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PRIVATIZING THE CARE FOR ELDERLY: PUBLIC AND PRIVATE HOME CARE SERVICES IN THE GOTHENBURG REGION, 2013

Summary

This paper is a reaction to a number of critical articles in Gothenburg's media about privatized care services for elderly, which were published in the last year. Home services for elderly are seldom studied separately. Nonetheless they deserve researchers' attention since the Swedish authority perceive home services as the best solution for older people according to Ädelreform of 1992, secured by the Social Service Act of 1980: 620 (Socialtjänstlag 1980: 620), 19§ and 20§ and its following adjustments that did not changed the first law in this regard (e.g., Socialtjänstlag 1997: 313; 1998: 384), and since especially knowledge about differences between public and private agencies providing home care services for the elderly is severely lacking (Öppna jämförelser: vård och omsorg om äldre, 2012). Hence, in this paper I ask: *What have the public and private home care providers in common? What differences can be observed in their understanding of home care services for elderly and working methods? What lessons can be learned from the implementation of the state delegation of home care services for elderly to the municipal authorities?*

The purpose of this study is to compare and evaluate the public and private home care services for elderly given economic limitations after delegating them to municipality in the Gothenburg Region. The additional aim is to make politicians conscious about this development. The theoretical model of delegation and decentralization by Cristiano Castelfranchi and Rino Falcone (1998) and the Resource Dependency Theory by Pfeffer and Salancik (1978)

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constitute the theoretical reference frame. The study is based on an analysis of state regulation, policy documents and semi-structured interviews with the chief responsible for public and private home care services for elderly at the municipal level.

This study reveals that the delegation of care for elderly to the municipalities faced some serious problems not be solved until 2013 and surprisingly that these problems are especially seen where the recipients of such care don't have a choice on their service provider.

The lesson drawn from the research is that if politicians or other authorities take away the right from people to make their own decisions about their own lives this inevitably results in dissatisfaction and subsequent reforms.

Key words: home care for elderly, public home care service, private home care for seniors, care for elderly, seniors, NPM, elderly delegation reform.

1. INTRODUCTION

This paper is a reaction to a number of critical articles in Gothenburg's media about privatized care services for elderly, which were published in the last year (GP 2012-11-30, p. 38; GP 2012-12-07, p. 12; GP 2013-02-05, p. 6; GP 2013-02-06, p. 9). One gets the impression that there is a severe crisis of quality in care for elderly,resistance towards private care providers and lacking trust in the political decisions concerning the organization of care for elderly in the Gothenburg Region.

How is this possible? Does all this give a true picture of a nasty situation or do journalists just blow up singular accidents, where in fact there are hardly problems? The constantly returning critical media coverage made me think. What has happened with care for elderly in the Gothenburg Region?

Sweden is known for being one of the wealthiest welfare in the world, especially during the industrial development [Lundberg 1985; Olsen 1990; Esping-Andersen 1999]. The central government by tradition transferred "more than three fifths of the nation's Gross Domestic Product" [Olsen 1990, s. 2]. But, it was expected that Sweden would pay the full bill in the future for "high taxes and welfare state subsidies" [Olsen 1990, p. 7]. In the early 1990s the decrease of economic efficiency, crisis and the collapse of communism in Central and East Europe contributed to a new debate on the future welfare model being in the "middle" between capitalism and communism. The state authorities had to

create conditions to increase efficiency and effectiveness of public sector. The subsequent budget cuts in consequence have affected the Swedish care for elderly.

This paper focuses on the practical implications of Edel Reform understood as the delegation of care for elderly to municipality and introduced on 1st January 1992 [Andersson & Karlberg, 2000: 1]. The reform is a good example of economic liberalization conducted in the spirit of New Public Management – the social movement that gone across the USA, Europe and other continents, like a fashion to follow, providing a universal receipt on how to manage the public administration in a crisis situation [Osborne and Gaebler 1992; Hood 1991, 1995; Pollitt & Dan 2011]. Hence I ask: *What have the public and private home care providers in common? What differences can be observed in their understanding of home care services for elderly and working methods? What lessons can be learned from the implementation of the state delegation of home care services for elderly to the municipal authorities?*

The purpose of this study is to compare and evaluate the public and private home care services for elderly given economic limitations after delegating them to municipalities in the Gothenburg Region. The additional aim is to make politicians conscious about this development. Home care services are understood as social and medical assistance that the elderly ought to receive at their homes to manage everyday situations. This research is based on the analysis of state regulation, policy documents and semi-structured interviews conducted with the middle rang mangers and the first line chiefs responsible for planning, organizing and providing care for elderly in both sectors. The study is located in Gothenburg and Molndal, two neighbouring municipalities within the Gothenburg Region. They run different models of home care services for elderly and it seems that one pattern is superior to the other. The paper is structured as follow: the introduced into the research problem and purpose is presented in section 1. Section 2 describes previous research about care for elderly in Sweden and the changes in the organization theory. In section 3, the research context and research methodology is explained. In section 4, the analysis of empirical data will follow. Finally in section 5, the research questions will be answered, the result of analysis discussed and conclusions will be drawn.

