Change, reorganization and quality of home carefor elderly people in Sweden during the 1990s : paper to 17:e Nordiska konferensen i gerontologi 23-26 maj 2004 i Stockholm

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CHANGE, REORGANIZATION AND QUALITY OF HOME CARE FOR ELDERLY PEOPLE IN SWEDEN DURING THE 1990S

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Abstract

During the 1990s several kinds of reorganization has taken place in public services in Sweden. Reorganizations according to the idea of market economy have been most salient and debated. In many municipalities private companies have started to organize home care service for elderly, financed by tax. Public home care organizations have reorganized the working organization and managing structure, partly to save money and partly to reach better quality of care. The home care services have a key role in the care of the elderly in the society. The quality of care is important for the possibility for elderly to stay as long as possible in their ordinary homes. We have performed a longitudinal study of the reorganizations during the 1990s in order to explore the consequences for quality of care.

The study was performed in seven districts in three different municipalities representing different types of municipalities and different kinds of reorganizations. It comprises private companies, traditional public organizations, public organizations with changed managing structure and co-ordination of home help and home health care. Quality of care is studied through assessment of the communication in the organization, the psychosocial working environment of the caregivers and the quality of the care work. Politicians, managers, ca. 100 care givers and ca. 500 elderly receiving help and care have been interviewed four times during the period (1993, 1995, 1997 and 2002/2003).

The traditional organization within small districts with small autonomous working teams and easy accessible supervisor expose the best quality. There are no unambiguous differences between public and private organizations. There is however a tendency for successive decline of quality for private companies after they have been established. Other aspects of the reorganizations, e. g. to have special officials for assessment of help need, do not contribute to better quality but create new communication gaps in the organization and have negative influence on the working environment.

Stability in the composition of the care worker teams, leadership, decision-making processes in the organization and the district area promote high quality of care. The reorganizations during the 1990s seem on the whole to function contrary to promotion of high quality in the care and service for the elderly.

Introduction

During the 1990s a massive reorganization has taken place in public services in Sweden. Changes following attempts to transplant market ideology into local politics have been the most salient and debated. The same process has taken place in other western countries too, especially in the UK during the 1980s (Mellet and Williams 1997, May& Brunsdon, 2002). In consequence parts of the public services financed by taxes have been contracted out to private companies (cf Montin, 1995). Internal quasi-markets have been established e g concerning the care of elderly people and health care. To buy care and services from private providers is no longer a marginal phenomenon. In 2003 about 6 % of the elderly care in Sweden was contracted out to private companies increasing from 1999 by 25% (Socialstyrelsen, 2004).

Swedish municipalities have considerable autonomy with regard to standards for the care and the services provided (Thorslund, et al 1997). That means that great differences in organization and scope of care supply have developed between the municipalities. However, the attitudes towards the public sector in Sweden are rather unambiguous. According to Andersson (1996) the majority of elderly people in Sweden in need of some form of care and service want to get it from the public sector. A majority of the Swedish population prefer publicly financed and controlled care systems for the elderly and for the health sector (See Bergmark, 2000).

The home help services have a key role for the care of elderly people in their own homes. They have been the objects of many types of organization changes during this period (Socialstyrelsen, 1994, 2000 and 2004). Besides privatisation the management of the organizations and assessment procedures for the need of care and service has been changed. Therefore it is a suitable example to illustrate the consequences of the changes in the public sector during the period in question. The direct consequences of the structural change in the care of the elderly have not been the object of many empirical studies. We have however performed a longitudinal study of the consequences of the organizational changes for the care quality and for the working environment for the caregivers during this period. In this paper we describe the different organizational changes that have taken place and discuss the consequences for the quality of the care for elderly people based on the results of our study. The methods of the study and parts of the results have been presented in detail elsewhere (Olsson & Ingvad, 2000).

