions). This would effectively mean that those patients will remain service users of home based care services, which would only put even more pressure the latter.

Considering those concerns, the following problem formulation has been stated:

What are the consequences of outsourcing on organizational performance in municipal care services?

Organizational performance is understood as its productivity – the way how services and goods are being produced. Although, mostly used in industry, the term “productivity” can also be applied to organizations in public sector. The term is discussed in more detail in

chapter 2.5, and more specifically – in the *Performance triangle*-model developed by Floriúteanus, where productivity is used as a collective term that includes both organizational effectiveness and efficiency and can be applicable to both public and private sector. Our understanding of organizational performance stems from the following definition: “[Organizational] performance is the result of the simultaneous pursuit of efficiency, effectiveness and a corresponding budget” (Profiroiu M., 2001: 8, cited in Mihaiu et al., 2010:138)

By stating the research question in such a way one wants to find out what kinds of mechanisms within the organizations does outsourcing trigger and whether we can observe some transformations either in the way workdays are organized, in the overall principles that determine work performance or simply among employees attitudes and their perception of their own workplace.

In order to better approach the problem statement, the following sub questions were posed:

- In which terms do organizations in different sectors define productivity and which instruments do they use to achieve effectiveness?
- How can effectiveness be measured?
- what determines efficiency in home-based care services?
- What impact can outsourcing have on the processes within the organization?
- What impact can outsourcing have on organizational culture?

1.3 Applicability and purpose of the study.

The existing literature on municipal outsourcing in Norway is not complete. Little attention had been paid to privatization within health and care services and the paper seeks to partly fill this gap. Moreover, by approaching the chosen topic from the perspective of organizational performance among municipal service providers this study wants to address some of the challenges the municipalities are facing in the way health and care service delivery is organized today.

An important assumption of this paper has been that experiences from other areas can only partly be transferred to health and care sector. While privatization in for example technical or financial sector can be curious and beneficial in the analysis of general privatization trend in Norway as a consequence of spread of New Public management paradigm in public administration, those experiences can barely be transferred to other sectors, which demand a research of their own.

1.4 Research delimitations.

The chosen subject of privatization of municipal services is a broad topic, but in this paper has been limited to privatization of health and care services. Further, we decided to limit research to home based health care. Two organizations within same municipality have been picked out in order to perform a comparative analysis.

The study has been carried out in such a way, that some aspects were NOT included in the research.

- 1) We have focused on organizational performance as perceived by employees in respective organizations. Even though we also use the terms effectiveness and efficiency, those terms are not considered from the perspective of corporate economics. It means that this study does not include detailed cost calculations, but rather presents employees own reflections around their work place.
- 2) In chapter 2 we briefly mention different reasons and prerequisites can stand behind the idea to outsource. Among other things, privatization can be introduced either as a measure to improve municipality's economic situation, or it can be an adaptation to a popular trend. However, in some cases, all those reasons aside, the privatization can appear first and foremost as a *politically driven* initiative.

The political aspect will be omitted from the study, and we have looked at privatization purely as a managerial, and not a political tool.

1.5 Definition of terms.

Public sector can be organized in several forms, where we can distinguish:

- 1) Direct administration – when all the production decisions belong to government, which is typically funded through taxation. Services are wholly provided and delivered by government.
- 2) Partial outsourcing – (also called out-tasking) implies that specific tasks are provided by external service providers.
- 3) Complete outsourcing - (also called contracting out) implies that delivering the entire service is outsourced to privately owned organization, although which it still provides on behalf of government.

All three forms are similar in a sense that it is government that has an overall responsibility for the delivery of services and its quality. A further step after complete outsourcing would be

privatization, which would mean that government is no longer liable for the service and in a very clear sense means a sale of municipal enterprise.

This case is of no interest and will not be included in further analysis. In Norway there are some private home care organizations, but they provide services alternatively to government and not on instead of government.

Norwegian language suggests a wide range of terms when referred to complete outsourcing. It is important to make clear what exact meaning is put into definitions we use further on in the paper.

Contracting-out (without tender) – (nor: **driftsutsetting**) – municipality hand control of public service over to private company which takes over the *responsibility of operation*, while a municipality remains having an overall control and responsibility (i.e. defining services and its recipients, financing, control and quality assurance).

Contracting-out with the use of **competitive tenders** (nor: **konkurranseutsetting**) – the same as contracting-out, but happens through competitive bidding, allowing companies to compete for the right to run services for a fixed number of years. Competition might take place within one sector i.e. between two or more private companies as well as across sectors, i.e. when municipal departments or offices can bid for a contract against private-sector companies.

It is curious that the word privatization (privatisering) is often used in this context in Norwegian language to stand for outsourcing. In this case it doesn't define privatization in its clear definitions, but stands for privatization of *operational responsibility*.

The words *privatization* and *outsourcing* will be interchangeably used further on in this paper, defining transfer of operational responsibility from public to private sector.

Following terms will be mentioned in the paper:

Activity-based funding (ABF) – is a form of result-based financing, when cash or material goods transfer from the government is proportional to the amount of performed work measured quantitatively (amount of hours, number of patients).

Block funding – an institution\organization receives a fixed amount of funding annually.

Other terms will be explained in the text as they will be introduced.

1.6 Structure of the paper.

Chapter 1 presented the background for the study, and provided for the choice of topic, problem formulation and research questions. In chapter 2 the central concepts are presented and discussed, relevant theoretical contributions are mentioned, forming a theoretical framework for the paper. Chapter 3 advocates for the choice of research method, presents an interactive model of research design and discusses it with reference to the notions of reliability, internal and external validity. Chapter 4 presents empirical findings according to the theoretical contributions, which are then summarized along the research questions. Tertiary data in a form of FAFO report (2013) is analyzed in order to have an insight into previous research. Chapter 5 Discussion presents some general reflections on the subject, specifics of work in home-based services and the consequences of recent reforms, changes and tendencies in the sphere of public administration. Conclusions are briefly presented in Chapter 6. Chapter 7 touches upon possibilities for future work and research.

Chapter 2 - Theory.

Blaikie underlines, that the use of theory in academic paper is not a goal in itself, but an instrument with which information can be better presented and analyzed; he says that theory is of value in empirical science only to the extent to which it connects fruitfully with the empirical world. Concepts are the means, and the only means of establishing such connections” (Blaikie, 2010:chapter 5)

We think it can be explained by two facts. First of all no theory is universal. Meaning that theory can not give us a final picture or a complete explanation of how things are. Rather, it is an instrument that allows to understand /analyze situation /information /phenomenon in a particular way. Consequently, it means that the same event can be understood in slightly different ways, if analyzed from different theoretical standpoints.

And second of all, theoretical knowledge is not steadfast but dynamic, which means it at all time develops as new relevant knowledge evolves. And this is applicable for all spheres and industries.

Canadian psychologist Donald O. Hebb sums it up the following way:

“A good theory is a theory that holds together long enough to get you to a better theory”.

When it comes to writing an academic paper like master thesis one can hardly say that the theory was chosen rightly or wrongly, but rather we can say if theory to a bigger or to a lesser degree is appropriate to address a particular chosen topic. We can conclude that a theory is a framework for understanding a chosen phenomenon.

2.1 Public sector’s role.

Norway is a clear example of what we refer to as universal welfare state model.

Welfare state is a concept that developed in European countries (and later in the USA) and had an objective to secure society's desires for economic prosperity and social security in after war times. In other words, a government undertakes a task to provide different social programmes that are intended to cover basic human needs – education, child allowance, health insurance, child care, old-age pensions, unemployment insurance etc, which is based on a principle of redistribution of wealth in the society.

Opposite to universal welfare model is a selective (targeted) welfare model, when the social programmes are targeted for the poor and recipients in need. A clear example of selective welfare model is USA, where social benefits have a character of short term cash

assistance and people who apply for them are being means tested. As a result, USA spends less on social programmes than any other democratic country. Norway, on the other hand, tops a list when it comes to welfare expenditures per capita and spends about twice as much as a percentage of GDP on social insurance and social assistance than the United States. That can be explained by the normative logic behind universal welfare model. Rothstein (1994:41) sums up the moral principle of universal welfare state the following way:

“If burdens are to be shared (such as taxes), and benefits are to be distributed (such as health care), they should be divided equally“.

In other words, in a government in universalistic welfare state there is a principle of equality of *highest standards*, and not equality of minimal needs for the poorest of the working class.

Such premises mean that the number of organizations within the public sector in Norway is substantial in comparison to other countries and it sets particular expectations towards organizational performance and quality of service delivery.

2.2 Public sector expansion.

Sørensen (2009) discussed the substantial role of Norwegian public sector, and argues that public spending will supposedly experience growth in years to come. He explains it by several factors. First of all he mentions Wagners law, which states that growing economy goes side by side with increase in citizens' demand for public services. It results in growth of public sector. Second of all, Sørensen refers to Baumol's cost disease. Baumol discusses the difference when it comes to production of manufactured commodities (i.e. private sector) versus production of services (i.e. public sector). He introduces the term productivity and claims that productivity tends to increase quite rapidly for manufactured goods and increases somewhat slower (if at all) for services. At the same time, to be able to compete for labor force, wage should increase in equal measure across sectors. And when that happens it leads to a result when services become more costly over time. Researches show that around 20-30% of public expenditures grows in recent years (as a part of GDP) can be explained by Baumol's cost disease. (Borcherding 1985, Borge and Rattsø 2002, cited in Sørensen 2009) At last, Sørensen points to demographic changes such as predicted ageing of population and female participation in the labor market, which results in the fact that many of the tasks that were previously taken care of within a family (such as child and elderly care) now become a task for public sector. We experience so called professionalization of care.

2.3 Growing expectations towards public sector.

Academic Julian Le Grant (2003) assumes the tendency that people's expectation towards public sector might grow in years to come. He explains it by several factor:

- 1) Since the postwar years amount of people with higher education has grown rapidly, and those people tend to have a different attitude toward «expert knowledge», allowing for more questioning and skepticism towards it.
- 2) People expect public sector to become more customer-centric, they seek to receive more personalized experience from public sector services. And one of the ways to gain a better understanding of customer needs is to create multiple delivery channels and give citizens the opportunity to themselves chose a provider.

One of the questions we are posing in this regard is whether outsourcing to the private sector or/and a transition of organization from public to private sector measures up to such expectations for more service-orientation and active user involvement.

2.4 New Public Management.

Both growing expectations towards public sector and its assumable expansion presented a challenge; since public sector is simply becoming “too heavy” - the number of performed services is growing as well as the size of population is in need of those services. It could possibly be resolved by reversing the further expansion of public sector by decreasing the variety of performed services. In other words, by starting providing less services, possibly delegating some of the tasks to other sectors – to volunteer organizations, families (for example by providing cash vouchers). But this option seems quite unlikely to be suitable for welfare state model which is universal to such an extend as it is in Norway. The second option can be to reconsider the ways public sector is managed and that governmental performance had to be sufficiently improved– it is simply unjustifiable if it is run cost-inefficiently.

The rise of New Public Management, which started in the late 80s and still gains popularity today might by some people be referred to as a manifestation of new global paradigm in public administration. This paradigm claims universality in theory and political neutrality. Indeed, history shows rapid spreading of NPM-inspired ideas across countries. Røvik's theory of translation of ideas (2007) can be used to understand how reform programs first appeared in New-Zealand and Australia, and were later transferred, or “translated” to be later applied to the European context.

The very word paradigm stays for quite broad concept that allows for some diversity and possibility for differences in implementation when it comes to different countries it has

been adapted within. Hood puts it like this: “It does not necessarily follow that administrative reforms were undertaken for the same reasons or will automatically have the same results in different countries.» (Hood, 1995:109). In other words, while it would be misleading to say that NPM is a universal concept, it doesn't affect the concept's applicability, which still can – although with certain modifications – be applied for various countries.

NPM is a logic that stands behind management practice. The basic idea is that public and private sectors traditionally use different instruments to achieve their respective objectives. Public sector is to a bigger extend dominated by task distribution, hierarchy, bureaucracy, lack of flexibility and performing tasks using established routines. Private sector on the other hand, exists independently from the government (except from being regulated by it) and is much more flexible as well as it is profit-oriented. The underlying idea behind NPM is to blot out the line between two sectors and to rethink what constitutes the role of public administration. It is assumed that traditional bureaucratic management model worked well in its time, but the time has changed and governments to a bigger extend have to adapt to new challenges as well as response to signals and expectations coming from the outside. Public sector could function better if it borrows and tries to apply some of the principles that dominate in private sector. Governments should run like a business, introducing marked mechanisms that can add more dynamics to service production and result in more effectiveness, more efficiency and create a motivation among organizations to deliver a service not only of sufficient – but of a better – quality.

An important dimension of NPM is a revised focus on service users. By applying to them the term “customer”, NPM reforms reconsider the very relationship between service provider and service user.

One curious aspect is worth mentioning, which comes along with this new understanding of governmental service provision mechanism. It has been noted that universal welfare state secures users equality of highest standards. It means that the government grants citizens the right of equal access to diverse welfare services. Applying the term *customer* leads to somewhat ambiguous result. On one hand, it is fair to say that it gives users more *empowerment*. But on the other hand, the role of *customer* is more limited than the role of *citizen*, because the underlying and fundamental democratic trusteeship is weakened.