2. DEVELOPMENTS IN THE POSITION OF STREET LEVEL BUREAUCRATS IN ELDERLY CARE IN SWEDEN

Although the scholarly research on welfare practices regarding care for elderly is very diverse [see: Sobis 2012; 2013], I have not found any comparative studies between the public and private home care services seen from the perspective of middle rang managers and first line chiefs. In this paper, it will be investigated this sensitive issue. Nevertheless, taking into account their perspective can give a quite different picture of home care services for elderly. One can imagine that working in the home care services for elderly is hard physical work with psychical strain and great responsibility. On the one hand such a job is highly regulated and steered by the state regulations and internal policy documents like e.g., hygiene routines, time schedules, security policy, medical treatment etc. On the other hand such jobs are badly paid, done by female workers especially within the group working in a direct contact with care users. Middle range and first line chiefs work under somewhat better financial conditions, but still not lucrative in payment with respect to their scope of responsibility and actions, when planning, organizing and delivering high level home care services.. Notwithstanding the low payment, the requirements to become a middle range chef or even a first line chef involve an academic degree in social work, nursing, or at least the completion of a nurse´s assistant program with additional courses or a degree in public management or health care administration.

Moreover, the Social Service Act [2001: 453, 3] demands extensive working experience and there is the expectation to be innovative, creative and flexible. Thus, it is not easy to become a manager in care for elderly; this work is really a challenge. One must be very high motivated to take work in the home care services for elderly independently, if it is occurring in the public or the private regime. Perhaps the bad situation on a labour market, the high level of unemployment, especially among people between 25–44 years old, and the vertical and horizontal segregation on the Swedish labour market can be seen as factors that still induce people to work in the field of home care services for elderly. Many advocate that this work is perceived as a temporary solution before acquiring new skills for new work challenges. Looking at the home pages of National Board of Health and Welfare (Socialstyrelsen), the Swedish Association of Local Authorities and Regions (SKL) or the West Gothenburg County (VGR) – a lot of research is done on care for elderly and a lot of the critique is addressed. Nonetheless, the execution of home care services is somewhat neglected by researchers. Relevant data are not exposed to the public in a transparent way.

All in all previous studies argue the difficult position of street-level bureaucrats, the limitations within which they have to work, and the resulting in problematic motivation among them.

The conditions under which the care workers have to do their work in Sweden has changed tremendously in the last two decades because of the intergovernmental changes that took place after decentralization understood as the delegation of responsibility for this care to municipalities.

Even if municipalities have a better judgment and freedom of choices in decision-making regarding organization of education, transportation, or education i.e., various services,municipality remains only a semi-autonomous organization controlled by central government. Municipalities are expected to follow central government's regulations and directives, which are institutional constraints having an impact on both street-level bureaucrats and on users of care services. Cristiano Castelfranchi and Rino Falcone (1998) have developed a model of *delegation and adoption* that combines the issues of *delegation* and *economic decentralization.* According to them, delegation and adaptation can affect the cognitive states of A-agent, who beliefs, has goals, intentions and commitments that another B-agenthas the capability and willingness to conduct the expected actions. Castelfranchi and Falcone have identified three basic types of delegation: (1) *weak delegation* that is based on the central government's exploitation and passive achievement; A-actor expects that B-actor just achieves A-actor's goals; (2) *mild delegation* means that A-actor is indirectly active. There is no formal agreement or request, but A-actor encourages B-actor's behaviours to take action; (3) *strict delegation* is based on "an explicit formal agreement" i.e., A-actor achieves the tasks/goals through an agreement with B-actor. In other words, B-actor adopts A-actor´s tasks, because B-actor has received a request or order from A-actor. In analogy to delegation, Castelfranchi and Falcone mention also another important dimension regarding delegation and adaption i.e., the specification of tasks. The tasks can be "minimally specified (open delegation),completely specified (close delegation) or specified at any intermediate level" [p. 14]. Thus, the object of delegation can essentially influence the contractor's autonomy especially the interpretation of tasks that can cause misunderstanding and conflicts among actors involved. There are different levels and types of delegation which "characterize the autonomy of the delegated agent" (p. 152). *Collaborative conflicts* usually arise "when the provided/proposed help does not match the intended delegation" [p. 156].

The Swedish government advocated for decentralization which was seen as the panacea to solve all economic problems. C. Hood [1991, 1995], J. Pierre

[1993] and S. Montin [1997] concluded that the Swedish public reforms towards decentralization were conducted in *a typical Swedish way*. It involved transferring authority to the local level and outsourcing of service delivery to the private market in order to induce competition between private and public service providers. But what does this typical Swedish way mean in practice? The Edel-Reform is the prime example of Swedish public reforms based on decentralization and internal control understood in the terms of delegation of care services to municipalities. The Edel-Reform can be seen as the turning point of care services for elderly in Sweden. The reform was conducted in a spirit of New Public Management [NPM] and the major idea was to motivate the public sector to take inspiration from the private sector when providing the municipal services to inhabitants. The consequence was that municipal street-level bureaucracies providing care services for elderly faced an era of austerity characterized by reduction of amount of benefits and public services addressed to seniors.

At the beginning of 1990, older people were perceived as "bed blockers" and the politicians argued: "cost for care of a person in a specialized ward is higher than in a nursing home" [Andersson & Karlberg, 2000: 2]. The subsequent right wing government assigned 5.5 billion SEK to restructure social- and health care services. Some amendments during the year of 1992–2011 completed the Edel-Reform e.g., the adjustments of the Social Services Act and the Health Care Act necessitated the social and medical sector to cooperate by creating a synergy effect when providing care services for seniors. The Social Services Act of 1993: 390 [SFS: Lag 1993: 390] and even the Act on Support and Service for persons with disability of 1993: 387 forced municipalities to plan their activities, cooperate with county councils, and other municipal agencies. The Social Services Act of 1997: 313 [SFS: Lag 1997: 313] modernized the Social Services Act of 1980: 620 [SFS: Lag 1980: 620] and according to §19 and §20, social welfare committees ought to ensure such care conditions that older people can live independently, safely, and with respect for their autonomy and integrity. This law emphasized that elderly should first get support and assistance at home, and only if absolutely necessary in care facilities. Thus, home care was perceived as the best solution for elderly. The Health Care Act of 1992: 567 of 1st July 1992 modernized the Health Care Act of 1982: 763 [FSF: Lag 1982: 763]. According to §24, municipalities were obligated to employ a nurse with a special medical responsibility [MAS] for older people. Since this regulation, it was possible to talk about the Whole-Elderly-Delegation-Reform [Hel-Ädel]. Bed-blockers were moved to open care for elderly. The expectation was, among others, to shorten waiting queues for medical treatment for other patients. Some years later, the Government Bill of

1996/97: 60 [Reg. proposition 1996/97: 60] made palliative- and long terminal care the first priority within the Swedish field of care for elderly.