The public service organization

The public sector organizations are financed by taxes and serve the public good. Therefore public control through politicians is necessary. The larger the public organizations have grown the larger the need of planning and administration has grown. The public organizations can be said to be composed of four domains: policy, management, professional (service) and users. In their "domain theory" Kouzes & Mico (1979) have emphasized that the domains constitute not only functional parts of the organization but also interest groups. The domains try to control the organization and its activity by different strategies (Olsson, 1988). Within the domains specific perspectives on the service develop. This results in differences between the domains in their perspective on the goal of the organization, on work modes, problem solving methods and change strategies (Kronvall et al, 1991, Borgert, 1992, Olsson & Ingvad, 2000). There is often tension and conflicts between the domains. The politicians have to decide the goals and the management has to formulate rules for and control the activity in the organization. The professionals have to realize the goals and solve specific problems in the encounter with the users. The management tries to obtain control over the professional domain and the professionals try to obtain autonomy and self-regulation to meet the needs of individual users (cf Szulkin, 1989). Kouzes and Mico (1977) say that each domain fights for

stability and " (to) resist the external , environmental threats to stability and also threats coming from the other domains" (p 461). The public service organizations tend to develop a high degree of hierarchy where the communication first and foremost goes from the top downwards, which adds to the tension in the organization and make conflict management between the domains very difficult. Olsson (1988) has shown the detrimental effect of conflicts between the domains on the outcome of a change process in a psychiatric organization.

Criticism of the public sector organizations

During the 1980s and the 1990s public sector organizations in Sweden and in other western countries were heavily criticised by politicians and researchers (Kronvall m fl, 1991, se also Blomquist & Rothstein, 2000). The management domain was considered to have grown without restraint. The professional domain was considered to have too little influence on its working situation with negative consequences on working environment and on the quality of the work (Broström, 1991). The political leadership was criticised for being vague and ill defined. The public service was said to be too fragmented. Different public activities had the same tasks or were poorly co-ordinated. The criticism also said that the public sector did not give the citizens an opportunity to make their own choices. The criticism coming from advocates for market ideology said that the development of the public sector had no driving force because of the lack of competition. The representatives of the market ideology naturally had the opinion that development of competition would result in a better service e.g. for the elderly and better health care. Influenced by an economic crises in Sweden in the beginning of the 1990s there also grew a demand for a more cost-efficient public sector. This also became a central argument for the predecessors of the market ideology.

Home-help services in Sweden

In Sweden both the home-care services and the institutional care for the elderly were enlarged during the 1960's and on into the second half of the 1970's. Meanwhile both forms of care have decreased in scope during the 1980's and 1990's, despite the fact that the proportion of those aged 80 years and older (4.5% of the total population) has increased by 60% since 1980. This development has led to many more of the very old and the elderly sick being cared for at home by the home-care services and to some extent by relatives. The operations are performed by *home-helpers*, and are mainly geared to elderly persons, comprising help with practical household chores (such as cleaning, shopping, laundry, and cooking), personal care (such as help to go to the toilet, to wash, to shower, and to dress), and social support (such as breaking isolation and increasing security and safety in the person's own home) (see Ingvad, 2003). The proportion of people aged 80 and over who receive home help today is ca 18%. For the part of the population aged over 65 the figure is ca 8%.

Reorganization and change during the 1990s

A political re-orientation towards new liberty and economic recess in Sweden created expectations of a reorganized public sector towards the end of the 1980s. The public sector should be more effective and create higher quality for lower costs through a massive reorganization. Several changes were started in most of the municipalities. There grow several change lines based on different argument and traditions. The effect of these different lines of change on home care services are discussed here (outline in Table 1).

TABLE 1 Changes and reorganization in home care services during the 1990s

Goal	Change model
Effective co-ordination	*ÄDEL-reform – co-ordination of provision of home help and health care for elderly* (statutory)
Competition, effective management and lower costs (market ideology)	*Market or quasimarket models* *Contracting -out – privatization* (in many municipalities) *Purchaser/provider split* (in many municipalities)
Citizen rights and citizen influence	*Assessment of need by special officials* (In 1999, 80 % of all municipalities) *Recipient choice system* (experiments) *Elderly check* (experiments) *Recipient co-operatives* (experiments)
Effective working organization	*Result units* *Flattening out the organization – fewer layers in the hierarchy and effective leadership* (very usual reform in most of the Swedish municipalities) *Self-managing working teams*

Co-ordination

Co-ordination efforts constitute a response to the critique that the public service in the health care sector has fragmented into parts doing the same job. The goal is to achieve higher quality, efficiency and to reduce costs. One example is the "ÄDEL-reform" where health care, social service and help services to the elderly are co-ordinated between the municipalities and the county councils (Proposition 1990/1991:14). The consequences are that more responsibility for the health care of the elderly in their homes and in the special housing is transferred from the counties to the municipalities. Funding is transferred from the counties to the municipalities. The reform was constituted in 1992. For the home help personnel it implies new tasks. Besides help with household and personal hygiene they have had to learn to give certain medical service.