In the light of the assumption of New Public Management about the inherent differences when it comes to organizational norms and performance of organizations in different sectors (where public sector is characterized by task distribution, hierarchy, lack of flexibility and established routines as opposed to private organizations that are much more flexible, profit-oriented and efficient), our research ambition seems particularly curious as we want to capture the very transformation and see what processes are being triggered as a result of outsourcing and in the moment of transition.

2.4.1. Introduction of principle of user choice (brukervalg) as a way to strengthen user orientation of home-based services.

Experiences show how NPM indirectly praises private sector and in many cases suggests privatization as a way to lessen the load of service provision of the government. However, government service provision that is **statutory** can not be a subject of privatization⁵.

Since 1984 home-based care and nursing in Norway has become a statutory service and that's why can not be privatized, i. e. municipality always carries the overall responsibility that the right home care services are provided for the right patients, and this responsibility can not be taken away and moved into public sector. Instead, a principle of user choice can be introduced which in theory means that several organizations compete and service user himself chooses what organization he wants to receive a service from. This presupposes that responsibility to *produce* services can be delegated from municipalities to other organizations, including private. And that is what within healthcare sector would be called privatization (for detailed clarifications of terms see chapter 1.5).

2.4.2 Principal-agent theory.

One of the reform methods within public administration implied the demarcation of the implementation function and policy making function, which in literature is referred to as Agent theory, Principal-agent theory or simply agentification. The theory means establishing of two independent unities/agencies that are connected by a relationship of dependency. In the public sector the role of the principal can be enacted by the government at any level, who becomes the public contracting authority that buys public services from the agent. The agent in this case can be any external body or a semi-autonomous organ which is a part of the public sector. The relationship between principal and agent are somewhat asymmetric, where agent has a subordinate position, because it is supposed to follow principal's instructions (typically, contractually agreed). Principal, on the other hand, is completely dependent on actions of an agent, over whom he has a control authority. According to the theory, principal and agent may have somewhat conflicting interests, since they typically pursue different goals. However, one of the advantages of principal-agent separations is responsibility clarification between different agencies, which first and foremost is supposed to lead to a better pursuance.

⁵(see: brochure «Brukervalg i kommunal tjenesteyting», developed by Deloitte).

2.4.3 Purchaser-provider split

A variant of principal-agent theory in practice is a formal organizational separation of policy and delivery agencies in health and care sector, or so called purchaser-provider model, which is an important prerequisite if a municipality chooses to adapt a principle of user choice. Purchaser-provider split leads to establishment of “purchaser organizations” separately from “provider organizations”, which draws a line between municipal administrative tasks to secure services on one side, and actual service production on the other.

Two aspects made this separation necessary:

- 1) To secure that municipality is impartial when it comes to service procurement, its control and follow-up work.
- 2) To secure that mapping and evaluation of users' needs happens independently and patients receive the help they need, and not the help that operating organizations would choose to provide exclusively on the basis of their capacities and the resources available.

In addition, purchaser-provider split secures that in a situation of potential competition municipal and private organizations operate under equal conditions.

Besides New Public Management, other outer factors and expectations towards healthcare were the driving force behind the model:

- 1) increased service users' participation,
- 2) quality precept from 1997.

Schematically, the Purchaser-provider split looks the following way:

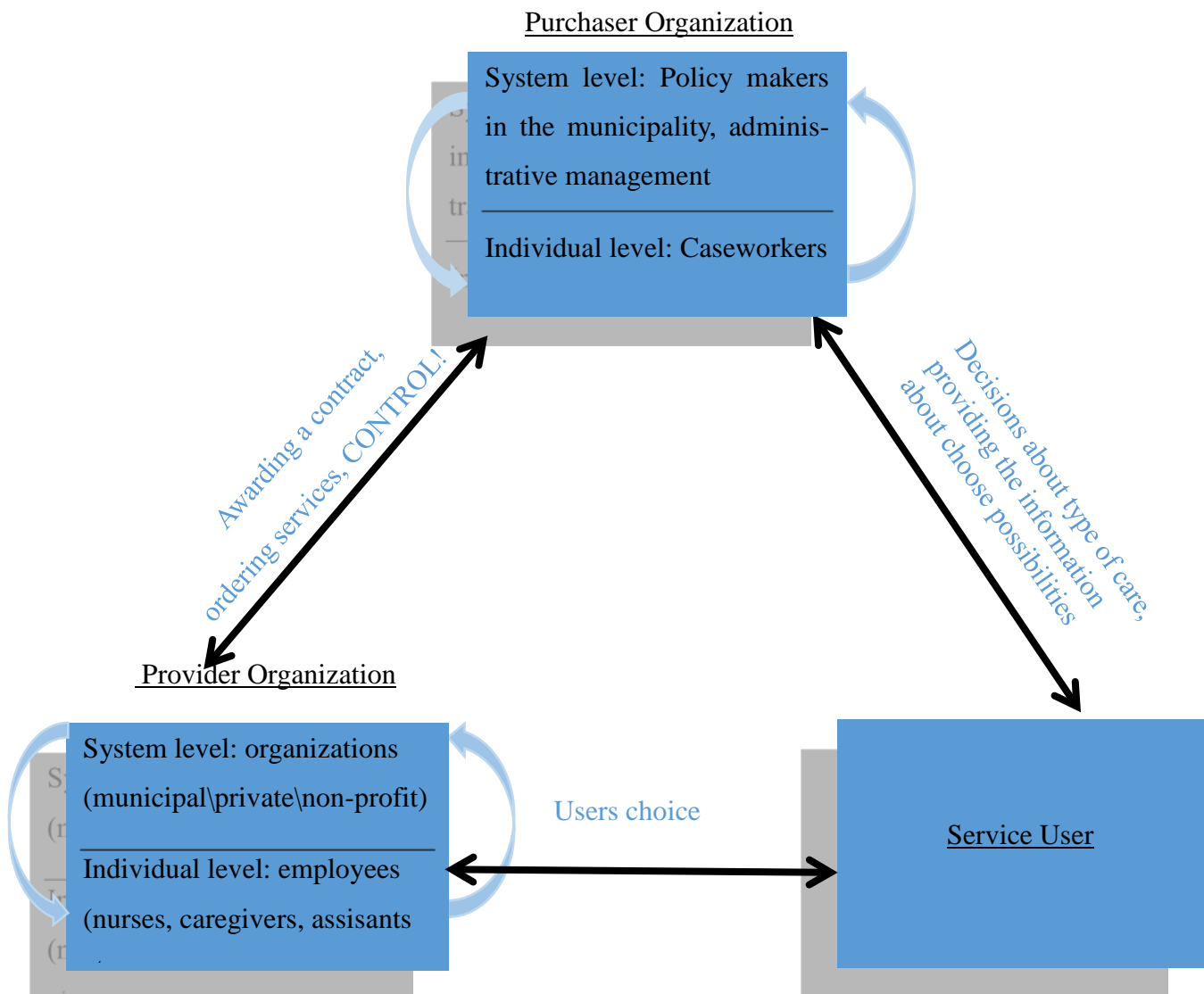


Figure 1

Purchaser organization is responsible to define what kinds of services need to be performed, set quality level and define service recipients. Purchaser organizations also function as “service office”, which patients can address if they have some questions, comments or requests. They also have controlling authority over provider organizations. Provider organization, on the other hand, is responsible for delivering the service according to the care plan. Provider organizations can be either municipal, private commercial or non-profit organizations. In our case all three types of organizations are represented in the chosen municipality.

Practical implications of the model are:

- Distribution of tasks and responsibilities,
- Clarification of services and their qualities
- Concentration of competencies

- Complete documentation on definition and execution of services, registered electronically in a form of mini-contracts between a purchaser and a provider.

From the figure 1 we see how separation between management and production happens at two levels – system and individual – in both purchaser and provider organizations.

Meanwhile the model clearly pursues some aims and objectives, it can as well result in some complicacy, as it requires not only close coordination between its different elements, but also close coordination between two levels **within** each organization. Moreover, we see asymmetry of information, which is typical between principal and agent, where principal (purchaser) has a decision making authority about what kind of services should be provided, although it is the agent (provider) who communicates with and has a close contact with service users.

This model (purchaser-provider split) is quite central for our study, where the two organizations picked out or the analysis play a role of providers, who share the same purchaser.

We are going to talk about the model and what implications it might have in municipalities of different geographic location and size, together with possible advantages and challenges, in more detail in chapter **5 Discussion**.

2.5 Effectiveness and efficiency as the main indicators of organizational performance.

Effectiveness and efficiency are two central terms used in measuring and assessing the organizational performance (Mouzas, 2006). Both define actions of organization, allowing to categorize them either as effective/ineffective or efficient/inefficient. Those two terms are often used in the literature and at times inconsistently. However, they have their own distinct meaning. Illustrative definitions are given by Drucker (1977), who defines effectiveness as «doing the right thing», and efficiency as «doing things right».

The triangle of the performance.

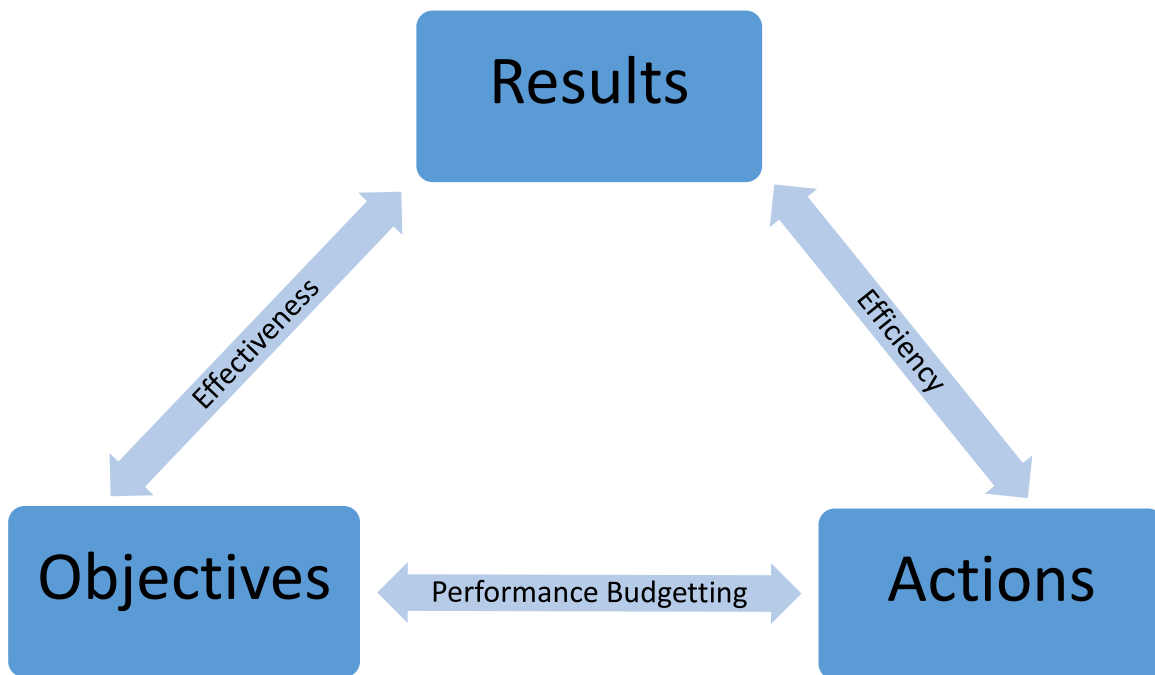


Figure 2 (Model by Floriúteanus, cited in Mihaiu et al., 2010)

Effectiveness tells about whether the policy objectives of organization are achieved. In simple words, organization is effective to the degree to which it manages to achieve its goals (Asmild et al., 2007). Efficiency, on the other hand, is about achieving maximizing results of an action in relation to the efforts or resources used. In Durker's words: a measure of efficiency assesses organization's ability to attain some outputs with the minimum level of inputs (Drucker, 1977).

Figure 2 schematically sums up the elements that form the overall performance of an organization. According to this model, effectiveness connects final results in relation to the initial objectives of organization. And efficiency connects results with the particular actions an organization has to undertake to achieve them.

It is possible for organization to be efficient, but not effective; it can also be effective, but not efficient. An example of efficient but not effective organization providing home based care services can be the one which manages to work within budget, where employees don't work overtime, but the patients don't receive the needed help (or the quality is much lower than expected). An organization that is effective but not efficient can be the one that works in

accordance with its main objectives, but doesn't manage to utilize resources in a smart way, which leads to growing expenditures over time.

Peter Drucker (2001) says there is no efficiency without effectiveness, because it is more important to do well what you have proposed (the effectiveness) than do well something else that was not necessarily concerned (Drucker, 2001: 147, cited in Mihaiu et al., 2010:136). The relationship between efficiency and effectiveness is that of a part to the whole, the effectiveness is a necessary condition to achieving efficiency.