To support economic liberalization, the Swedish Parliament passed the complementary Act on System of Choice (Lag omvalfrihetssystem – LOV) [SFS Lag 2008: 962]. This law opened new opportunities for municipalities to increase competitiveness on a market. Municipalities and counties could delegate choice of services to the users. Choice system was regulated by the Public Procurement Act (Lag omoffentligupphandling – LOU) that was adjusted many times but opened a market to private alternatives providing services [Lag 1992: 1528; 1994: 615; 2007: 1091; 2008: 962]. Municipality or county had only to advertise openly bidders, to approve and sign contracts with those private service-performers who live up to required standards. Regarding health care and social services, all performers have been reimbursed in the same way. Thus competitions concerns only quality and allows individual citizens freely choose from all the approved service providers. Municipality or county is still responsible for all the business occurring on their areas [SKL, 10 December 2012]. It should be emphasized that choice system from the beginning was not obligatory and during 2008–2011 was granted 327 million SEK in grants to 248 of 290 Swedish municipalities for introducing free choice system. In 2012, the central government allocated 22 million SEK as the stimulus grants for municipalities to investigate the outcomes of choice system. From 1st January 2010, it is mandatory for all counties and regions to have choice system in primary health care (SFS 2009: 140) but not necessary in social services. In social services, the central government appointed a committee on September 2012 to analyze and evaluate the effects of the introduction of choice system. The investigator will report the results on 15 January 2014. According to information from the Swedish Association of Local Authorities and Regions' (Svenska Kommuner och Landsting, SKL) home page, the Welfare Board has a mandate to decide and distribute stimulus funds among municipalities that have decided to follow the choice system. About ca 254 municipalities have received an incentive payment for this purpose [10 December 2012]. Thus, home care services for elderly, perceived as the best solution, could be provided by private firms.

Summing up, the Health Care Act of 1992: 567; the Social Services Act of 1993: 390; the Act on Support and Service for Persons with Disability of 1993: 387, the Public Procurement Act of 1992: 1528 [adjusted; 1994: 615; 2007: 1091; 2008: 962] and the Act on System Choice of 2008: 962 have been securing the development of care for elderly according to the Edel-Reform and these state regulations opened opportunities for the economic liberalization in Sweden.

These developments could have consequences for the elderly care, but also for the street-level bureaucrats responsible for such care. The developments could even have a varying impact on such workers dependent on whether they work in the public or private sector. These developments in Sweden have clearly witnessed the changes within the social context, in which these people are working, changes in their resources, and perhaps also their objectives and hence their power. All these factors are deemed important from what is known as the Resource Dependency Theory (RDT) as elaborated by Pfeffer and Salancik [1978]. RDT is based on three fundamental ideas: (1) *Importance of social context*; it allows understanding of an organization's choices and taken actions. To study the organization's social context means in practice to make an analysis of its environment. The environment consists of many other stakeholders and organizations existing there and having demands. All organizations are dependent on resources e.g., capital, labour, material, ready products etc. These resources are in an organization's environment but the resources one organization needs are usually in the hand of other organizations. Resources within the environment constitute a basis of power. Social context or rather knowledge about the organization's environment is informative enough to understand; arising challenges, conflicts, complexity, worked out strategies for action, cooperation and finally organizational behaviours. (2) *Importance of strategy*; each organization has to have a strategy for reaching its major objectives but also to take opportunities for action to increase the organization's independence, pursue their interests in order to uphold autonomy. However, even legally independent organizations are still dependent on each other only because every time, when organization is acting, it tries to influence other organizations within the environment and in consequence the organization goes into a new dependency. This dependency can be again negotiated with other stakeholders within environment. (3) *Importance of power*; power and resource dependency are linked together however, power is always relational, situational and potentially mutual. To understand an organization's actions it is necessary to analyze how power is constructed within the organization's environment. This knowledge is important to understand the intra-organizational and inter-organizational relations. RDT seems to share some aspects with institutional theory presented below.

Are these expectations reflected in a change in the beliefs, motivation, goals and problems experienced by street-level bureaucrats in the care for elderly? That will be investigated below.

3. THE CONTEXT AND THE RESEARCH METHOD

The empirical part of this study is located in the Gothenburg Region in Swedenthat consists of 13 municipalities (Ale, Alingsås, Härrydda, Göteborg, Kungälv, Kungsbacka, Lerum, Lilla Edet, Mölndal, Orust, Partille, Stengusund, Öckerö). This research is about two organizations providing home care services for elderly i.e., a public home service provider from Gothenburg Municipality [Göteborgs Stad] steered by no absolute majority and a private home service provider from Molndal Municipality[Mölndals Stad] steered by a non socialist majority (M+C+FP+KD) after the 2010 election. These municipalities have developed different models of home care services for elderly. It seems that the variation of political steering has influenced how the politicians have interpreted the care delegation to their municipality and what type of home care services have appeared in both municipalities.