Market and quasi-market -- Separation of responsibility

A market model or a quasi-managed market, with the separation of purchasers from providers was introduced into health and social care (see also Johnson & Cullen, 2000, Andersen, 2000) in the beginning of the 1990s in some municipalities. The politicians restricted their responsibility only to purchase service and care in accordance with the needs of the citizens. Their responsibility to manage the operative organizations was reduced. A quasi-market in the public sector was created, where different companies could compete. This is named the *purchaser- provider-model*. It has been given different design in different municipalities. In its pure form the model means that the service and care are contracted out to private or public providers. The administration of the public service and the care work is parted. The public authority assesses the need of the elderly, decides about the need of care and has to look after the interests of the purchaser. The provider company has the responsibility for the management of the care-giving and has the responsibility for personnel and working environment. The goal of the model was to force high quality and cost efficiency through the created com-

petition. The arguments for the model have been to reach more flexibility in the care resources. Private companies have especially argued that their existence on the market give the elderly freedom of choice (Andersen, 2000), that they can combine the best of the public sector and the best of the private sector. Andersen (a a) means that during the 1990s the private companies have begun to use more and more political instead of economic arguments to gain access to this new market.

Citizen rights and citizen influence

One argument for the changes has been to satisfy the rights of the citizen and to give the individual possibilities to make choices. In the earlier system of home-care the same official did the assessment of the need, decided about the amount of care and also managed the working force. In many municipalities a purchaser-provider model without contracting out to private companies was introduced in order to satisfy the rights of the citizen better. Here the model is not a real purchaser-provider model but a separation between the "ordering" of the service and the "carrying out" of services. The responsibility for the "ordering" is given to a special official who also has the task to assess the need of the elderly and decide the amount of help they are entitled to (cf Fuglsang, 2001). In some municipalities the elderly are given possibility to choose the provider of the care. *Recipient choice system* and *elderly checks* are such ideas used in some municipalities as experiments. These models are also created in order to reduce the costs of the care.

Efficiency in the working organization

Independent of the market ideology other ideas for change of the care organizations have been brought up by organization researchers and management experts. These ideas are especially built on critique of the administration and the management of the organizations. As a cure for complicated decision processes and lack of possibilities for the personnel to take initiative, reduction of the levels in the organization and autonomous work units is suggested. We have called this model "flattening out" of the organization. The result has often been fewer supervisors. One type of “flattening out” was the result unit. That means that a small unit of workers was given autonomous power over a limited budget to perform a decided workload. These reformations of the organizations as a consequence mean that those companies performing the care in the purchaser – provider model can have very different structures. In the literature about organisations and organisation theory these models have often during the last 10 years been discussed under the umbrella term “New Public Management” (Hood, 1995; Blomberg, 2004).

The costs

Rising costs for the care of the elderly have been a motive for all organization changes and reformations during the 1990s.The rising costs partly depend on the fact that the proportion of elderly people in society is increasing. Partly this question concerns political ideology and national economics e g how high taxation can be tolerated. The discussion of the organization of the care of the elderly during the 1990s has been concentrated more on how to lower costs than how to produce a higher value of care. This naturally depends on the fact that it is much easier to measure costs than to measure values. Reduced costs are, however, not in themselves the same as higher values (see Jackson, 2001). Contracting out has been considered to result in lower costs because of the competition. Result units have been considered to make the personnel more conscious of the costs and able to participate actively in money saving programs. Within the home care service the endeavour to reduce costs has also resulted in decrease and concentration of the resources on the elderly with the greatest need. There is also an increasing press on relatives to take more responsibility for the care of the elderly. As a consequence

of the endeavour to reduce costs the recipient of home care has – since the middle of the 1980s – gradually become older and weaker. Stricter rules for receiving home help have been formulated and charges have been increased. This gradually changing situation makes it very difficult to study the consequences of the organization changes and reforms per se.