The ways effectiveness and efficiency can be achieved varies across sectors and that is first and foremost due to the fact that the terms originally have different implications in different sectors. We can not allow full comparability of public and private sector, because they are not interchangeable because of the different objectives they pursue. The differences between the two sectors are put in a simple table (figure 3) which highlights some of particular aspects typical for each of them. However, how the second part of the figure shows, the distinction gradually becomes more diffuse.

| | | | |
|--|--|--|---|
| <p>Public sector organizations</p> | <p>Objectives pursued: obtain social benefits (ensure public welfare) citizens poorly informed funding available from government budget</p> | <p>Public sector organizations</p> | <p>Growing focus on economic side of performance, Better public-orientation More focus on efficiency</p> |
| <p>Private sector Organizations</p> | <p>Obtain economic benefits (aims for profit) active involvement of stakeholders, well informed are financed under its productivity</p> | <p>Private sector organizations</p> | <p>Growing concern for the social and environmental issues (introducing sustainable development policies, Corporate Social Responsibility principles)</p> |

Figure 3

Figure 3 is developed by me, but some important points were borrowed from the model

presented by Kotler & Lee (Kotler & Lee, 2008:18, cited in Mihaiu et al., 2010:133). It shows that one of the typical things for private sector is its dependence on its own financial sufficiency. That explains that the main objective of organization in the private sector would typically be to obtain some *economic* benefits – that is to be able to continue to operate, and – of course – to make a profit. Private sector organizations are, in addition, dependent on having a close communication with client and shareholders and keep them well informed. A consequence of these aspects is a strong focus organizations within private sector have on efficiency.

Public sector, on the other, is less dependent on efficiency, as the needed funding are usually available and are being received from government's budget, which it allocates so that public sector organizations are able to fulfill their purpose – to ensure public welfare (and in such a way to obtain *social* benefits). Provision of information to citizens is typically worse developed than in the private sector, because organizations don't receive any particular gain from it – so it would typically be up to citizens to find the needed information about services they have right to.

What happened in the second part of the figure, however, is that sectors nowadays begin to act more similarly and that the initial distinction gradually becomes more diffuse. In order to achieve a good reputation and survive in the market, private organizations nowadays start showing a growing concern with environmental and social issues (for example by adapting tendencies that go under the popular trends Corporate Social Responsibility and sustainable development). Public sector, on the other hand, reveals growing concern with the economic aspect of performance at the same time as organizations are becoming more public-oriented and service-oriented, – among other things as a consequence of NPM and the other prerequisites, briefly discussed in the previous chapters.

We claim that such a development indeed takes place, and sectors indeed become more alike, when they in practice “borrow” some characteristics typical for another sector, which potentially makes organizations within different sectors more similar. Nevertheless, several critics have questioned whether it is at all possible to transfer theories from the private market over the public sector, and the other way around, and whether it would give the expected effect (Christensen & Lægheid, 2002). Our research can partly contribute to clarification of this question.

2.5.1. What constitutes effectiveness in home-based services?

In marketing and economics service provision is defined as economic activity that does not result in ownership: it is a process that creates benefits by facilitating either a change in customers, a change in their physical possessions, or a change in their intangible assets. Service can be further defined the following way: “application of specialized competences through deeds, processes, and performance to benefit another” (Vargo & Lusch, 2004:3).

According to the Law of Municipal Health Services (§ 1-1 og § 1- 3) ⁶, home based health care is a statutory service, which means that a municipality has to provide each person living within the municipality with the necessary medical care and nursing in his home.

Figure 2 shows that organizational *effectiveness* connects the results in relation to the initial goals of organization. Effectiveness of home-based services thus connects the efforts made by organization with some final health outcomes for service users. Effectiveness of service provision is harder to evaluate (e.g. opposite to goods-provision) because outcomes are harder to quantify. But they are typically connected with the initial objective of home based services, that is: to maintain a quality of life, by promoting health, preventing disease, injuries or simply satisfy basic social needs. Some of measurement criteria can be amount of lives saved, life years gained, number of recoveries etc.

To be able to measure effectiveness one has to analyze whether actual interventions and use of resources (provided home-based care and nursing services) comply with the purpose of activity (care plan for service user). An important component of effectiveness is quality of performed services.

Besides general effectiveness, we can speak about **preferential effectiveness**, which says whether service provision optimally reflects local preferences and needs. For example, municipalities’ proximity to citizens gives them opportunities to ensure better compliance between the used resource and needs. The closer caregiver is to the patient, the more likely it is that the patient will receive the needed help faster.

2.5.2 What constitutes efficiency in home-based services?

While effectiveness connects resource inputs (such as budget estimate) and labor (employees at work) with *final* outcomes, which in home-based care is promoting health for

⁶See Loven om helsetjenester i kommunen: <https://lovdata.no/dokument/NL/lov/2011-06-24-30>, accessed on 31.05.2015

service users, efficiency would typically connect resource inputs with *intermediate* outputs, in the model marked as Actions (see Figure 2). Those intermediate outputs are somewhat easier to measure and can be expressed as concrete steps or actions that are undertaken by employees – for example, number of service users treated, number of home visits during one shift, total work time etc – in other words, the characteristics of actual performed work.

Economic theories suggest a lot of literature on efficiency and argue that aiming for greater efficiency from scarce resources should be a major criterion for setting priorities (Palmer & Torgersen, 1999).

Svensson (2008) distinguishes between two types of organizational resources. First is what he calls “organizational resources”, which includes not only technical equipment, but also a set of norms, rules, procedure descriptions and routines that determines how employees work with service users. The second type of resources is “professional resources”, which includes knowledge, experience and ethics guidelines that guide employees in their work when performed home-based nursing services.

Efficiency understood in socio-economic terms can be connected to Pareto-optimality, which, if reformulated in the context of home-based services, can sound as follows: When it is not possible to perform a better help to at least one service user without it going at expense of at least one another service user, i.e. it is not possible to improve a service for at least one user without it becoming worse for at least one other user.

For closer discussion on what constitutes efficiency in home care, several variants of the term efficiency should be named.

Technical efficiency looks at the relation between resources (efforts) and result. We can say that intervention is technically efficient when a set of resource inputs obtains the maximum result, while technical *inefficient* intervention means that the same (or greater) outcome could be produced with less of one type of input. For example if a service user can be treated with some amount of medicine but was prescribed a bigger dose than necessary, it would be technically inefficient. Another example can be a service user that has a wound that needs care. Employees would not need to visit service user and perform wound care 5 times a week, if 3 times would be sufficient.

It has been said that technical efficiency might be a lower priority due to the lack of competitive pressure (Currstine et al., 2007). I.e. public sector organizations can be said to be especially exposed to that.

Productive efficiency.

While technical efficiency says something about whether a particular resource/a single type of input was used optimally, productive efficiency looks at whether several types of inputs/resources/interventions were considered in order to find which one would lead to more efficient result. It means that whether a better results (possibly with different types of interventions) could be achieved at the same cost. Productive efficiency implies technical efficiency (Palmer & Torgersen, 1999).

Thus effectiveness considers if the use of resources (provided services) comply with the purpose of activity;

Preferential effectiveness considers if the right priorities has been taken into account while performing the service;

Technical efficiency addresses the issue of using *given* resources to maximum advantage;

Productive efficiency addresses the issue of choosing *different* combinations of resources to achieve the maximum health benefit for a given cost.

Inefficiency in this case can appear in case resources could be reallocated in such a way that it would increase the health outcomes produced.

2.5.3 From block funding to activity-based funding as a path towards more efficiency in healthcare sector.

As a way to improve efficiency of service provision within healthcare sector, the principle of activity-based funding was introduced. The common policy objective for this implementation is to create incentives for increasing efficiency, productivity and to achieve transparency in funding (Sutherland & Repin, 2012)

Activity-based funding model replaced so-called block funding, which implied that funders transfer a fixed amount to the provider annually, and that regardless of the accrued expenses. Typically this amount would reflect the **expected** cost the performance carries.

Under activity-based funding organizations no longer receive an operational budget in the beginning of the year, instead, they are financed on the basis of: 1) ordered services (by the purchaser) 2) actually performed services.

2.6 Chapter Summary

The theoretical contributions that were presented and analyzed constitute the basis for the future analysis of collected data and are summarized briefly in this section:

Public sector plays a central role in provision of social welfare in Norway, as Norway is a clear example of universalistic welfare state model. Moreover, there are some indications that the initially extensive public sector will experience even bigger expansion in years to come. The climate of opinion in the society develops in such a manner that citizens begin to have more expectations to public sector organizations, among other things calling in question expert knowledge and expecting more customer-orientation and higher level of involvement – perhaps as an outcome of higher level of education in the population in general.

New Public Management stands for series of reforms within public administration introduced in order to achieve a more efficient performance. An important tool is a role separation between different agencies, in theoretical literature referred to as Principal-Agent theory.

A variant of this theory in health and care sector and especially in home based care is establishment of so-called purchaser-provider split, which contributes to clarification of responsibilities, impartiality and legality, but at the same time results in some communicative complexity and close and consequent coordination between different agencies is needed.

It is important to mention that even though the purchaser-provider split can be said to be a possible variant of principal agent theory, in the given context there is no sign of equality between the two. Both have slightly different implications for organizations within healthcare sector. While the implication of principal-agent theory for Norwegian healthcare sector had first and foremost led to responsibility clarification between different agencies responsible for the overall service provision, the purchaser-provider split represents the ideological principle of NPM, by helping to realize the idea of user's choice. Also it opens up for tendering and competition between providers, which not only is supposed to create incentives for cost efficient performance, but also result in quality improvement, because organization would want to keep their service users and get contract extension for the next periods.

Further on in the chapter, a way to assess organizational performance was discussed – by looking at organizational performance as a combination of its effectiveness and efficiency. Those terms were further broken down into several components: preferential effectiveness, technical efficiency and productive efficiency.

In the end a transition from block funding to activity-based funding was mentioned as a way Norwegian government chooses to attain more efficiency.

A variety of theoretical literature presents a cluster of somewhat inhomogeneous ideas about public administration and its future role in the Norwegian society. Theoretical

assumptions point to different directions and don't lead to any unambiguous conclusion, which makes it harder for us to conclude what real implications outsourcing can have on organizational performance in health and care sector.

We have considered outsourcing in the light of several theoretical insights and we see it as a growing tendency in the public sector that goes side by side – and can be said to be a logical consequence of – the actual reforms that take place in the public administration.

Alongside positive thinking and enthusiasm around recent actual reformations, such as gradual introduction of institutional separation of principals and agents in the public administration, the following spreading of purchaser-provider split in the sphere of care and nursing services, which all goes under the overall conceptual model of New Public management that forecasts both the increase on quality of performance and decrease in public spending, the following concerns have been expressed: would the increased use of outsourcing reinforce the view that government cannot be expected to perform well? How realistic are the expectations that economic efficiency of a performer can be accompanied by the quality improvement of the performance? Would privatization jeopardize the governmental role as a provider of universal welfare services? And finally, would private organizations be solely guided by self-interest and a desire for economic efficiency, thus crippling the values of welfare service provision?

The latter concerns are rather common. It has been claimed that outsourcing /contracting-out can be seen as an instrument to attain a better quality and achieve a better efficiency, at the same time as this gives an opportunity to provide cheaper services. Some people claim that private sector managers have a share of self-interest and are more motivated to manage resources in a more efficient way (Ståhlberg: 1996:59). The last argument can be understood as a direct criticism against outsourcing. According to this logic it has been claimed that public sector should not delegate away the tasks that are historically counted as primary responsibilities of the government. That is partly due to this reasoning, that we see more and more often the term *privatization* being abandoned in the favour of *public-private partnerships*, as a sign that is supposed to signal that the government is not abandoning or delegating its duty, but quite the opposite – is all the time in search for better solutions and tries out different organizational forms – all for the sole purpose of obtaining its basic objectives.

A variety of theoretical assumptions found in the relevant literature doesn't allow us to formulate a clear point of departure ahead of the study and formulate any particular expectations about the potential findings we could have had at this point. However, along the

lines of the stated problem formulation, we expect that outsourcing will inevitably affect organizational performance in one way or another and is bound to trigger some processes and mechanisms both internally within organizations as well as in their interacting with the surroundings they operate in.

In the next chapters those consequences will be tried to be explored further within the context of chosen case.

All the information presented earlier in this chapter outlines a theoretical framework for the study, and all the findings will be analyzed in the reference to them.

Chapter 3 - Methodology.

Key methodological terms employed in this work will be gone through one by one and they are the following:

- qualitative research
- comparative research design

3.1 Qualitative research design.

Qualitative research method discovers meaning through detailed explanations that do not take place in quantitative studies (Filstead, 1979). As my problem formulation revolves around organizations performing municipal services and their further privatization (outsourcing), a series of interviews has been conducted in order to find answers on research questions. A flexible research methodology in a form of qualitative research suits well for this kind of study.

Research design is usually understood as “a plan or protocol for carrying out or accomplishing something (ex. scientific experiment)” (Design, 1984:343 in Maxwell, 2013) This definition presents design either as some prescribed steps/concrete sequential tasks in order to carry out the research or as choosing a particular scenario of already existing models. Maxwell (2013) mentions that neither typological nor sequential research model fits well for qualitative research. The attempt to plan the essential steps of research in advance and effort to predict the future study in every detail is not only challenging but also risky. At worst, the attempt to forecast the scenario of future research can result into bias – the course of the research can be jeopardized by researcher’s expectations. Qualitative design calls for more *flexible* approach that would be able to adapt to changes in circumstances, new insights or new developments during the study. A researcher might suddenly discover that in order to give a better explanation of a chosen phenomenon, some of the components of research design should be reconsidered/modified along the study. Since qualitative research is by definition aimed at *in-depth* understanding of chosen phenomenon, it is important to keep in mind that the understanding is being created not so much beforehand as *during* the study.