These municipalities are different in wealth and demographics. The regional GDP per inhabitant in 2010 was about 354 000 SEK per inhabitant in Sweden, 461 000 SEK per inhabitant in Gothenburg and 505 000 SEK per inhabitant in Molndal. The municipal tax rate was 31,7% in Sweden, 32,3% in Gothenburg, 31,4% in Molndal. Basic services for elderly and disabled in the form of home care services are covered from the municipal taxes.

The population of Gothenburg was about 520 374 inhabitants and 61 337 inhabitants was living in Molndal. The percentage of population being 65 or older living with home assistance was 15,5% in Gothenburg respective 7,8% in Molndal. The elderly, who used 25 hours or more of home assistance per month constituted 33% in Gothenburg and 53% in Molndal [Öppna Jömförelser: Vårdochomsorgomäldre, 2012]. Municipality gross expenses on assistance for the disabled and aged in Sweden was 18 736 SEK in 2011, in Gothenburg 16 151 crowns, and in Molndal 15 761 crowns, which shows that Gothenburg and Molndal spent less than average on elderly care [Regionfakta, 2011-09-22]. Other research [*Öppna Jämforelser – vård och omsorg om äldre*, 2012] shows that Gothenburg spent approximately 18 468 SEK per inhabitant being 65 and

older, and approximately 105 830 SEK per home-care-user at the age of 65 or older in 2011. The corresponding sums for Molndal during the same time are 19 443 SEK per inhabitant respective and approximately 250 130 crowns per home-care-users in age 65 and older.

From the same research appears that 75% of the investigated elderly users of home assistance in Gothenburg were satisfied about the time care performers had for their duties, while in Molndal 83% home care users were positive about this. In Gothenburg 48% and in Molndal 56% the elderly care users say that they can influence the actual use of assigned hours of care. In Gothenburg 78% and in Molndal 86% of the home care users were pleased with their home care performers. According to the elderly, care performers did take the users' points of views and wishes regarding assistance they received into account. The home care users' opportunity to assistant nurses with comments or complaints looked was also better in Molndal (67%) than in Gothenburg (59%). Even the contacts of the elderly and the care providers' response to the elderly needs was better assessed in Molndal than in Gothenburg by the users of home care services. The feeling of security was perceived to be rather low in both municipalities; in Gothenburg only 35% elderly were pleased with security, in Molndal about 40%. All this implies that the way in whichhome care services are provided in both municipalities proved rather different.

3.1. Home care services in Gothenburg Municipality

Gothenburg Municipality has an organization with both administrations and companies. The city has a turnover of 34 billion SEK and the number of employees is 48 600; more than 33,000 of the employees work in 10 district administrations (Angered, Askim-Frölunda-Högsbo, Centrum, Lundby, Majorna-Linné, Norra Hisingen, Västra Göteborg, Västra Hissingen, Örgryte-Härlanda, and Östra Göteborg). It is not transparent how many employees are working in home care.

The older people in Gothenburg Municipality looking for home assistance can get only a municipal home care. Gothenburg does not use a free choice system [LOV]. The elderly can find out on the home page of municipality how they should apply about assistance, how much it will cost. This home page also presents a case illustrating an assistance administrative executive's judgment including, when the assistance administrative executive rejects the application about a nursing home and opts for home care. The fee for home care service includes such the duties like e.g., assistance with meals, personal hygiene, laundry, cleaning, shopping. The older person pays 88 SEK per hour and never pays form ore than twenty hours

per month i.e. 1 760 SEK monthly. If the person needs health care, it does not cost anything. Emergency medical alarm costs 88 SEK per month per household. The elderly can get so-called fixe-services,which can help the older person with practical things in his/her home to avoid accidents. Such fixe-services are for free, butt he elderly pays him/herself any costs for materials. From the home page, it appears that no matter where the elderly live in Gothenburg, they are served a meal that is good, useful, environmentally friendly and pleasurable-cooked and served by knowledgeable and service oriented staff. Food portions consist of varied and nutritious diets and are often adapted for diabetics, if necessary. The food costs 52 SEK per serving or 56SEK, if the older person also wants to have dessert. The assistance administrative executive assesses the older person's need to get the food delivered home.

3.2. Home care in Molndal Municipality

Molndal Municipality [Mölndals Stad] has approximately 4800 employees working inten district administrations. The municipal staffs working in home care within the whole Molndal consists of approximately 180 employees working in different geographic areas: Bifrost/Krokslätt,Centrum/Terrakotta, Stensjön/Pile, Åby/Balltorp, Kållered, and Lindome.

Home services include: (a) various service and fixe-services, (b) personal care, (c) social support and (d) reliving for relatives. Molndal Municipality has seven home care providers: one public (Mölndals Stad) and six private firms providing home care and services.(Aida Vårdservice, CASA Berget, Göteborgs Kyrkliga Stadsmission, Homec, Jakobsdal Vård och omsorg, Kooperativet Olga,). The private providers of home care services have to meet formal criteria imposed by the municipal authorities.

The elderly entitled to home care services are allowed to choose their care provider according to the Act on the system of choice, LOV. The aim is to increase the home care users' influence and participation and to create opportunities for them to live independently and remain at their home as long as one desires. Personal assistance includes: washing, cleaning, purchasing of goods and delivery of food. The elderly of 75 years old or more are entitled to support without individual examination. Information about the providers of home care services for seniors is available on Molndal Municipality's home pages. The quality of public and private home care services is regularly monitored in the same way by Molndal Municipality. Regarding cost for home services, the fee varies depending on the income of the elderly and how much support they need. The maximum

charge is 1780 SEK per month. If an old person is entitled to several efforts then the payment is never higher than that amount. Portion cost of cooked food is not included in the maximum charge.