Working environment

Improvement of working environment has seldom been mentioned as a motive for organization changes during the 1990s. Indeed result units, flattening out and contracting out, have been considered to give the personnel possibilities to develop the quality of the work and have more influence on their working environment. But the need of a healthier working environment has not been the immediate motive for the reforms and changes during the 1990s. The discussion has been concentrated on efficiency and quality of the care and on cost reduction. In the purchaser-provider model the working environment becomes a responsibility of the providing company. There have been expectations that the competition on the market (or quasi-market) gives incentives for the companies to provide a good working environment. The politicians and the administrators in the municipalities have therefore failed to take the immediate responsibility for the health of the personnel. In the beginning of the first decade of the new millennium the rate of sick members of the work force has risen to a very high level. All the changes during the 1990s may have contributed to this very bad situation with high costs for the state.

A longitudinal study of the quality of home help services during the 1990s

Method and material

Our project (see Olsson & Ingvad, 2000) involves seven different districts in three municipalities. The municipalities have been chosen to represent the most usual types of municipalities in Sweden as to size and geographical characteristics. Municipality A is a fairly small municipality (pop. about 9 000) with built-up areas with industrial character and sparsely populated forest areas. Municipality B (pop. about 25 000) has as its centre a rather small town (pop. about 16 000), which is surrounded by level country. Municipality C is a large town (pop. about 250 000). The changes discussed above have been performed in different ways and to a different extent in the seven districts (table 2).

In two districts (Private I and Private II) the home help services has been contracted out to private companies.One of these (Private II) has changed back to public management. In one district (Kommunal) the purchaser-provider model was used from the beginning of the study without contracting out (differentiation between "ordering" and "carrying out"). In two districts in municipality B there was performed from the beginning of the study a change in the management structure. These organizations have been flattened out. These districts have to some extension been changed to a less flattened organisation before the last measurement. In the districts within the smallest municipality, A, no major organization change had been done in the beginning of the study period. They have worked according to a traditional model. One of those districts however, some years earlier had introduced smaller working teams with more influence on the planning of the work than in the other districts. Municipality A and B have introduced special assessment officials (differentiation between "ordering" and "carrying out") before our last measurement 2002/2003 (see table 2).

Table 2 Description of the organization characteristics and the changes of the different districts in the study

District	Characteristics and changes during the 1990s
Oak valley (1200 inhabitants); municipality A	Small autonomous working teams, "traditional organisation" 1993 - 1998. 1998 division of "ordering" and "carrying out" with separate assessment officials.
Moheden (3000 inhabitants); municipality A	Small working teams, "traditional organisation" 1993 – 1998. 1996: reorganisation of the work teams.1998: division of "ordering" and "carrying out" with separate assessment officials.
The Center (3000 inhabitants); municipality B	Change of the management to a flattened organization 1992; division of "ordering" and "carrying out" 1998 with separate assessment officials. From 1998 strengthened team leadership and smaller work teams.
The Plain (1400 inhabitants); municipality B	Change of the management to a flattened organization 1992; division of "ordering" and "carrying out" 1998 with separate assessment officials. 1997: Merging of the work teams. From 1998 strengthened team leadership.
Private 1 (3000 inhabitants); municipality B	Contracted out to the same private company during the whole study period.
Kommunal (5000 inhabitants); municipality C	Purchaser-provider model from 1992 with public management of the services with separate assessment officials. Several changes in the administration and work team composition during the study period. 2001: Smaller work teams and strengthening of the team leadership.
Private II (6000 inhabitants) municipality C	Purchaser – provider model: contracted out to private companies 1992; 1996: shift to a new private company; 2001: shift to "ordering" – "carrying out" and public management.