Maxwell (2013:5) suggests an *interactive model* of research design that helps to develop a flexible approach to the problem statement at the same time as it sets frames within which problem formulation is to be analyzed.

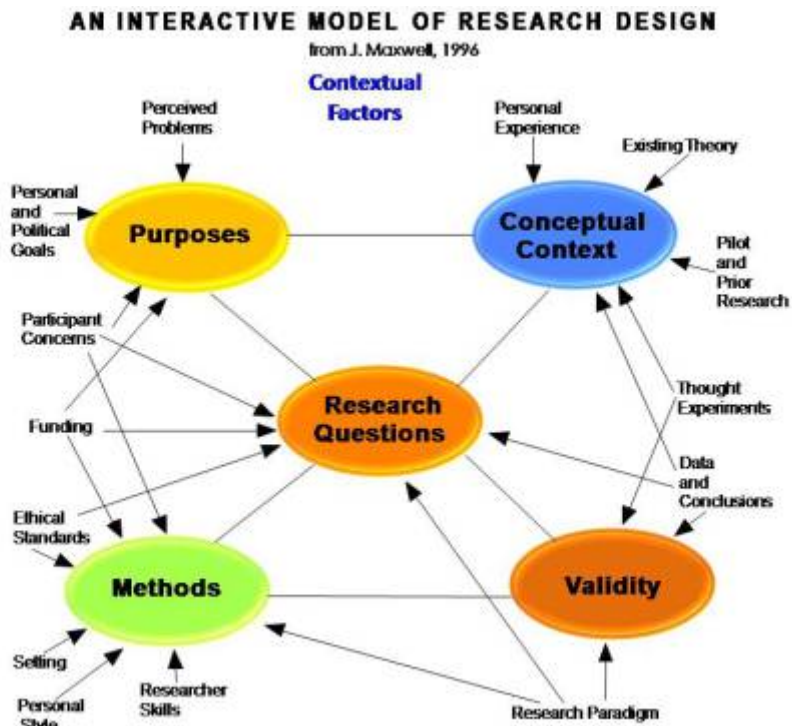


Figure 4. Maxwell's interactive model of research design

The most important point of the model is that problem formulation does not appear by itself and stand independently, but that it is being generated in the context of some broader problematics that take place. That's why problem formulation, according to this model, is not the starting point of the design to which all the components should relate. Quite the opposite, it is dependent on the other elements, such as Purposes of the study, Conceptual context, Methods and Validity.

The context for our study was discussed in the first chapter, where the purpose of Research was advocated for; in reference to the actual tendencies and developments in Norwegian health and care sector. Those tendencies constitute the conceptual framework of the research.

According to Maxwell, the component **methods** consists of the following elements: a) establish relationship with the informants b) selection of settings, participants, timing of data collection and other sources of data such as documents c) methods of data collection d) data analysis technique. This component is discussed closer in the next chapters in the paper. The last component **validity** is discussed in more detail in chapters 3.7 and 3.8.

3.2 Comparative research design.

Comparative research or comparative analysis is a broad term that can include both quantitative and qualitative comparison of chosen elements. Comparative research is conducted in order to detect variance or similarities. When choosing a comparative study as a method, the researcher has an opportunity to go beyond simple exploratory case studies and move to a more advanced level; when general theoretical assumptions can be formed. It means that while the exploratory study gives a depiction of a studied phenomenon, a comparative study searches for form for causality. Sartori (1991: 244--5) points out that we need to compare to be able to control the observed units of variation or the variables that make up the theoretical relationship. In our case, two organizations have been chosen for comparison, and we seek to study the effects organization's ownership structure might have on organizational performance. Practically, comparative research presupposes that two or several objects are being compared. They are similar in as many aspects as possible and at the same time, they differ in some particular aspect. This is what is sometimes called *Ceteris Paribus* clause – which is directly translated from Latin as «other things being similar». This strategy is also what Lijphar calls Most Similar System Design, when a researcher chooses objects that are similar in so many variables as possible with the exception of the phenomenon to be examined.

We have kept this in mind and have chosen for the analysis two organizations that share many similarities: we have chosen two organizations that are providers of home-based care services for the population. Those are the organizations of approximately same size when it comes to number of employees and similar geographical area within which they operate. Moreover, both organizations can be said to be “agents” to the same “principal” – they get orders from the same “purchaser organization”.

Although we understand that no two organizations can be completely alike, as they are made up by different individuals, characterized by different management practices and organizational culture, the ambition of the research has been to pick two organization that share as many characteristics as possible, and in our case– the same external context. The only thing that seems to differ is the form of ownership.

3.3 Selection of research objects.

Data for the study has been collected through all together three sources of information:

1) 7 in-depth interviews with representatives from respective organizations,

2) tertiary data sources

3) relevant legal acts, mentioned underway.

3.3.1 Choice of informants for qualitative interviews.

All together 7 informants within the same municipality were interviewed. Choice of informants allows drawing a holistic picture, since informants come from different levels within the municipality:

macro level: 1 representative from municipal authority,

meso level: 2 top managers from respectively municipal and private organizations,

mikro level: 4 first-line employees; two from each company.

All four first-line employees are nurses working a permanent 100% position. All of them have a good acquaintance with healthcare sector in Norway; have sufficient work experience and understanding of the circumstances and settings their organization is operating within. In addition, the informants from the private organization have experience working in municipal nursing organizations, so they have a firsthand experience of transition from public and over to private sector.

Information was gathered with a help of semi-structured in-depth interviews. Before conducting interviews an interview guide was worked out, a tool that allowed to lead the interviews in a chosen direction. At the same time, the questions were not direct, but more open, in case informants would come up with some insights which I myself did not take into consideration. Yes/no questions were avoided, and were asked mostly as follow-up questions in order to clarify the answers.

Interviews took place at the informants' offices during their work time, and 1 hour has been set for each interview. Municipal authority and top managers were interviewed one-on-one, while front line employees were interviewed in pairs, which worked out to the advantage as it allowed the interviewer to form a clearer picture, as information given by one informant could be immediately "validated" by the other at the same time as informants complemented each other's answers.

Under the interviews, a data recording device was used as well as some notes by hand were made. Interviews were held in Norwegian, but the quotations in this text will be presented translated into English. Quotations are translated as closely as possible to the

original, with interjection and pauses; that is in order to retain informants' thoughts and emotions, which are important to pay attention to during qualitative in-depth interviews.

3.3.2 Tertiary sources.

Some tertiary data was used during the study in order to consider the findings in the context of results of already existing research. Two documents turned out to be relevant for this purpose: FAFO rapport 2013 «**Consequences of outsourcing - quality, efficiency and working conditions in nursing homes and home-based care services**» which maps current consequences of privatization trend in Norwegian health care sector, and a **Manual for Calculating Units Cost in healthcare services** (2013, developed in collaboration between Virke, NHO and KS).

3.4 Ethical considerations.

The project is not subject to notification to NSD (Data Protection Official for Research), as information is registered exclusively anonymously and I provide neither the names of informants nor the chosen municipality.

All the conditions stated by NSD are fulfilled: neither names nor any personally identifying background information was registered at any point of research, and quotations and references can not be traceable to individuals. Even though audio recorder was used during information gathering, the interview guide is designed in such a manner that no personal data could appear in the recordings. Both written and audio materials were deleted after the end of study.

3.5 Validity.

Patton (2002) says that preoccupation with validity and reliability should be accompanying a researcher throughout the whole research process and should predominate both while designing a study, analyzing the results and evaluating study's quality.

The term validity within quantitative research signifies whether research study truly measures what it is intended to measure and whether the results can be used to answer a particular research question, which is the main goal of the study. When findings are considered valid, they can be generalized to a broader context, thus pointing to the external validity of the research.

However, when applied to qualitative studies, the term of validity is discussed quite broadly and is described by not single but a wide range of terms. There does not exist any universal definition, rather, the concept of validity is constructed and inescapably grounded in

the processes and intentions of particular research methodologies and projects (Winter, 2000) Qualitative research is an *interpretive* one, consequently, we cannot understand validity in the same terms as we do when applied to quantitative methods. A researcher stands more freely to define validity in his own terms, what would be appropriate to his particular research and chosen research methodology.

Out of a big range of available theoretical literature on reliability and validity, in this paper we chose to use terms introduced by Lincoln and Guba.

Lincoln and Guba (1985) claim that while reliability and validity are typically quantitative-oriented criteria, when it comes to qualitative research new more suitable criteria are needed.

They present three concepts, which can be associated with traditional notions of external validity, internal validity, and objectivity respectively and those are – *transferability*, *confirmability* and *credibility*.

Transferability. Transferability of research is related to the problem of generalization. Maxwell mentions that the degree to which something can be considered generalizable is exactly the factor that distinguishes quantitative from qualitative research (Maxwell, 1992). The opportunity to generalize the findings of qualitative research would in each particular case depend on topic selected.

I assume that my findings would be possible to generalize only to a certain degree. After analyzing one public and one private home based care organization, I believe the findings can be generalized to a broader number of home-based care organizations in Norwegian urban areas. That is due to the fact that all those organizations are driven according to the same rules, practices and guidelines that are developed in Norway to apply to all the institutions of that kind. In other words, the way work routines are organized can not possibly differ greatly in the same kinds of organizations across the country. What seems to set some limits to the ability to generalize is the peculiarity of Norwegian geography. That is not to say that the findings could **not** hypothetically be generalized to less densely populated areas, but first of all, privatization wave within healthcare sector has not yet reached smaller towns and rural areas, and second of all, in case it does, it would most likely require a research of its own, because of the specific implications such settings might have on organizational performance.⁷

⁷Indeed, the way home-based care organizations work in big towns and rural areas: say, in North Norway, vary greatly. In the latter case organizations are most likely to cover bigger

Credibility. *Credibility (internal validity)* says something about whether the results of qualitative research can be considered trustworthy, believable. Since qualitative analysis is aiming at in-depth understanding or description of a chosen phenomenon, and typically - from the eyes of participants, so technically, it is participants who are the only ones to be able to evaluate the credibility. *Credibility* of the study was secured by the choice of appropriate informants, i.e. informants who have the needed competences and knowledge in place to be able to provide me with the information about the research topic.

All 6 informants from the organizations work 100% position have sufficient work experience and a long history of working in their respective organizations. The first person that was contacted for the research was councilor for healthcare sector in the case municipality. We agreed upon an interview, however, I was later send over to another person, presumably with more knowledge and competences to provide me with answers to my questions. That strengthened the *credibility* of the study, as it secured that the right informant was interviewed.

Confirmability. *Confirmability* points out to whether research conclusions are indeed supported by the collected material. To evaluate confirmability means to make sure that the findings of a study are neutral and are based on the analyzed information, and are not affected by researcher bias, motivation, personal interest etc. Bradley explains conformability this way: it refers to the extent to which characteristics of data, as presented and analyzed by the researcher, would be confirmed by reviewers or readers of the research results (Bradley, 1993).

To achieve comfirmability the ambition has been to begin the analysis with no expectations about possible findings. Neither is there an interest of motivation for findings to be inclined any direction. Researcher should also be careful and try to avoid instrument bias. Instrument bias can arise if researcher changes *measuring instrument* over time, which leads to change in results. During the whole process, the researcher was careful and made sure at any time adhere to the same logic when gathering information, for example by using the same interview guides for the interviews and using the same analyzing technique.

3.6 Reliability.

Reliability is defined by Joppe as: to which extend the results are consistent over time and are an accurate representation of the total population under study. When the results of a

geographic areas and it involves much more driving. They might then choose to organize their work routine in a way that is slightly different, moreover, they might develop own measurement criteria for their performance.

study could be reproduced under similar methodology, then the instrument of research can be considered to be reliable (Joppe:2000). Following, it is noted that a high degree of stability of chosen instruments of analysis indicates the level of reliability.

However, this definition by Joppe seems to apply mostly for quantitative research methods.

It has been claimed that when applied to qualitative study, the notion of reliability changes. According to Stenbacka, the difference in purpose and evaluating the quality of studies in quantitative versus in qualitative research is one of the reasons that “the concept of reliability is irrelevant and even misleading in qualitative research” (Stenbacka, 2001:552).

Lincoln and Guba (1985) suggest substituting reliability with the analogous concept of *dependability*. While during quantitative study one measures reliability in terms of repeatability, dependability tells something about *consistency* of the inquiry process. For Lincoln and Guba (1985) it means that researcher’s logic while conceptualizing the study, collecting material, interpreting the findings and performing the result should be clear and be explained and elaborated on. The more consistent the researcher has been during the processes that constitute the research, the more dependable are the results. It also implies the “probability that the repetition of the same procedures by the same researcher will produce the same results” (Briggs, 1986:23). For this purpose *standardization* of data collection technique was used, which means that each informant was interviewed in exactly the same manner, asked the same questions that were posed in the same way. Briggs even specifies “the interviewer’s inflection and intonation should be the same for each respondent” (Briggs, *ibid*: 24). During data gathering, this advice has been followed as far as practicable.

Chapter 4 – Findings.