3.3. The used empirical data

To have a better understanding of home care services for elderly, many reports were assessed from the Swedish Association of Local Authorities and Regions [SKL] and the National Board of Health and Welfare (Socialstyrelsen). The official reports were expected to provide an understanding on the actual work in the home care services for elderly. However, to my surprise, there was not too much on this topic. The research about home care services seem to be marginalized.

This research is qualitative in its character and based on: (1) the state regulations, (2) the municipal policy documents, (3) internal documents from studied organizations, and (4) seven semi-structured interviews conducted with the first line chiefs responsible for the chosen organization's personnel and home care services at users' homes (two from each organization), and two interviews with the middle range managers responsible for the sector and district from the public sector and one manger of quality and working environment from the private organization.

The respondents were expected to share information about (1) the respondent (e.g., position, work duties, formal education, competences etc.), (2) how they perceive the state regulations that the organization has to conform to in everyday work, (3) information about the organization (e.g., organization's major objectives, strategies to fulfil the goals, values, characteristic of users, number employee, sex and diversity among employee, forms of employment, demanded competences, development of skills, diversity, incomes, working methods), and (4) information about the organization's environment (e.g., knowledge about other stakeholders, press coming from them, cooperation with other organizations from environment. Thus, those topics have been anchored in the theoretical frame for the study. However, the respondents also were enabled to tell about issues not included to the interview guide, but which they perceived as important and relevant. The interviews were conducted during the period from November 2012 to March 2013.

It seems important to guarantee anonymity to the respondents from whom I have learned most. On average, the interviews took between one and one and half hour. All interviews were recorded on a digital voice recorder and transcribed afterwards. Each transcript was numbered and divided in the thematic sections before analyzing them. When listening to the respondents and reading the

transcripts, it was clear that the respondents often used similar wording as could be found in the theoretical frame.

4. THE ANALYSIS

In this section is presented the result of analysis of interviews and internal documents from the public home care providers in Gothenburg and the private one in Molndal. Respondents No. 1, 2, 3, and 4 are from the public sector. Respondents No. 5, 6, and 7 are from the private business. It will be used abbreviations e.g., R1 or R2 etc. when referring to the interviews.

4. 1. About the respondents' background and their approach to home care services

From the interviews it appears that all the respondents, independently of the sector they work in, have gone through academic education programs: social work, a nursing program, a nurse's assistant program, economy, sociology, psychology, pedagogics in working life and society, public management, or health care administration, i.e., academic programs or corresponding education required for a management position as stipulated by state regulations. Two first line managers (one from public and one from the private sector) have finished education on a bachelor level and completed their degrees with additional courses in a health care administration or public management. Five managers (three from the public and two from the private sector) had more than two academic degrees (a bachelor and master or two masters), they finished also a nursing program with diploma.The most popular combination of formal merits is to have completed a program in nursing and social work, followed by two or three courses in public management, respective health care administration. The respondents have at least a minimum of seven years and at maximum 40 years of working experiences in: health care, care for elderly (nursing homes or home care services) or as social assistant for the elderly or the disabled. On the question *what does it imply for you to give home care for elderly?* The respondents from both sectors answered in a similar way: "to meet the old persons with respect, support them and give them the feeling of being in focus" (R1), "each person ought to get an individualized care" (R2). Another one argued:

> [...] independently if it is an old or a young disabled person, home care is about to give a human time i.e., to show that you care about that person. It is not thinking in terms of

> paragraphs, what you are allowed to do, what it is forbidden... You must listen to what the older person needs (R3).

The middle range manager from the private sector on the same question responded that such work involves a huge responsibility because it concerns vulnerable people who need help, and who are unable to manage their own affairs:

> It is important to take responsibility. Someone might say you cannot do it because you depart from a business idea, but it is not true. We do a lot of planning and take into account users' preferences. We consider how to organize home care. We meet home care users and their families to create an individualized care for every older person. The care user is in the centre, not our staff. But obviously you have to get good working conditions and a good working environment for your staff, if you expect that they deliver high quality care. We are doing a good job for our customers (R7).

The first line chief from the same private organization said: "To give home care means to meet the users' basic needs in terms of health care and their stated needs (R5). However this respondent was of the opinion that "care users have higher demands onus than on municipal services. They expect us to be more flexible, they demand more action" (R5)

The respondents' answers seem to be similar. Everybody is talking about the elderly as being in the centre, about respect and human time. However, the remark of respondent 3 from the public home care about paragraphs suggests that this care for elderly is sometimes too bureaucratic. So, let us see what respondents say about the municipal regulations.

4.2. The respondents about the state and the municipal regulations of care for elderly

The respondents from both sectors have emphasized that they have to follow the same state regulations when planning, organizing and delivering home care services for elderly, i.e. the Health Care Act of 1992: 567; the Social Services Act of 1993: 390; the Act on Support and Service for Persons with Disability of 1993: 387,the Public Procurement Act of 1992: 1528 [adjusted; 1994: 615; 2007: 1091; 2008: 962], the Act on System of Choice of 2008:962 and other regulations of complementary character e.g., the Working Hours Act [1982: 673], Systematic environmental work [AFS 2001: 01], the general regulations of National Board of Health and Welfare but also their advice on leading system and quality work [SOSFS 2011: 9], general advice on reporting obligation under *Lex Maria* [SOSFS 2005: 28] and *Lex Sarah* [SOSFS 2011: 5] and the Law on Protection against

Accidents (SFS 2003: 778). Thus, the institutional context is the same for both the public and private providers of home care services for elderly.