Three main aspects of the organization have been studied. Together they can be said to form a definition of the quality of the care:

1. *Communication within the organization*: The communication within the organizations was studied through documents and interviews with politicians, managers and team leaders. We have also observed different kinds of meetings. The following aspects were coded through a qualitative analysis of data:
    a. The communication as a whole, especially the flow of information between the domains of the organization, conflict management and decision making procedures.
    b. Personnel administration. Efforts to improve work environment and the education of the personnel.
    c. Change strategies. Efforts to co-ordination between different interests in the organization. Three different types are coded according to Olsson (1988): *power strategies*, *defensive strategies* or *collaboration.* Collaboration is seen as the more constructive strategy.

2. *Working environment:* The working environment of the home helpers were studied by questionnaires, interviews and observation in the home helpers working teams:
    a. Collective influence on working team decisions was coded from direct observation of group meetings.
    b. Group climate of the working teams. This characteristic was studied by a standardized method built on the adjectival list (Hansson & Olsson, 1991; Olsson et al, 1995, Ols-

son & Ingvad, 2000, 2001). The climate can be signified as *open, cohesive, stable* or as *a state of conflict*

c. *Work strain.* This was coded from the home-helpers rating of the emotional climate in relation to the recipients. It was studied with the help of an adjectival list. By this method the emotional climate can be signified as *friendly*, *instrumental*, *emotional*, *heavy* or charged with *conflict.* (see Olsson & Ingvad, 2000, 2001)

3. *Quality of the care*. The quality of the performance of the home care was studied by means of questionnaires, interviews and observation. The following aspects were studied:
   a. *Continuity.* The number of home-care workers assisting the recipient. Highest continuity is coded when only one worker assists the care recipient.
   b. *Care climate.* The emotional climate in the relationship between the recipient and the home-helper was measured by the help of an adjectival list. The care climate can be signified as *friendly*, *rational*, *emotional* or *uncertain.* (see Olsson & Ingvad, 2000, 2001)
   c. *Participation.* The possibility of the recipient to take part in the planning of her/his help in the organization.

A longitudinal design was applied. The districts have been studied four times during a ten-year period:

1. 1993, Only communication within the organization and working environment
2. 1995, all aspects
3. 1997, all aspects
4. 2002/2003 (the study started late 2002 and ended early 2003), all aspects

The design makes it possible to compare the different districts at the different points of time and also to compare the development within the districts over time.

Results

In order to compare the quality in the different districts an index for each aspect of quality and an overall index of quality was computed. For each aspect the districts were given an overall evaluation based on the qualitative or quantitative results on the aspects described above (for more detail see Olsson & Ingvad, 2000, Olsson & Ingvad, 2001 and Olsson & Ingvad, 2004). The evaluation goes from –1 to 1 for all aspects besides the care climate of the recipient. The judgement of the care climate is multiplied with 2 because this aspect is known from earlier studies to be central in the judgement of the quality of the care (Olsson & Ingvad, 2000).

The result on the overall index is presented in table 3. There is a tendency to a general deterioration of the care quality during the 1990s. This is especially due to negative changes in working environment and the care climate. In table 3 it is most clearly shown for the two districts of the big city. It is even more evident when you analyse the detailed results not shown in this article (Olsson & Ingvad, 2000). This tendency may depend on the recipients becoming older and that the help first and foremost is given to those with the greatest help need. Thus this effect may partly be a result of a general downsizing of elderly care in the country during the study period. The two districts with public management in municipality B have however a slightly better quality 2002/2003 than before. This fact may depend on a strengthening of the team leadership in those two districts.

The "ÄDEL-reform", which - in 1992 - prescribed by law co-ordination of the care services and medical care, has been implemented to a different extent in the municipalities. It has been carried out earlier in the smaller municipalities than in the big city where it has been realised only to a small extent in 2002. This reform produces new tasks for the personnel in the home help services. There have been some conflicts still active in 2002/2003 around the

implementation of more medical tasks for the home-helpers. But this reform has also forced the organizations to give the personnel better education in care work.