Gathering of empirical data in this research revolved around problem statement that sounded the following way:

What are the consequences of outsourcing on organizational performance in municipal care services?

The analysis was further narrowed down to address home based nursing services and two organizations were chosen from the same municipality.

The term productivity was closely discussed in chapter 2.5, and more specifically – in the *Performance triangle*-model developed by Floriúteanus, where productivity is used as a collective term that includes both effectiveness and efficiency.

The following questions were considered which could help to address the problem statement:

- In which terms do organizations in different sectors define productivity and which instruments do they use to achieve effectiveness?
- What determines productivity and effectiveness in home care?
- How effectiveness can be measured?
- What impact can outsourcing have on the processes within the organization?
- What impact can outsourcing have on organizational culture?

4.1 Municipality's attitude to privatization in health and care sector.

To be able to draw a more holistic picture of the effects privatization might have on organizational performance, we wondered what logic guided political decision makers on a municipality levels when the idea to outsource appeared in the first place. For this purpose it was decided to interview a representative from municipal authority. Although the questions were broad and were about outsourcing in general, they implied outsourcing within the healthcare sector exclusively.

The case municipality started to outsource in 2003. On the question about the driving forces behind privatization, a complex of reasons was mentioned: it was a combination of pursuit of efficiency, better quality of services, but it was also a politically driven initiative – a desire to introduce a principle of user's choice, which they had an ambition to realize within the whole range of services. As a result privatization applied to a big range of health and care

services – residential care, home-based care, personal assistance, residential accommodation, child welfare services and cleaning.

When asked who *de facto* stood behind the idea to outsource, the informant replied:

“It was controversial. From the political perspective we wanted to offer citizens user’s choose. Administration thought about economy.”

Privatization was implemented both through contracting-out with the use of competitive tenders (applied for commercial organizations) and contracting out without tendering (for ideal organizations).

Municipality’s desire to implement privatization was not a pursuit of a popular trend, but rather as a way to resolve some internal challenges. However, they establish a close connection with other municipalities, who have already started to outsource before, including annual meetings on exchange of experience. It was highlighted that

“Exchange of experience goes both ways.”

Besides, the informant answered, that experienced from other Nordic countries are paid close attention to as well.

The informant revealed that there were several challenges when it came to outsourcing the services.

*“Well, there are very complex regulations and it is important with competences – first of all professional competence when it comes to implementation process...
... There is such a thing, as “neglecting the competitors”. Have you heard about it? (I shake my head). When we were to put personal assistance out to tender, there were all together 16 providers to choose between. And they don’t quite understand how important the competition is..... because... everybody thinks they will get it. And we actually have to check each provider. In future we have to limit how much we should tender out.”*

On the follow-up question whether the municipality needed to use some external expertise during privatization process the answer was a firm no.

Case municipality makes mandatory effectiveness- and quality evaluations of private provider organizations by performing an annual contract follow-up and a meeting (minimally). There is no any form for external evaluation.

When the informant was asked about what is employees' attitude to such an arrangement, and what was the attitudes towards outsourcing in general, the answer was:

“It is really hard to say. Now it feels like it was so long time ago we started it. But I remember that the biggest resistance was in home-based services”.

The last question was about informant's perception about what were the biggest advantages when outsourcing healthcare services.

The answer was the possibility of organizational learning.

“For example, a big value for service users is continuity. And when there are capacity needs, private organizations act faster”.

4.2 Effectiveness.

According to Mouzas (2006), effectiveness is the central term in measuring and assessing organizational performance. Drucker (1977) says that effectiveness means that organization is «doing the right thing». It has also been mentioned that effectiveness says something about whether final results correspond with organization's initial objectives.

Objectives of home-based care organizations are partly defined by the very nature of performed services and partly – by the institutional context they operate within. That makes the measurement of effectiveness of home-based services twofold. First of all, we can say that the objective of two home-based care organizations chosen for the case is to obtain social benefits in a form of delivery of care and nursing services for service users in their homes. At the same time, both organizations are in a close relation with the common “purchaser organization” within the same municipality (with which they are connected by purchaser-provider split). In other words, the other way to measure effectiveness is see how accurately serviced are performed by provider organizations (agent) and whether they are in appliance with the orders from purchaser organization (principal).

In simple words, two questions can be asked: Do provider organizations act according to a purchasers' order? And does purchaser order what is really needed for the patient?

The second question falls out of the context of this research, as we study exclusively provider and not purchaser organizations. Moreover, in the second case – when understanding effectiveness on a *societal level*, as a welfare good – operationalizing effectiveness seems quite challenging, as it becomes hard, if not impossible, to quantify. Possible measurement

criteria might have been a number of lives saved, life years gained, number of recoveries etc. None of informants revealed that such statistics or measurement criteria exist. But neither are they required, as nursing and care services is an end in itself, allowing service users living in their homes as long as possible.

We are left with measuring provider's effectiveness in terms of how closely they follow directions of their purchaser and whether the interaction between two agencies is problem free. Provider's compliance is easy to verify, since service performance is determined by concrete instructions by the purchaser. Each (potential) service user has a coordinator in the purchaser organization, who is responsible for mapping his needs and presenting a small "contract", with detailed care plan for each patient, that provider has to follow. Care plan includes service details and calculated time required to perform the service.

Two case organizations have somewhat different experiences when it comes to contact with a purchaser.

The private organization experiences communication with the purchaser as mostly positive, but that *"with some people in the organization it is a bit problematic."*

"We have a lot of phone contact. But it is mostly very brief. And it is all double checking. For example when a patient is suddenly discharged from the hospital... Or if we get a new service user tomorrow... They call us to double check ... to make sure that we got this information. They don't only make a new "order" and register this patient in our programme."

The public organization expresses their experience with the purchaser the following way:

"We have some contact with the purchaser yes. Sometimes it concerns service users."

Besides, the informants reveal the following tendency:

«Not everybody of service users or relatives understands this with the purchaser organization. So we have to explain that if they have some dissatisfaction with the amount of help they are getting or if there is something they want to change, they have to talk with their coordinator. So they take contact directly with the coordinator."

The next curious finding consists of the following: the private organization developed a routine for evaluating organization's effectiveness weekly, where it is measured in terms of face-to-face contact with service users, since it is this interpersonal contact which constitute

the essence of work at home-based services. A special scheme has been developed for this purpose, which is being gone through during weekly-held meetings. The scheme calculates the total time that was ordered by a purchaser, the actual time of performed work and duration of each more visit. An effectiveness goal is set to be 66% face-to-face contact with service users.

The municipal organization doesn't have any similar practice. There the effectiveness is simply understood in terms of that employees accomplish all the tasks of their worksheets.

4.3 Technical efficiency

Technical efficiency addresses the issue of using some particular resource to maximum advantage. Technically efficient intervention takes place when a set of resource inputs obtains the maximum result, and the same (or greater) outcome could not be achieved with less input.

The most important recourse at the disposal of employees at home-based care institutions is time.

Time management turned out to be an important tool in both municipal and private organization. Especially after introduction of performance-based financing, when time pressure become to a much bigger degree dominate their workday.

4.3.1 Funding models and their implication.

Both municipal and private organization expressed dissatisfaction with the existing activity based funding model. Employees from the municipal organizations admitted that this model allows offering service users a better and a more holistic service. Previously the budget was calculated a year ahead, and people had to work with it. It was simply not possible to perform more work than what organization had a capacity to. That's why patients who were sicker had to be prioritized. Introduction of activity-based funding allowed providing more help, because funding from the government now grows proportionally with the number of patients.

At the same time, the informants mentioned that the new funding model led to much more workload than what was the case under the block-funding model. They feel that it gives somewhat skewed picture of time distribution at the work place, as it exclusively calculates the time spent in patients home, and neglects both driving time, time at the office etc.

“Calculate, for example... On a 7,5 hours shift we often have 4,5 – 5 hours of workload (and that is only time spent at patients' homes). 30 minutes for reading through the journal before

the shift starts, 30 minutes for lunch, 30-45 minutes for daily middle-of-the-day-meeting. So you can see, not much time left for driving, writing in patients' journal, writing care plans and so on.”

“Back in the old days, when I began, we had a smaller geographic area, fewer service users, who were in a better form... they could get a place in a nursing home much faster. Because of fewer service users and simpler illnesses, we knew much more about them, and that resulted in a better care and observations. We also talked more about each patient, we had time to it.”

Employees in the private organization didn't have much acquaintance with different funding models. It can be explained by the fact that their organization was established already after the introduction of activity-based funding, which is the only model they are familiar with.

The management from the private organization however, expressed a concern by saying that the choice of funding model is irrelevant as long as the unit price is calculated correctly, which is not the case.

“There is a budget increase, when municipality gives more and more funding to home-based services. But it does not serve the purpose if such a budget increase is disproportional towards increase in spending, for example general salary increase. And this disproportion exists and it will only increase with time. That's why it is important that unit prices are calculated correctly. And that is what municipalities do wrong. They count wrong. Home-based services are in the worst position of all healthcare services, because it is important to take into consideration absolutely ALL the aspects of work.”

The essential part of employees' work at home-based care service organizations is the direct contact with service users. Each employee makes x-number of visits during one shift, and that's why the way service users are distributed among people of a shift plays an important role. Time pressure made is especially important that it is done in the way that is most appropriate.

Different routines are adopted in the two organizations in this regard. In order to save some time and thus achieve more efficiency, in the public organizations the worksheets⁸ are usually prepared several weeks in advance, taking into consideration busy conditions of the

⁸ Worksheet – a paper each employee gets before shift starts with a list of patients that should be visited, and detailed description of work tasks (what kind of help a patient needs)

nurses. They do a lot of work in the office, and therefore get fewer service users on their worksheets.

However, one of the employees reflects that lists are not always optimal:

“Sometimes.. if you have restless patients.. Or patients are in bad conditions, it takes extra-long time. We who are nurses are much busier than others sometimes. We have to go through care plans, dose, and follow up “out patients”. It is always something that makes it busy at the office: there can always be errors for example with orderings.. Pharmacy delivers wrongly etc etc I feel we not always have time to do all those things”.

“Sometimes it gets extra busy if service users are not distributed geographically”.

Having worksheets prepared long in advanced showed a disadvantage: sometimes people take a liberty to change them themselves:

“Somebody is taken more care of than others. Besides, people log into the system and change the worksheets”.

Although familiar with the practice of preparing the worksheets in advance, the private organization eventually concluded that this practice was ill suited.

One of the informants from the private organization says that the worksheets are actually made each day before the shift starts.

“The works sheets can not be the same every day. They can not be made several days in advance, because there are changes in service users’ needs every day and we should take this into consideration.”

Additionally, it gives the opportunity to correct possible mistakes on the spot:

“If we see that the work sheets are not composed optimally, we give a notice right away”.

4.4 Productive efficiency

Productive efficiency implies technical efficiency (Palmer & Torgersen, 1999), meaning that not only each resource (single type of input) is used optimally, but different types of interventions and different ways to perform task are considered in order to find a more appropriate and efficient way.

When it comes to trying out different ways to organize a work process, a bigger variation in this sense can be found in the private organization. Meanwhile in the public

organization employees experience that they don't have a feeling that their voices can be heard. Moreover, some of the employees experience procedural injustice.

He/she reflects on own experience:

«At our place, there is a bit of procedural injustice sometimes. They who prepare worksheets are not always fair.»

The informants from the private organization mention that even though *«It is always something that could be done better..»*, *“...but we discuss a lot..»*.

Even though a search for more efficient way to organize work practices is important, it is first of all providing help for service users that stands in focus in both organizations.

When asked about what employees can do and whom to contact in case they have any questions regarding their work, the two organizations give somewhat different answers. The public organization said that each employee is given a mandatory training before starting working independently, but in case there are some questions; it is always a possibility to ask a colleague or a nurse in charge. The informants found it hard to remember any particular case when some of the employees had some challenges with some of the service users. However, sometimes it happens that somebody expresses a desire about what service users they want to go to or if there are particular service users they wouldn't like to go to (because they are insecure, afraid or any other reason). Such desires would usually be taken into consideration to the degree it is possible given the current pressure at work. Otherwise, employees can freely settle in among themselves, for example by changing a patient with a colleague.

The private organization has a similar practice with mandatory training for new employees. They also say that the nurse in charge is a contact person in case somebody has questions.

But the informant specifies explicitly:

«If you have a gut-feeling that [going to a particular patient] is something you are not comfortable with – you say about it, and you don't need to do it. It is a message everybody gets when they start working here »

4.5 Preferential effectiveness

Preferential effectiveness considers if the right priorities has been taken into account while performing the service and whether service provision optimally reflects local preferences and needs. In the context of the study we also wanted to look at the way resources

within the organization were utilized. Here we think about Svensson's (2008) categorizations of resources as "organizational resources" and "professional resources".

One of the things that characterize organizations that provide home-based care services is a big variation among employees when it comes to age, background, experience and qualifications, which includes both nurses, nursing assistants, apprentices, but also unskilled assistants. That is due to the fact that work tasks vary. Nurses are responsible for some tasks in the office – dosing medicine, contacting the purchaser, placing orders to the pharmacy etc. In addition they each have service users they are contact persons for (i.e. users they have primary responsibility for). There are some tasks at service users' homes which only people with nurse education can perform - insulin injections, treating patients with narcotic drugs, i.e. types of more complex treatments. But the majority of nursing services (assistance, supervision, care) can be performed by all the employees, without requirement for special education.