4.2.1. The public sector in Gothenburg

The sector manager from Gothenburg on the question: *what do you think about the state regulations of care for elderly since implementing the Edel-Reform and the following regulations* answered:"The idea was very good, some positive changes were visible, but the promise of collaboration between social services and health was not fulfilled in practice" (R4) hence, the desired organization of care for elderly is still discussed. There is a large group of pensioners, who are more alert for a longer time. When they get sick then they will need more assistance and probably in nursing homes or special facilities. "Thus, the issue of care for elderly seems to be problematic and it falls between two cracks" (R4). One of the explanations is that different organizations have the different financial resources. The work of each organization is controlled by what they do with this money, while in health care they are confronted all the time with new but expensive medical treatments. The new treatments create a demand for these new services, which are often costly, while organizations have to save money:

> "We have a demanding budget. It's very easy to say, this is our responsibility, or that ... but different organizations have different organizational cultures. Then it is very easy to create myths about each other. [...] We always are in a tight spot and we can't go beyond the agreement we have signed" (R4).

The care for elderly is absolutely steered by Health Care Act, Social Services Act, Public Procurement Acts and other regulations. The care providers have to follow a legal process. They learn a lot from signed public procurements, but Gothenburg Municipality does not want to introduce the free-choice system (LOV). It is a political decision however; the politicians want to show that the inhabitants have a free choice but in *a Gothenburg way*:

> They started to consider home services from the perspective of assistance administrative executive. If you have received one type of home care service from assistance administrative executive then you can control it yourself. You decide what kind of service you want e.g., I come to you in the morning, you should take a shower according our plan but you say; 'no, I do not want to wash today. I want to go to a park instead' ... We can only measure 'the needs in a moment' (R4).

The same respondent admitted that "the municipality experiences a large turnover on the first line manager positions within the home care services for elderly" (R4), which confirmed the interviews with the first line chiefs, who were very critical towards the municipal practice. One of the respondents argues:

> I'm pretty critical regarding the changes. Before the districts were merged in 2010 from 21 to 10, we had better opportunities to provide a high quality care services for elderly. Changes do not always go hand in hand with something positive. It costs money. The municipal authority created many restrictive functions. They introduced a huge bureaucracy; decision-making is a much longer process now then it was before. The tax-payers money goes to managerial positions. They introduced time standardization for our services addressed to elderly. This occurs at the expense of elderly and that assistance elderly ought to get from us (R1).

Another respondent argued that from the beginning, in the public sector a manager worked in two roles: as an assistance administrative executive and as an entity manager:

> Firstly, I made an inquiry about an older person's needs and character. I was informed about this person's family situation, health problem or social needs. Secondly, I adapted the assistance efforts to this person and was watching that the assistance plan was executed in practice. These two roles had a complementary value. Since 2010, these roles are separated in the name of professionalization; the assistance administrative executive just investigates the needs of older person, while the entity chief takes care about staff and watches that the executive decisions are conducted. Since that, I never received full information about any care user. I couldn't even inform my staff about the needs and character of older person to help this person in a write way. It didn't work. I quitted this work some weeks ago. (R3).

The preliminary conclusion cannot but be that not one respondent is pleased with the municipal regulations that influence the organization and performance of home care services for the elderly in the studied district and all see a destructive and huge bureaucratization of elderly care.

4.2.2. The private sector in Molndal

In Molndal, the bourgeois majority governing for multiple terms proved to be much friendly to the implementation of the Act on System of Choice. Six private home care providers have appeared on a common market beside the public sector activities and public home care providers. The investigated private organization providing home care services for elderly is cooperating with the municipality from the beginning. The three interviewed persons are pleased with this cooperation. It was the Municipal Council of Molndal, which accepted the private home care provider in agreement with the Swedish ISO Certification. The private organization had to fulfil all the demands of Quality Management System [ISO 9001: 2008] and Environmental Management System [ISO 14001: 2004], because the private firms providing care have to follow the same regulations as the public ones. In comparison to Gothenburg, the municipal authorities of Molndal have chosen another way of local development. They do not object to the private home care services. The private actors participate in a competition

with the municipal actors on the same market however the municipality still has a supervisory responsibility over the private business. They control a private organization's activities a couple times a year.

The quality and environmental manager asked about the state and the municipal regulations asserts that theirs organization has no problem with any regulations. Opposite, they are necessary and appreciated. Thanks to regulations, the organization learns how to develop and improve their home care services for elderly:

> The municipality is very careful when controlling the private providers. They look at the smallest details. I would wish they would be as careful when evaluating and monitoring the public care providers. Public providers are not often audited. In my 25 years experience of working in a municipality, it happened very seldom that the National Board of Health and Welfare came to visit and do follow-ups. We as a private organization have a lot of follow-ups during a year. If they had really developed the same routines for the public performers, for the sake of learning, it would have essentially contributed to the development of public services. There are many positive things in the public sector, but you can always develop it into something better (R7).

All the respondents emphasized that they have their own follow-ups e.g., users' measurements and own system of documentation. They work actively on the quality of their services. If the National Board changes something they immediately adapt their internal system to the new conditions. They are bounded to the collective staff agreements in the same way as it is in the public sector. A signed procurement contract obligates the private home care provider to follow all the regulations. The respondent said: "It creates order... this activity is highly regulated and it must be in this way" (R7).

Summing up, no one manager from both sectors was critical about the state regulations as such, but the respondents' complaints were directed to the municipalities. The difference is that the managers from the public sector complain over the municipal steering, while the managers from the private sector perceive the municipal monitoring as the lessons to learn, to improve care for elderly but they feel to be unjust treated by the state and municipal authorities.

4.3. Respondents about organization

The home care services in the public sector have as long a tradition as the Swedish welfare state itself, but not so in the private sector. Hence the municipal managers from Gothenburg have at least 20 years and some even 40 years experiences in home care services for elderly. The private care providers appeared on a market in Molndal at the beginning of 1990s, but the investigated

private organization is working since 2009. Thus the respondents from the private sector have in the best case five years experiences. Moreover, according to the respondents' statements, the private organizations providing home care and services for elderly face many prejudices from politicians, other organizations with whom they have to cooperate and even from inhabitants. Below, it will be presented how the managers are presenting their organizations.