A comparison between districts with different organization and organization development does not give (Olsson & Ingvad, 2000) an unambiguous picture. The district *Oak Valley* with a traditional organization with small autonomous working teams has the best quality according to the index in table 3. It has a higher quality than other districts on almost all aspects studied and especially positive values on care relationship and measures of working environment. This district has however a lesser value in 2002/2003 probably depending on the bad management of conflicts around implementing special assessment officials in the municipality.

There seem to be especially negative consequences of the flattening out of the organization illustrated by The Centre. In 1995 and 1997 a greater proportion of the recipients rate the care relationship as *uncertain* than in any other district. The district has a somewhat better overall value in 2002/2003 but still a negative value. This change may depend on the strengthening of leadership and reorganisation of the work teams into smaller units.

Contracting out does not have unambiguous consequences for the quality. It is not possible to draw any clear-cut conclusions from the results for districts, which have contracted out and to private companies. They do not differ from some of the public organizations. Private II is somewhat better than the public organization in the same municipality in the beginning (1993 – 1995) but this difference diminishes in the long run. After going back to public management the value is still sinking. This may depend on the consequences of many changes in the organisation during the whole study period. Private I was not completely studied from the beginning. It has 2002/2003 lowest value of all districts at all points of the study. Especially the care climate as judged by the care recipients becomes negative from 1997 to 2002/2003. This may add to the idea that the private companies start with high quality and then go on downsizing in order to get a higher profit. Both big city districts show a decreasing quality in 2002/2003. A gradual impairment of the working environment is shown in district Private II, especially after changing company in 1997. The public organization, Kommunal, is influenced negatively by the contracting out in Private II and some other districts in the big town as a competition about personnel have begun. The younger home-helpers were the first to apply for the jobs at the newborn private companies. The personnel at the public company therefore got a higher average age. Therefore this study does not give any arguments for contracting out as a key to better quality in the home help.

Table 3 The overall judgement of the quality in the districts.
The highest possible value of the index is 10 and the lowest is –10.

	Quality index		
District	1995	1997	2002/03
Oak valley (1200 inhabitants); municipality A	6	6	2
Moheden (3000 inhabitants); municipality A	1	-1	-3
The Centre (3000 inhabitants); municipality B	-7	-6	-5
The Plain (1400 inhabitants); municipality B	1	-4	2
Private 1 (3000 inhabitants); municipality B	>-5 (data not complete)	> -3 (data not complete)	-10
Kommunal (5000 inhabitants); municipality C	-3	-4	-5
Private II (6000 inhabitants) Municipality C	-1	-5	-7

The distinction between "ordering" and "carrying out" was applied in the two districts in the big city and in Privaten 1 in municipality B in 1992. A communication gap in the organisation was observed in our observation studies in the two districts in the big city 1995 and 1997 (Olsson & Ingvad, 2000). There appeared misunderstanding as the communication of ordering often goes by mail or fax to the home-helper. In both municipality A and B this structure was implemented 1998. Especially in municipality A there appears detrimental conflicts between levels in the management structure as a consequence of this reorganisation. In interviews in all districts 2002/2003 we observed that the assessment officials had no time to do follow-ups in order to evaluate the result of their orderings. This means that the expected effect of this reform to secure the legal rights of the individual is not fulfilled.

In order to analyse the results further correlation coefficients between certain organisation characteristics and quality measures for communication, working environment, care work and the total quality measure have been computed. Organisation characteristics are coded:

1. *Municipality and district size* in number of thousand inhabitants.
2. Degree of *divided organisation* in three levels: Traditional organisation (1); ordering – carrying out (2); contracting out (3).
3. Degree of *flattening out* in three levels: Team leader in every work team (1); Manager with responsibility for several work teams with rather good accessibility (2); Manager with responsibility for several work teams not easily accessible (3)
4. Degree of *work load* is coded as the percent of recipients with daily care
5. The *time* variable is the three assessment points: 1995 (1); 1997 (2); 2002/2003 (3)

Table 4 Correlations between quality measures and organisation characteristics and time.