Both case-organizations have a big variety when it comes to employees' background. Out of approximately 8-15 employees on a shift, there are typically 2-4 nurses (one of them is nurse in charge for the shift). Nurses have somehow superior position over others, although only informally – i.e. they don't have a decision authority over other employees, but they are typically the ones with more experience and competence.

As a way to achieve effectiveness of service performance, two meetings traditionally take place during the shift in home-based services organizations: the morning meeting before the start of the shift, and the middle-of-the-day meeting. It is mandatory for everybody to participate. Those meetings are led by the nurse in charge, who reads out the relevant information from patients' journals and reads up important notices and messages concerning changes in help for some of the service users the actual day (requests for an earlier visit, doctor appointments, etc). That practice remains in the public organization and are dedicated to discussing service users (in addition to the fact that everybody read journals of their patients before the start of the shift). After the employees are dismissed from the meeting, they can begin with the job.

Work routines are also busy in the private organization, but they have different approach to time distribution.

The overall principle that determines work routines at the office is, to use the informants' formulation, "separation between profession and organizational drift".

The informant from the private organization says:

“We have strong separation between “profession” – i.e. the actual work in the patients’ homes, and “organizational drift” – car, keys, preparation work. In fact, we have a special person, who comes earlier each day, distributes service users among employees and prints worksheets out, prepares keys, car keys and puts the needed equipment on the table for each employee. So that those who drive do not do unnecessary things. When you come to work and everything is prepared for you to start a shift, then you maybe have time for an extra patient.”

Another characteristic of work routines in the office in the private organization is strict task-distribution among the nurses.

The informant tells:

“Everyone knows what they do. For example, I know that every nurse can dose. Everybody can, but only one does. If you do it from time to time, you spend a lot more time. If a person does that every day several times a day then it goes much quicker. Everyone knows who is responsible for what. I dose. I can also make an order from the pharmacy, but I know that a colleague is responsible for that and she can do it, so I don’t do it. I write a little reminder-note to her that this and this patient needs this and this medicine. Much more effective when only one person does a task, and not everyone. Actually, we have a much better statistics as a result. Less confusion and mess, easier when the same person doses, orders. For example, before there were a lot of baskets filled with missing pills. It is not anymore”.

The next step in achieving a better efficiency and effectiveness for the private organization was to stop both morning and middle-of the day-meetings. Typically, the discussion would regard only some and not all of service users, so on every meeting there are some employees who are not involved, and just sit and wait, because the service users they have on their worksheet are not being discussed. According to the informants from the private organization, this time could be put to a better use, for example an extra service user could be visited. What the organization has adapted instead, is a practice, when, instead of long meetings, the nurse in charge goes through the journals and notes the important relevant information directly on the work sheets (for example that a particular patient need an earlier help that day, or a reminder about doctor appointment). Meeting, where employees jointly discuss service users and their needs are changed from a daily to a weekly basis.

4.6 Summary of tertiary sources analysis.

Getting acquainted with the results of the previous research was an essential step in the data collection in the study.

Although, as mentioned in the introduction, there is a gap in the existing literature on

municipal outsourcing in Norway within health and care sector, such a research is not absent.

In this subsection the relevant results will be presented rather briefly, in a form of thesis summary that includes the most interesting conclusions.

The following theses are taken from the Fafo-rapport «**Consequences of outsourcing - quality, efficiency and working conditions in nursing homes and home-based care services**» that was written in 2013.

The rapport shows the increasing scope of privatization of nursing institutions and home based care services, and at the same time as the repeating surveys signal about increasing confidence and trust in privatization among the employees.

The rapport shows that the use of experiences from other, mostly Nordic, countries has been an important component of introduction of privatization in Norwegian health and care sector. However, they could only be used to a certain degree. First of all, the researches performed in the Nordic countries are rather fragmented and don't seem to draw a holistic picture. Moreover, the results of the existing studies don't reveal any particular correlation between organizational performance (measured in terms of efficiency, delivered quality and working environment) and the form of ownership. For example, Szebehely says that the existing research shows no clear consequences of privatization, either with regard to cost efficiency or quality (Szebehely, 2011: 251, cited in FAFO rapport 2013) That's why in Norway, any expectations connected to outsourcing in healthcare sector are first and foremost based on own assumptions.

The rapport puts privatization in a wider societal context and researches on what visions different organizations express when it comes to outsourcing within health and care services. The Norwegian Confederation of Trade Unions expresses quite an unambiguous view that outsourcing, even though resulting into cheaper operating costs, necessitates extra costs connected with tendering processes and follow-up and monitoring work. When it comes to working conditions, the Trade unions admit, that there is no particular differences regarding salary and pension, but that the very change in the ownership created a situation of uncertainty among employees about their work situations. There is also some uncertainty around the fact that more and more international organizations enter the market in order to make a profit.

After interviewing the case municipalities, the rapport concludes by saying that the informants revealed insufficient follow-up of private organizations from the municipal side. Neither do the municipalities have a complete overview over the spendings.

When it comes to the processes in the organization internally, it was said that there is more flexibility in the private organizations and there is a “short distance between an idea and action”.

The rapport reveals people’s skepticism towards outsourcing when more than 50% answers than they would prefer receiving service from municipal organizations. The survey reveals that the opinions are equally disturbed between man and woman, but that there is a proportion of older people who prefer the municipal services. People with higher education are less skeptical towards private service providers.

Finally, the rapport reveals that the informants from Oslo and Akershus stand out from the rest of the informants – significantly fewer would choose municipal providers.

After the interview with the informant from the private organization, where he/she expressed a concern with municipalities counting unit prices in the wrong way, we felt it was important to investigate this question closer. We found the document “Calculating of unit costs in health and care services. Basis for cost and quality” that was developed in 2013 by NHO (Confederation of Norwegian Enterprise), KS (Norwegian Association of Local and Regional Authorities) and Virke (Enterprise Federation of Norway). The document expresses the need for municipalities to have a good understanding of all the components that should be taken into account and which together make the correct basis for calculations. In our framework the right form of budgeting is a prerequisite for establishing a connection between organization’s concrete actions and overall objectives (see figure 2: Organizational Performance Triangle). Without it, organization would not be able to perform optimally, thus jeopardizing both effectiveness and efficiency.

There is no space in this paper for a more profound discussion on the topic, but we thought it was important to include this link to the guidelines worked out for municipalities who wish to calculate their unit price in a right way. They are presented on the official web page of Confederation of Norwegian Enterprise:

http://www.nhoservice.no/getfile.php/Filer/Dokumenter%20helse%20og%20ern%C3%A6ring/Veileder%20enhetskostnader%20Pleie%20og%20omsorg%20Rapport%20Nov2014_web.pdf

4.7 Summary. Findings.

This part of the chapter suggests a summary of the findings, which for a better overview are recapitulated along the research sub questions.

4.7.1 In which terms do organizations in different sectors define productivity and which instruments do they use to achieve effectiveness?

The study showed that both private and public organizations are preoccupied with effectiveness. They understand effectiveness of their organizations in terms of task execution, i.e. how many service users they visit, and how much care and nursing is being performed for the population. Organizations get those tasks in a form of “orders” that they receive from the purchaser.

After the introduction of Activity-based funding, the amount of workload increased, as organizations now could perform more work: visit more patients and provide them with more help, because every increase in the workload for the organization will be accompanied with additional funding.

As a way to secure effectiveness, i.e. that service users receive the type of help and assistance they need, systematic meetings take place in both organizations. On those meetings service users, their needs or/and potential problem areas are discussed. In the private organization meetings take place on a weekly, and in the public – on a daily basis.

4.7.2 How effectiveness can be measured?

Effectiveness in both organizations is measured quantitatively, in form of registration of the total time that was ordered by a purchaser, actual time of performed work and duration of each visit. The private organization has developed a specific effectiveness target, which is 66% of interpersonal contact with service users. A corresponding effectiveness scheme is being gone through on a weekly basis. The public organization has no similar practice. Registration of nonconformance and corrective action reporting is another important instrument to measure effectiveness, that is used in both organizations.

4.7.3 What determines efficiency in home care?

Introduction of Activity Based Funding indirectly led to more workload for healthcare and nursing services providers. Consequently, for organizations internally, such a general increase in organizational productivity resulted into busier workdays, tighter schedules and time pressure.

Achieving efficiency in home-based care services should not be understood in terms of performing one’s job faster, i.e. it doesn’t mean that employees should try to make home visits last shorter, but it means that they should report precise changes in patients’ needs. For example, that Mrs. Jensen doesn’t need a home visit that lasts 1 hour, and it is enough with 20 minutes. Then efficiency can be achieved by making a change in the system, which will be manifested in the next worksheets, which would give opportunity for an extra home visit. But

it is important that a pursuit of more efficiency doesn't go at the expense of effectiveness, i.e doesn't go at expense of quality of performed service.

All in all, the requirements for more efficiency for the organizations were met with different measures.

In the municipal organization it resulted into more strict time management and control; employees have to make sure, that the work is being done, and potential situations of working overtime should be followed by a written explanation. Such a work practice led to more stress and resulted in undermined trust in the organization internally as a result of this control.

The private organization is more eagerly searching for new solutions, preferably, through a dialogue with everyone who is involved.

The study showed that efficiency could also be achieved by right utilization of "professional" resources – that the nurses on a shift divide responsibilities and don't do double work.

4.7.4 What impact can outsourcing have on the processes within the organization?

When asked about what they think is the advantage of organizations in private sector, the informants from both organizations replied that private organizations tend to be less formal. It means less hierarchy during organization of work, more informal communication patterns and practices. It corresponds to the information from the FAFO rapport (2013) that detected some flexibility when it comes to the internal processes in the organization, and that "there is a short distance between an idea and action".

Our case revealed, that there is indeed more flexibility in the private organization, where employees feel free to come with suggestions about their own work practice, because they know that those suggestions at least would be considered or discussed.

- **4.7.5 What impact can outsourcing have on organizational culture?**

Organizational culture doesn't stand apart from actual organizational processes but in many ways defines them. Organizational culture can be defined as a set of assumptions, values, norms, habits and an overall approach towards the work process that dominate on the workplace and that is shared by the majority of employees in the organization. As opposed to a set of mandatory documentation that define organizational drift and that each organization has to have because of some statutory requirements for such a documentation imposed on each organizations, organizational culture is a collective term for the unquantifiable factors of organizational performance. Consequently, each staff member is not only an employee who mechanically perform their work tasks, but becomes a carrier of a particular organizational culture.

One informant gave a following answer to the questions “Is it busy at your workplace?”:

“In depends if the right people are at work”

With that, the informant meant that it is important to have at work people with good experience, good knowledge of work routines, who knows how to work on a subconscious level.

A clear division of tasks have led to the fact that organizational culture in the private organization is to a bigger extend characterized by predictability and trust between employees. When asked whether the organization has a written employee handbook where this information is stated, the answer was: “*no, everybody just knows how it is*”. This signals quite distinctive and rooted organizational culture.

Chapter 5 – Discussion.

5.1 Characteristics of home-based nursing services.

In chapter 2 we discussed growing expectations towards public sector and its service delivery capacity. Assuming that it is unlikely that the political prerequisites behind an extensive service provision will change, it means that public sector should search for more effective and not least efficient ways to organize. At the same time, several factors indicate that home-based nursing services on a continuous basis is facing new challenges, partly as a result of the very nature of the service, and partly as a result of modifications and refocusing of legal acts that apply.

Coordination reform⁹ has been gradually introduced in Norway since 2012. It presupposes more responsibility to be conferred to municipalities (with corresponding money transfers of budget means from national government to the municipalities). The main objectives of the reform is a better coordination between different health and care services, which would give patients a more consistent and holistic follow-up. It grants patients more rights in terms of what kind of services they can receive. In practice it results in increased workload on home-based services, since now their responsibility includes taking care of discharged patients, who after hospitalization come right back home. Moreover, providers of home-based services have to deal with patients with increasingly complex clinical picture. This applies to both mental and somatic health. At the same time there is also an increase in care provision for substance abuser in their homes (Hofseth & Norvoll, 2003; stortingsmelding 34, 1999-00, stortingsmelding 25, 1996-97). Besides, the Coordination reform put at new focus on preventative measures. Which means that employees don't only help service users with already existing health problems, but some of the help simply has a preventative character. Increased amount of cases of acquired dementia puts an extra pressure on organizational capacity.

Vabø (2007) talks about "wicked problems" in health and care sector, in order to highlight the unpredictability and variety in service users' mass that providers have to deal with. Both unpredictability and variation makes it harder to plan, evaluate and control work performance both economically and qualitatively.

⁹See Samhandlingsreformen -

https://www.regjeringen.no/globalassets/upload/hod/dokumenter20info/samhandling-engelsk_pdfs.pdf

Outsourcing has been a growing trend, which successfully took over some of the spheres of municipal services, mostly technical and financial, but also – to a much lesser degree – health and care sector. Both Denmark and Sweden are some steps ahead in this regard, but slow but sure we see a similar development in Norway; privatization of municipal health and care services.