4.3.1. The public sector

When the district manager was asked about: *the major objectives ofcare services for elderly in the public sector*, the respondent answered that the goal is that the elderly have an influence on their daily lives but:

> When you work in the Municipality of Gothenburg there is the Municipal Council i.e., politicians, who give us the objectives. Simultaneously we have our own District Committee that also has its own goals. They look at the goals of the Municipal Council and work them out and adapt them to our situation. Those two levels have never gone hand in hand (R2).

The first line chiefs go into more details. One of them said the major goal is: "[...] to follow the Social Services Act and keep the budget" (R3). Another respondent asserts: "to have satisfied employees, who like their work, and to have happy customers. The care users are in a centre and deserve to be treated with respect" (R2). Each first line chief has about 30 employees but not everybody is full-time employed. Respondent 1 emphasized that talented persons, usually students are working temporary as supply-staff (ca 8 persons). They work by the hours and disappear quickly. The second manager worked out own employment strategy:

> I learned quickly how to manage the limited budget. It was a challenge. I found people who were working by the hours. They were inside our organizations, when I had a lot of work to do, but politicians instructed us that we should employ them on a month. Such things are easy to say, but it makes impossible to keep a budget in balance. In the case of care user's death or if old person moved to a nursing home or changed a district, the number of full-time employees must be limited otherwise I have too much staff. It was not smart, but I knew my area and had to be sensitive to it (R3).

Staffs are definitely overrepresented by the females' co-workers, there are about 20 women and 2–3 men that constituted the full time-employment. They provide care to approximately 100 care users and 400 older persons having an emergency medical alarm. Diversity among staff causes that many language skills are present (Arabic, Finnish, Hungarian, Polish, Persian, Spanish). Respondent 1 is of the opinion that this is very positive and necessary in the working group and

for home care users but another respondent expressed somewhat mixed feelings about that:

> I had a girl who had Arabic as her mother tongue and an elderly requiring care, who also was talking the Arabic language. I sent her there but it didn't work. She was abused because of the culture. The care user was older than our service staff. According to their culture, the young person cannot deny to perform tasks. Our staff had fallen into a conflict because she knew what she ought to do, while the care user put other requirements. [...] I had to send other staff able to speak English; the user could speak this language a bit. The problem was solved (R3).

This chief was convinced that the formal merits were much more important than anything else and concluded: "You may think that if the care provider speaks the same language as the care user, everything will work out, but it is just not true. Sometimes it is better to use interpreters" (R3).

Regarding the formal merits of staff, Respondent 3 emphasized that it was needed the personnel that had at least completed a nurse's assistance program or corresponding education, could speak the Swedish language and had a driving license because the district is huge and home care providers are working from 7:00 to 24:00 o'clock. It happens that the required formal merits are not fulfilled; the driving license has usually a decisive importance for getting a job. The driving license in Sweden is expensive, not everybody has it, especially young people who work on hours.

Both interviewed stressed that it is very difficult to recruit adequate staff. The earnings are not impressive, approximately 22 0000 SEK for a nurse's assistant and about 36 000 SEK for the first line manager on average. They have to follow the collective agreements and earnings vary due to many factors. When recruiting staff, beyond the formal merits, they pay attention to the values and humanity of potential co-workers. Care workers have to be sociable, friendly, humble and patient. The employer is limited by the insufficient budget and currently cannot propose any development of competences for staff:

> "Nowadays, we cannot propose a competence development. I mean, since 2010, when the Municipality of Gothenburg introduced the merging of districts. Before, it was possible to send staff on conferences or courses. But this is no longer possible" (R1).

The respondents admitted that many people have left the municipal organization, because the working climate was bad, and communication was lacking. Perhaps it influenced the higher management; they have more focus on staff currently.

Regarding working methods, the municipal home care providers are working according to the municipal pattern of time standardization, in which a time is

specified for each task e.g., shower 30 minutes, clothing 15 minutes, breakfast 15 minutes, walk one hour a week or half an hour twice a week etc. In practice the standardization goes pretty far:

> If you use a wheelchair and have been granted a walk, half an hour ... We come to you to take you on the walk, but because you have the wheelchair it is difficult to put clothes on. That takes 10 minutes. To put shoes on, it takes again 5 minutes. After this we take the elevator and go out ... Then one quarter has passed, we need go back to take the clothes, shoes off ... The time is already gone (R3).

Older persons need other services than the personnel assistance e.g., delivery of food, laundry, cleaning, washing windows. To provide these services, the first line chiefs have to cooperate with many procured cleaning companies, companies hiring cars or delivering coffee, or companies producing food for example:

> We do not have time to cook for the elderly, but we see that ready lunches will be delivered directly to a care user's home by the procured company producing food. Care user gets 10 cold meals boxes at once delivery, not liked as much, and which is twice more expensive than from the local food producers. They [Municipality] made us quit the collaboration with our local delivers because the last ones not were procured. Instead, the food was driven from Uppsala to Gothenburg. A cold food for 10 days! I would never buy it for myself. Elderly need nourishment. Why the elderly should get it? (R3).

Moreover, all the procured companies became additional personnel at older person's home. Thus, around 20–26 unfamiliar people were visiting one user's home. There is completely lacking any continuation in care providing.