Quality /Organisation characteristic	Municipality size	District size	Flattening	Divided org	Work load	Time
Org communication	-0,55**	-0,59**	-0,29+	-0,30	0,00	0,11
Working environment	-0,36	-0,47*	-0,18	-0,52*	-0,40*	-0,33
Care work	-0,38	-0,39	-0,33	-0,03	-0,35	-0,41*
Total quality measure	-0,55**	-0,61***	-0,32	-0,32	-0,29	-0,28

*= 0,05> p >0,01; ** = 0,01> p >0,001; *** = p< 0,001

The results are shown in table 4, which shows that municipal size and district size is important for the quality. The degree of divided organisation has an impact on the working environment. Care work shows sinking quality with time. As the different organisational characteristics are correlated to each other regression analysis was applied to find out which characteristics had the highest influence on the quality measures. The results of the regression analyses are shown in table 5. Here we can read that district size is most important for the communication in the organisation and the total quality measure. The results in table 5 also show that working environment is influenced by the degree of division of the organisation and that the flattening of the organisation to some extent influences the quality of the care work. According to these analysis the changes of the organisations introduced during the 1990s have to some extent negative influence on the caring work and the working environment. There are no signs of positive influences of the organisation changes upon quality. Most of the changes done during the 1990s have had negative effects not removed in the long run as far as our study is performed. The positive changes in quality from 1997 to 2002/2003 shown for dis-

tricts Center and The Plain may be the results of making the organisations less flattened. It should however be observed that the district size is a very important factor for the quality of the home help. But the small districts are also sensitive to changes like flattening of the organisation and bad implementing processes as can be shown for the Plain in 1997 and for Oak valley in 2002/2003.

Table 5 Regression analysis of the contribution of organisation variables to the variation of the quality measures.

Quality measures	Organisation variables	Beta value	R^2
Organisation communication	**District size**	**-0,57****	**0,33**
Working environment	**Degree of devided organisation**	**-0,56***	**0,31**
Care work	**Time** **Flattening out**	**-0,44*** **-0,36 (p= 0,1)**	**0,27**
Total quality measure	**District size**	**-0,55***	**0,3**

* = 0,05> p >0,01; ** = 0,01> p >0,001; *** = p< 0,001

Discussion

The big wave of organization change in the public sector starting at the beginning of the 1990s did not start on the ground of scientific evidence that they should result in better care quality. There was no such evidence that private companies had a better control over the tasks and division of responsibility than public organizations. In an international comparative study Szulkin (1989) has compared private companies with public organizations. According to this study the public organizations are controlled from the top to a higher degree. However, the personnel have more influence in the planning of their work than in private companies. There is no convincing evidence that private companies can achieve better quality than public organization in care or health work.

According to Jackson (2001) the changes of the public sector taking place in the UK during the1980s, known as the Thatcher reforms, had their intellectual foundations in the American Public Choice theorists' notions of the public sector failure plus ideas of Milton Friedman. Jackson (a a) asserts that these reforms were based upon theories that had never been adequately subjected to empirical testing. They were working hypotheses.

In the UK the start of the quasi-market in the hospitals in 1991 was motivated by the management's lack of control over the activity at the hospitals. Kitchener (1998) claims there was no evidence that the hospitals functioned badly. He describes the introduction of a new model for hospital administration in a quasi-market from an institutionalist theory. He gives no evidence of better function or quality, only a better information system for control over the activity of the hospital. It seems that the management domain has taken more control over the doctors, who had been in command since 1948. After a break-through of the model at one hospital others followed their lead and by 1995 70 % of the hospitals were transformed. The process in Sweden introducing "ordering" and "carrying out" is similar. In a few years most of the municipalities have adopted this idea, which has not been subjected to extensive scientific studies.

Problems regarding the relations between the public sector and the private companies have been mentioned in several studies in the UK as a defence of the market ideology. The relationship between the local authorities and private companies is reported to be lacking in con-

fidence. 51 % of the home care (publicly funded) is provided by the independent sector (private companies) by a few big companies and many small ones. The share has grown very fast from 1995 to 1999 (Ware, 2001). The companies are not very satisfied with the contracts. The private companies assert that they do not receive information to be able to plan for their future (Fillinson, 1998). They find it impossible to develop long-term relationships with local authorities. It is rare to have contracts, which respond to changes in user needs. Small companies are reported to have great difficulties in staying on the market.