The general division of opinions about privatizations can be connected to several aspects. One of them is the following: opponents of privatization say that when service provision is outsourced to public sector, public sector starts providing services instead/on behalf of municipality, which means that municipality itself loses professional competences in this sphere. And this is tricky, because it in a long run can jeopardize government's role as welfare service provider. "Wicked problems" in healthcare sector (big variety of tasks, patients with different and complex clinical pictures) makes it extremely important that employees have the right professional competences to be able to do their job well. In this contexts the questions is no longer whether those competences should be situated in public or private sector, but in which sector is there a bigger potential that those resources can be utilized to its fullest potential, where are the best possibilities for learning, professional growth and the best use of one's competences. By studying one public and one private organization we tried to establish a connection; what impact can outsourcing have on organizations, organizational culture and work processes. We detected differences in the way employees themselves perceive their workplace. The public organization experienced more stress, time pressure and the fact that they have so much to do in the office that they sometimes have very little time left for other important tasks. The private organization experiences equal time pressure, but they developed routines which helped them to achieve a better efficiency at the office, leaving more time for their primary duties.

5.2 Home-based services and purchaser-provider split.

The fact that the performance of home-based services is arranged according to purchaser-provider split, to a large extent determines the way local government carried out these types of services, something that reveals both the model's advantages and its inherent weaknesses. There is no secret that increasing the number of agencies leads to more bureaucratization. At the same time it is justified by the fact, that there exists a distinct clarification of roles (prompted and advocated for by the Agent theory), which is supposed to make the transformation uncomplicated. Indeed, while a typical principal-agent interrelation presupposes some inherent conflict of interests, this aspect is not strikingly obvious in the case of purchaser-provider split. It can be explained by the fact that both agencies serve the

same overall purpose and together represent a holistic service provision in the sphere of healthcare and nursing. That is also due to the fact that within health and care sector, the provision of services and nursing is being defined as an activity that first and foremost is politically important and carries important values on a societal level (constituting a big share of universalistic welfare services). It means that governmental provision of care and nursing services is something the government sees as its obligation to the citizens, and it is unlikely to be the area where government would strive for any kind of economic gain. Principal and agent are therefore in this case not looked at as two agencies with conflicting interests, but quite the opposite – they seem to constitute two sides of the same coin.

The introduction of purchaser-provider split requires a need for good coordination and clear communication between a purchaser and a provider. It has already been mentioned that each of the agencies experiences an internal separation between management and production, which happens at both system and individual levels. System level in a purchaser organization is constituted by policy makers in the municipality and administrative management, while individual level is constituted by caseworkers (for clarity see figure 1 in Chapter 2.) It can be said that caseworkers do a practical work by taking the policies that have been developed and adapted on a purchaser’s system level – by policy makers and administration, – and then implement these policies in practice; by mapping patients’ needs and working out concrete care plans, assumedly, in accordance to these policies.

Similar separation can be seen in a provider organization as well, where system level consists of management, who develops the overall vision for the organization, and individual level is constituted by first-line employees.

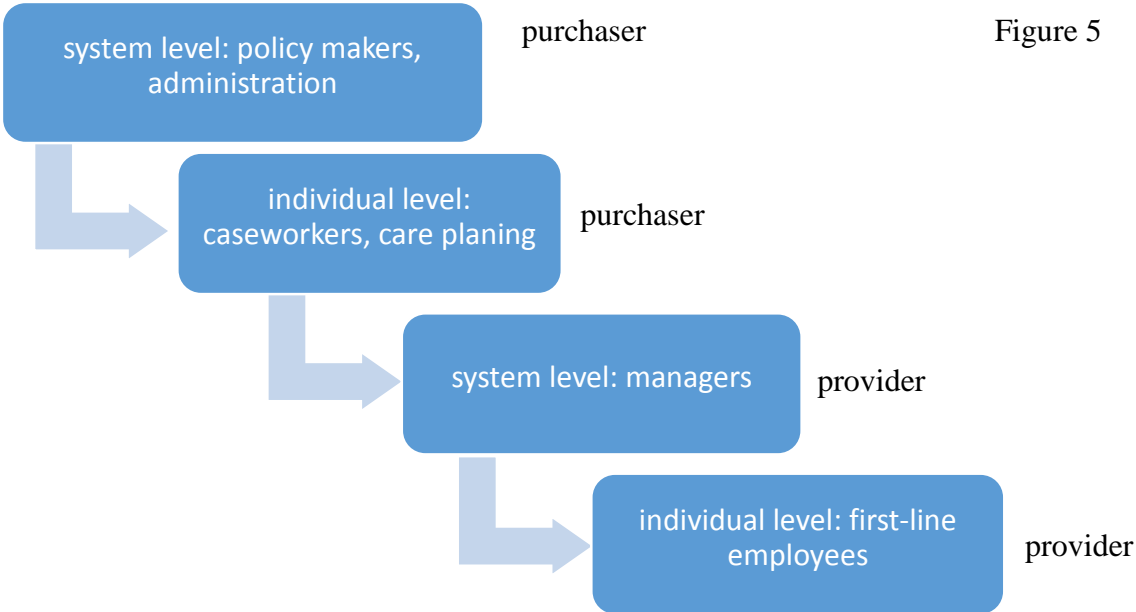


Figure 5 shows the dynamics of communication in a purchaser-provider split, which is marked with the arrows. It is an example of a typical top-down communication model with an inherent asymmetry that follows and where more pressure is being put on the lowest level – first-line employees, who perform work both according to the instructions developed by the purchaser, and in accordance to the policies of own provider organization. Ironically enough, in this model first-line employees are the only ones who have are familiar and have a daily direct contact with service users.

What seems missing from the model, is that the purchaser-provider split doesn't take into consideration the dynamics and communication complexity that provider organization experiences. Especially after the introduction of Coordination reform the number of instances or agencies that a provider organization has to have almost a daily contact with grows rapidly. It includes doctors, pharmacies, assistive device center, hospitals, residential care institutions, relief centers etc. As a result, it is important that purchaser-provider split works out optimally for both organizations, and that such an organization doesn't put an extra and unnecessary pressure on a provider organization.

The interviewed public organization revealed some cases of direct communication between service users and their relatives and the purchaser organization, or the “principal”. A purchaser organization can indeed function as “service office”, which patients can address if they have some questions or comments, since technically it is a purchaser and not a provider who has a decision-making authority. At the same time, it is not obvious why issues couldn't in theory be settled on the lowest level – between service users and people who they meet on a daily basis, people who actually perform the work and with whom they have personal acquaintance. Model is supposed to be self-sufficient in this sense – no communication outside of this pattern should be necessary. The fact that in some situations service users feel a need to contact a provider organization directly (or ask their relatives to do it on their behalf) shows the imperfection of the model.

For the most part, we don't find any references to purchaser-provider split as something negative in the relevant literature, even though it reveals some obvious shortcomings. That is due to the big role it is intended to play in the light of reconsidered positioning of public service provisioning, a positioning that took place since the spread of New Public Management. Purchaser-provider split first and foremost allows introducing and realizing the principle of users' choice, which is an end in itself.

In order for purchaser-provider split to function optimally, several steps can be taken by both purchaser and provider:

- 1) Both organizations should aim for a substantive dialog with service users, in order to inform them about the system, how work apparatus is organized and not least about their rights.
- 2) The conditions should be created in order to facilitate the possibility of communication to freely flow both ways, and not strictly top down.

Those points will become especially important in the case of (potential) increase of outsourcing.

5.3 Home-based services and time management.

The existing challenges that call for more coordination and increased organizational efficiency in home-based care services were in both met organizations with awareness, a greater attention to the ways work should be organized and enhanced control over time use. But the ways organizations have implemented it varied. While private organization actively used cooperation with own employees as a way to find solution through dialog and organizational learning, the municipal organization found a solution in reinforced time management – with use of devices that calculate the exact time of task performance, a practice, that hardly finds a support among own employees. Employees must each time document how many minutes they spent at the home of each service user and correct if the estimated time was not precise. Moreover, employer fear innovations that such time management will reach new heights with the use of manual devises, that are already implemented in some municipalities. Those devices are being carried around, and by pressing the button they start calculating the exact time from the moment employee enters service user's home and until he walks out. It then gives either red or green light depending on whether one managed to perform the visit within a given time frame.

Some believe that such control over work practices is comparable to the principle of Scientific Management. This theory started with Frederick Taylor who believed that work tasks should be combined in such a way as to achieve the highest efficiency and productivity. This means that work process is divided into smaller sections and employees get clearly defined tasks. Taylor said that while management undertakes work on mental level, the staff is left to deal with simple execution of given instructions. Scientific management presupposes then strict control over how the work is performed.

Tayloristic approach appeared in a specific time and was well suited for big manufacturing organizations; a context within which this approach originally originated. It presupposes a big deal of predictability, which is possible in manufacturing organizations, when work routines can be broken out to a smaller sequential actions and each can be spelled

out in detail. In home-based services, however, such predictability can hardly be achieved, exactly due to the aspects discussed earlier in this chapter, section 5.1, which makes existing control practices simply ill suited. Moreover, such a control is simply misleading, as it neglects such work routines as driving to the service users' home, time spent at the office working with documentation, medicine orders etc.

An efficient utilization of not only “organizational” (material) but also of “professional” (human) resources is essential for good productivity in value-based services. Home-based nursing can be called a value-based service, since its objectives are connected to values that are important on the societal level. By providing service users with the needed help, care, assistance and support, home-based nursing services promote values such as continuity, predictability, quality of life and mastery. When employees' job is directly connected with working with and for people and involves interpersonal contact, it is especially important that employees' knowledge, experience and professional ethic (or, to use Svenssons' classification – organization's professional resources) are utilized in a way that is most beneficial for service users.

In the pursuit of efficiency it should not be forgotten that the main objective of home-based care services are unquantifiable (maintain a quality of life, promoting health, preventing disease, injuries or satisfy basic social needs). That's why employees should be given some discretionary powers to be able to perform the task at his discretion and not under strict supervision.

Our study revealed that informants from the public sector experience that they are being more controlled and less trusted. This is quite an unfortunate development, as it simply leads to disempowerment of employees who don't feel they have any freedom and decision authority over one's own work routines. This can have consequences such as less work satisfaction, frustration and indifference which all together pose a threat to the quality of work.

Chapter 6 – Conclusions.

In nowadays economy, in the situation of growing expectations towards public sector capacity, an important issue for both national and local policy and decision makers will be to explore opportunities and measures for improved efficiency and effectiveness of public service provision in healthcare sector.

We conducted the study with the reference to the outlined theoretical frame, which partly included discussion about tendencies that took place in the sphere of Norwegian public administration, and partly mirrored the existing research on the subject matter, which is, however, somewhat fragmented.

The study posed a question:

What are the consequences of outsourcing on organizational performance in municipal care services?

i.e. we tried to find out what kind of processes both internally within organizations as well as in their interaction with the surroundings they operate in are being triggered as a result of shifted form of ownership. Indirectly, we have also wondered whether outsourcing /privatization could be a good solution to attain more effectiveness and efficiency of service provision in home-based nursing services.

The open question, posed in the end of Chapter 2 was related to the concern whether or not nowadays market-thinking is beginning to dominate and the ambition to cut costs is taking over the public sector. The question was whether this could result into the reinforced view that the government cannot be expected to perform well and jeopardize the governmental role as a provider of universal welfare services.

The author thinks that such a concern is at the moment missing any serious ground. In fact, it turned out that the desire to cut costs (which indeed takes place) appears at the same time as the government actually reinforces its role as a welfare service provider. It becomes obvious especially during introduction of the Coordination reform, which aims for more coordination between different health and care services and providing citizens with even more consistent and holistic help apparatus in the sphere of healthcare and nursing. The reform resulted, among other things, in the fact that many more different groups in the society now can receive home-based care services at their homes. Some of the reasons for this development are: the technology that allows for more advanced assistive devices that can help service users in their homes, limited capacity of nursing institutions, but first and foremost it is connected with the desire to grant patients democratic rights such as maintaining life

quality and freedom, which in this context are manifested in the opportunity to live at their own homes.

The most important thing that deserves a mentioning is that regardless of the scope of outsourcing in health and care sector, until a service remains statutory, it is the government who carries an overall responsibility for the service provision, and in this sense we can not say that the role of government as a provider of universal welfare services can be jeopardized. Rather than deemphasizing the role of government, outsourcing of operational responsibility becomes a signal that the government becomes more flexible in a search for alternative instruments to get tasks performed.

It has been found out that under the same circumstances, the two organizations behave quite differently when it comes to the way work routines are organized. The public organization is much occupied with efficiency and actively uses instruments such as reinforced top-down control over work routines and time management tightening. However, this results in employees' disempowerment and undermined trust on the work place.

The private organization addresses effectiveness and efficiency of organizational performance simultaneously. It evaluates organization's effectiveness weekly according to a specially developed scheme. Moreover, it tries to achieve better efficiency by optimizing the work routines that take place outside of service users' homes (driving, time at the office). The municipal organization doesn't have a similar practice.

The private organization is characterized by continuous development of internal work practices, as the informants confess that "it hasn't always been like this and it took us time to arrive to where we are now". Possibility of influencing one's own work gives informants a feeling of democracy on the work place. It also results into higher potential for organizational learning.