According to Andersen (2000) the quasi market in Denmark is still under construction and that goes for the rest of Scandinavia too. It is not clear today what proportion of the care for the elderly will be contracted out to private companies or which role they will play in the future. In Sweden the debate is for the moment more concentrated on the voluntary sector, especially on how the relatives can contribute to the care of the growing number of people over 80. The development depends to a high degree on the political winds now turning away from the new liberalism that speeded up the process of the change of the public sector in the 1980s.

Our study does not give any support to the value of the organization changes for the elderly or for society at large. Neither is there any unambiguous scientific support for cost efficiency by contracting out the care of the elderly (Edebalk & Lindgren, 1995). Still it is a very interesting question how these planned changes have reached such an extent in this short time without any convincing proof of their value. Røvik (2000) has discussed this complex of problems by analysing the development of organizations within the public sector since the 1960s. He means that new concepts of organizations seldom are anchored in scientific proofs. They are not new inventions but may have originated in the wake of organization research from long ago. They depend on fashions and function as a varnish or façade which the organizations wear in order to make the impression of confidence on the environment and on other organizations. Røvik (a a) means that the concepts or prescriptions may serve the development of the identity or self picture of the organization according to a new institutional theory (Meyer & Rowan, 1977). It is also important for every organization to design the concept in a unique way. To lay stress on this the organization may give the model the name of the municipality. During a period of time a concept may dominate the language in a popular organization or management literature. This literature often breathes great optimism but lacks a scientifically based critical examination. The authors often avoid discussions about conflicts of interests and other conflicts that normally characterize public organizations because they are built on political decisions (Kronvall & Olsson, 1991).

Different concepts on organization solutions replace each other but can also exist at the same time in spite of being contradictory. Goal steering and result measurement were concepts characterizing the 1980s (Rombach, 1991). Steering by quality and the customers' influence on the "production" were central concepts during the 1990s. E g within the public sector the freedom of choice is emphasized as an argument for contracting out the services. It is assumed that the customer can choose between different competing alternatives. It does not mean that there are real possibilities to make choices. The concepts are especially part of the rhetoric within the political and the administrative domain and are used as arguments in the decision process or perhaps to control the professional domain. We may assume that the concepts are components of the administrative language by which the administrative domain tries to take control over the organization. In our research it is very clear that the changes during the 1990s have resulted in deeper cleavages between the domains of the organizations in the public sector. The purchaser/provider model seems to strengthen the possibility of the administrative domain to control the professional domain. The administrative domain gets a possibility to an effective management of the economy. That does not mean that the quality of the work will change in any predicted direction. The professionals (home-helpers) in the home help services may have difficulties to assert their judgements of the needs of the elderly and

their own claims on the working environment against the administrative rhetoric on the demands of the *new* organization.

What about the recipients in this change process? Our results tell that they do not receive better care with any kind of change in the organisations. The rhetoric of the new system says that it will take better care of the rights of the recipients and of their possibility to make own choices. Nothing in the results of our study shows that the recipients have got more influence or increasing freedom of choice in the care they receive. The observed communication gap in the organisation following contracting out and new special assessment officials may make it more difficult for the recipients to influence the decision about their help and to communicate deficiencies in the care to the right instance.

We will also put forward quite another aspect of the changes of the 1990s and that is the change processes in themselves. The problems or costs of changing the public organizations have seldom been discussed in the public debate or in the scientific publications during the decade. Within an organization, despite of its ideology and structure, parts are dependent of each other; people within the organisation are dependent of each other to be able to perform their tasks. Changing an organization in one aspect will also result in changes in all other aspects (see Olsson, 1988). That means that the change may not give results according to the plans but produce a lot of new problems that the organization may not have readiness to solve. Miller (1997) has compiled empirical studies about organization change and comes to the conclusion that transformative organisational change is " far more difficult to accomplish than the normative literature would acknowledge." (p 7). It is possible that the quality of care and other aspects of the home care service organization in our study are more influenced by the change processes in themselves than by the character of the organization. This conclusion is supported by the fact that the organization with almost no changes (Oak valley) has the best quality of all districts before the division of the organisation in “ordering and carrying out” in 2001.

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