The theoretical assumption about inherent flexibility of public sector proved true in the study, as there were much better prerequisites for dialogue, organizational learning and change in the private organization than in the public. That is not to say that the public organization is less occupied with effectiveness, but it chooses to keep to old instruments of control and revealed less eagerness for innovation and change.

Even though we had an ambition to look at the consequences of outsourcing on organizations, we can not be sure that the detected differences can be explained by the change of ownership exclusively. We are careful with making a conclusion about what particular aspects have caused a decisive impact on organizational performance; since most likely it was a combination of factors, where it is not easy to say which played a key role.

Neither does the existing empirical literature provide a sufficient support to crucial role of privatization, and it generally is rather fragmented.

Hall & Lobina (2005) claim that

“It is impossible to express a relevant conclusion in terms of efficiency in the two sectors, as the ineffectiveness of an organization is not entirely influenced by its ownership” (Hall D., Lobina E., 2005:3).

Moreover, Szebehely concludes that the same can be said about quality.

“The existing research shows no clear consequences of privatization, ... with regard to ... quality (Szebehely, 2011:251).”

Effectiveness and efficiency of organizations operating in different sectors turned out to be hard to measure and compare due to the lack of common systems of measurement indicators.

However, we think that even though the current study didn't result into some unambiguous conclusion about consequences of outsourcing on organizational performance, it revealed some curious patterns on its own.

The research was performed in a form of comparative study, and it has been mentioned in Chapter 3 that this method allows for the opportunity to go beyond simple exploratory case studies and move to a more advanced level; when general theoretical assumptions can be formed. We are however careful with making particular conclusions at this point, but we think that the current results can give a good starting point for more laborious research on this topic and a closer investigation of possibility for causality between organizational performance and a form for ownership.

Chapter 7 – Possibilities for Future Work and Research.

The choice of the method (qualitative in-depth interviews) allowed for the depth of the research but less for its breadth. However, the fact that the case community is in fact one of the very **few** municipalities that started outsourcing within healthcare sector, makes the results somewhat more substantial. In addition, our study is not standalone, but we have *contextualized* it, by examining it in a context of already existing broader research, represented by the tertiary sources. Nevertheless, one of the possibilities for future research can be a more extensive research design, including more research objects. Such a research could provide more breadth, increasing its internal and external validity.

Our study turned out to be partly consistent with the findings of previous researches on a subject matter that were revealed by the analysis of tertiary data, and partly discovered some patterns on its own. For instance, our research revealed quite some differences when it comes to organizational performance and organizational behavior in the organizations in different sectors, while the analyzed documents (FAFO-rapports) didn't detect any particular variation among the organizations that could be traced to the form of ownership. Moreover, the reports draw a more negative picture of the consequences of outsourcing in Norwegian healthcare services, than what this study suggests.

This result in itself indicates that there does not yet exist any consistency in empirical evidence in this domain. A more systematic research in the sphere of outsourcing within healthcare and nursing services is needed.

Another research possibility is to study less densely populated areas in Norway and research on what impacts do New Public Management-inspired ideas have on public sector organizations, and investigate the possibility of privatization in these areas.

Moreover, a more consistent quantitative survey among the broader population is needed, in order to follow up the development of public opinion around privatization, which, as FAFO-rapport confirms, is gradually changing.

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Appendix 1.

Interview guide: municipal authority.

Hei, jeg heter Sofie og jeg skriver en masteroppgave som dreier seg om anbudsutsetting og privatisering av kommunale tjenester innen pleie og omsorg, med et spesielt fokus på hjemmesykepleien. Med privatisering mener jeg at kommunen har gitt private kommersielle virksomheter muligheten for å utføre oppgaver som tidligere ble utført av kommunale eller kommunalt eide enheter. Jeg tenker på tilfeller hvor kommunen fortsatt har et overordnet ansvar for at oppgaven utføres og hvor kommunen finansierer oppgaven. Du kan til enhver tid kontakte meg eller min veileder for nærmere opplysninger om vårt forskningsprosjekt. Alle data fra undersøkelsen vil bli behandlet slik at de som blir intervjuet er sikret fullt anonymitet.

Jeg ber deg om å svare på følgende spørsmål og jeg setter pris på om svarene er litt utdypende.

På forhånd tusen takk for samarbeid.

- 1) Er det mange tjenester som er privatisert\delprivatisert i deres kommune?
- 2) Når startet kommunen med privatiseringen av helse og omsorg tjenester?
- 3) Hva er etter din oppfatning den viktigste drivkraftene til at kommunen har valgt å privatisere helse og omsorg tjenester (hjemmesykepleien)?
(Svaralternativer:
 - a) *Privatisering er en trend som viste gode resultater i andre kommuner\sektorer*
 - b) *Som et forsøk på å finne alternative løsninger på aktuelle utfordringer helse og omsorg sektoren står overfor.*)
- 1) I hvilken grad kan man si at kommunen hentet erfaringer fra andre sektorer\kommuner når spørsmål om privatisering av helse og omsorgstjenester ble vurdert?
- 2) Hvem i kommunen har tatt initiativet til å privatisere helse og omsorgtjenester?
- 3) Hva etter din mening er utfordringer med privatisering i helse og omsorgssektor?
- 4) Hva etter din mening er de største fordelene med innføringen av konkurranseutsetting\anbudsutsetting\privatiseringen innen helse og omsorg?
- 5) Hvordan foregår resultat- og effektivitetsevaluering av privatiserte virksomheter?
- 6) Hvordan tror du er holdningen blant de ansatte til de endringene som har skjedd?
- 7) Måtte kommunen benytte seg av *ekstern kompetanse* i løpet av privatisering- og konkurranseutsettingsprosessen?

Appendix 2.

Interview guide: management in organizations.

Hei, jeg heter Sofie og jeg skriver en masteroppgave som dreier seg om anbudsutsetting og privatisering av kommunale tjenester innen pleie og omsorg, med et spesielt fokus på hjemmesykepleien. Med privatisering mener jeg at kommunen har gitt private kommersielle virksomheter muligheten for å utføre oppgaver som tidligere ble utført av kommunale eller kommunalt eide enheter. Jeg tenker på tilfeller hvor kommunen fortsatt har et overordnet ansvar for at oppgaven utføres og hvor kommunen finansierer oppgaven. Du kan til enhver tid kontakte meg eller min veileder for nærmere opplysninger om vårt forskningsprosjekt. Alle data fra undersøkelsen vil bli behandlet slik at de som blir intervjuet er sikret fullt anonymitet.

Jeg ber deg om å svare på følgende spørsmål og jeg setter pris på om svarene er litt utdypende.

På forhånd tusen takk for samarbeid.

- 1) Hvor mange ansatte har erfaring fra tjenesteyting i offentlig sektor? Hvor mange har erfaring fra offentlig sektor før de startet i deres virksomhet?
 - 1.1. Utdypende spørsmål: Hva etter din\deres mening er den største forskjellen mellom virksomhet som drives i privat regi versus i kommunal regi?
- 2) Hva etter din mening er de største fordelene med innføringen av konkurranseutsetting\anbudsutsetting\privatiseringen innen helse og omsorg?
- 3) Hva etter din mening er de største utfordringene med innføringen av konkurranseutsetting\anbudsutsetting\privatiseringen innen helse og omsorg?
- 4) Hvor ofte har deres virksomhet kontakt med kommune? Hvordan foregår resultat- og effektivitetsevaluering av deres virksomhet? (*f.eks: tverrgående brukerundersøkelser, sammenligning resultatmål, m.m.*)
- 5) Har du opplevd noen problemer\utfordringer\svakheter i deres avtale med kommunen?
- 6) Har det vært et problem at det ikke er satt opp målsettinger som gjør det mulig å stille klare nok krav til kvaliteten på tjenestene?
- 7) Tror du at private virksomheter er i stand til å levere tjenester på en mer kostnadseffektiv måte enn kommunale virksomheter? 4.1) Hvis ja: Hvordan?
- 8) Hvordan tror du effektivitet av tjenesteyting sørges for i din virksomhet? Hvilke tiltak har blitt utarbeidet med hensikt på å øke effektivitet? (*Svaralternativene: detaljert arbeidsbeskrivelser, time management (tidsrammer for oppdragene) m.m.*)
- 9) Hvordan oppnår deres virksomhet kostnadseffektivitet?
- 10) Tror du at for mye fokus på kostnadseffektivitet kan gå på bekostning av kvalitet på tjenester?
- 11) Hvordan organisasjonen selv foretar resultat- og effektivitetsevaluering av sin drift?
- 12) Hvor kan ansatte henvende seg i tilfelle de har noen spørsmål angående sine arbeidsoppgaver?

13) Hvordan sørger deres virksomhet for effektivitet i tjenesteyting? (*Svaralternativene: kompetanseheving for ansatte, gjennom utdypende opplæring av nye medarbeidere, brukerundersøkelser m.m.*)

14) Tror du at stykkprisfinansiering er en optimal økonomisk modell for finansiering av helse og omsorgstjenester?

Appendix 3.

Interview guide: (tillitsvalgte) employees in organizations.

Hei, jeg heter Sofie og jeg skriver en masteroppgave som dreier seg om anbudsutsetting og privatisering av kommunale tjenester innen pleie og omsorg, med et spesielt fokus på hjemmesykepleien. Med privatisering mener jeg at kommunen har gitt private kommersielle virksomheter muligheten for å utføre oppgaver som tidligere ble utført av kommunale eller kommunalt eide enheter. Jeg tenker på tilfeller hvor kommunen fortsatt har et overordnet ansvar for at oppgaven utføres og hvor kommunen finansierer oppgaven. Du kan til enhver tid kontakte meg eller min veileder for nærmere opplysninger om vårt forskningsprosjekt. Alle data fra undersøkelsen vil bli behandlet slik at de som blir intervjuet er sikret fullt anonymitet.

Jeg ber deg om å svare på følgende spørsmål og jeg setter pris på om svarene er litt utdypende.

På forhånd tusen takk for samarbeid.

- 1) Har du erfaring med å jobbe med helse og omsorgstjenester i offentlig sektor?
 - 1.1) Utdypende spørsmål: Hva etter din\deres mening er den største forskjellen mellom å jobbe i offentlig sektor og en privat virksomhet, for eksempel deres virksomhet?
 2. Hva etter din mening er de største fordelene med å jobbe i en virksomhet som drives i privat regi?
 3. Hva etter din mening er de største utfordringene med å jobbe i en virksomhet som drives i privat regi?
 4. Tror du at private virksomheter er i stand til å levere tjenester på en mer kostnadseffektiv måte enn kommunale virksomheter?
 5. Hvordan etter din oppfatning oppnås kostnadseffektivitet i deres virksomhet?
 6. Hva legger du i begrep effektivitet når det anvendes til helse og omsorgstjenester?
 7. Hvor kan ansatte henvende seg i tilfelle de har noen spørsmål angående sine arbeidsoppgaver?
 8. Hvordan tror du effektivitet av tjenesteyting sørges for i din virksomhet? Hvilke tiltak har blitt utarbeidet med hensikt på å øke effektivitet? (*Svaralternativene: detaljert arbeidsbeskrivelser, time management (tidsrammer for oppdragene) m.m.*)
 9. Tror du at for mye fokus på effektivitet kan gå på bekostning av kvalitet på tjenester?
 10. Føler du at du har det travelt på arbeidsplassen?
 11. Tror du at prisstykkfinansiering er en optimal modell for finansiering av helse og omsorgstjenester?
 12. Hvis det var opp til deg, hva ville du forandret i den måten arbeidsprosessen er organisert på nå?

Forespørsel om deltakelse i forskningsprosjektet

«Does outsourcing increase or decrease productivity in municipal care services?

(norsk: Driftsutsetting av kommunale helse- og omsorgstjenester – til hjelp eller hinder for effektivitet?)»

Bakgrunn og formål

Prosjektet dreier seg om anbudsutsetting og privatisering av kommunale tjenester innen pleie og omsorg, med et spesielt fokus på hjemmesykepleien. Med privatisering mener jeg at kommunen har gitt private kommersielle virksomheter muligheten for å utføre oppgaver som tidligere ble utført av kommunale eller kommunalt eide enheter. Jeg tenker på tilfeller hvor kommunen fortsatt har et overordnet ansvar for at oppgaven utføres og hvor kommunen finansierer oppgaven.

Formålet med prosjektet er å sammenligne en kommunal og en privat virksomhet og se om valg av driftsform kan ha virkning på effektivitet.

Grunnen at det ikke finnes private tjenesteleverandører i Stavanger, ble det bestemt å velge deres kommune.

Hva innebærer deltakelse i studien?

Datainnsamlingen skal foretas ved hjelp av kvalitative intervjuer. Spørsmålene skal omhandle ansattes egen oppfatning av sin virksomhet og virksomhetens effektivitet. Data skal registreres med notater og lydopptak.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt. Det er kun student og veileder som vil ha tilgang til personopplysninger.

Verken virksomheten eller deltakerne vil kunne gjenkjennes i den endelige publikasjonen.

Prosjektet skal etter planen avsluttes i juni. Datamaterialet skal anonymiseres og opptaket skal slettes ved prosjektslutt.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med:

Sofie Gorozhankina, student. Tlf: 95008336 eller

Lars Klemsdal, veileder. Epost: lars.klemsdal@uis.no.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

(Signert av prosjektdeltaker, dato)

Jeg samtykker til å delta i intervju