4.3.2. The private sector

The organization of home care services in the corresponding private company looks quite different. Regarding the major objective, the middle range manager said: "We want to create individualized care, our care users are in the centre" (R7). Another responded added: "Our goals are the high quality of our care and services, pleased users, and good working climate for our staff" (R6). To achieve these goals, the leadership is developing the organization's culture, they are working actively with values, norms for behaviour and such the way of thinking that reflects what the organization stands for etc. All the employees are perceived as the carriers of organization's values, as the ambassadors of organization to the outside world. Respondent 7 explained:

> It's not the easiest task to build an organization from the beginning and at the same time create an organizational culture. After five years, we see how much has been changed. You work through dialogue and communication but you have to translate own values and vision into planning, strategy and execution. I think long-term. But anyone who works with us as nurse or assistant staff does not care about it. Then it's also very important how our vision

> and strategy should be transferred to our staff. There are various opportunities to maintain dialogue: working meetings, conferences and tutorials. We work with our staffs' values, attitudes and we follow-up difficult questions at different levels (R7).

One of the entity chiefs working in the organization from the beginning confirms and completes this opinion:

> Our business has grown by itself and each entity has created its own little organization, which caused that the whole organization does not yet have the clear procedures, policies, practices, but it is so if you open a new business. Thus, each manager has created own organization based on the person's own idea about how home care for elderly should work in practice. There are many requirements imposed on us from the municipalities and we do our best to follow the state regulations. Nevertheless, it is unique how we are working in each entity. We have failed to create a unified organization. There is lacking the clearly structure and the standardization of some duties. We have got so mer requirements from the municipalities in which we are operating that we have to fulfil e.g., we must report about how we are working with the elderly, by law we have to report deviations but we hardly talk about that with the first line chiefs from other entities. We need clear lines about what to do,if something happens. There are discrepancies in our behaviours; we invent a wheel each time. There is no collaboration around it. We should standardize what is possible to act in the same way, if something happing. However, each municipality sets different requirements e.g., it is important to have procedures for how our staff should use a care user's private properties like cash or a Visa card when staff is shopping for the elderly (Respondent 5).

The home care users are divided into two groups: those over 75 years who need home services such as laundry, shopping, cleaning, but with time they need a little more personnel care e.g., assistance in talking a shower or personal hygiene, assistance with lunch, or when going on a walk, it grows on. The second group needs more time and care because users have a disability. Waiting time on the granted assistance vary in the municipalities from 24 to 48 hours.

This organization employ about 100 home care providers, 90 women up to 10 men who provide home care services to circa 150–160 users in different municipalities, not only Molndal. 60–65 persons have full-time employment, others (35–40%) work full-time as guest-co-workers or on the hours. Those who work on the hours but want to work on full-time as the guest-co-workers, it's no any problem to change the agreement but this organization cannot have only full employment of the same reasons as the respondent from the public sector explained. Regarding the recruitment to home care services, the decisive importance has a work-seeker's skills and working experiences. Diversity is positive perceived but the middle range manager explains:

> It does not matter where from the personnel is, from Thailand, Norway or any other country. Staff must have skills to do the job. They must have gone through the nursing program

> or equivalent education. The only exception is if job-seeker has worked many years with similar tasks, i.e. has working experience (R7).

A starting salary for a nurse is 24 000 SEK per month, for a nurse's assistant 22 000–23 000 SEK, for a first line manager 32 000–36 000 SEK. However, staff's earnings are due to many factors e.g., working experiences, additional skills, the collective and the Unions' negotiations. Thus, it is similar situation to the public sector.

The first line chefs are managing 12–15 employed on average. Regarding the development of competence, the organization follows the directives of National Board of Health and Welfare and the personnel participated in various courses in 2012 e.g., the course on the basis of value within care, courses about the delegation of medicine, rehabilitation, course about the validity of nurse´s assistants, IT-technique. The organization's staff can register for courses organized by the municipality. For some courses the private care providers have to pay e.g., for the course in a palliative care. In other courses they participate without payment. They look for information about the courses on the municipality's home page.

From the interviews with the first line chiefs, it appears that home care as a concept is divided into two types of achievements: first, the care time, which includes social assistance like e.g., assistance in the personal hygiene, in getting up an older person from a bed, in taking a shower, dressing, preparing breakfast, lunch or supper, going on a walk, taking off clothes before bedding time, dosing of medicine etc. However, this care time sometimes demands additional support in form of medical treatment e.g., giving an injection, bandage changing, rehabilitation, which not always can conduct the ordinary personnel from the home care organization. Then the social workers have to cooperate with other organizations responsible for medical care or rehabilitation. The second type of home care constitutes the various types of *home services* – the time necessary to keep order in older person's home e.g., shopping, flat cleaning, window cleaning, washing, and even social relations. The elderly can buy additional services – the time, which has not been awarded by the assistance administrative executive e.g., assistance in a garden work, extra window cleaning before Christmas or Easter. The private home care providers fix everything by themselves. Due to physical and psychical health condition demand for care and services varies among care users. However, this private organization has its own concept how to provide the individualized care for the elderly;they keep the continuity of provided care services for the elderly.

This continuity is based on three pillars: (1) *person's continuity*, which means that as few people as possible visit a user, (2) *continuity of time* i.e., staff comes always on an appointment in time and stay as long as the time that has been granted. If anything happens, staff calls in advance to a care user and agrees on a different time on the same day, or they agreed about a different day. The user decides what care and services s/he likes and wants, and (3) *continuity of care*, which means that staff works in a similar way for all the users (R5 and R7). Respondent 6 emphasizes the short ways to make decisions cause that the users feel that they can influence their situation anytime:

> We try to accomplish that our user meets as small number of our staff as possible. We must take into account the staff's holidays, vacation, and sick leave. We send about 3–4 people per month. Other municipalities send about 15–20 people per month to the same user. We have a good continuity; it is the reason why they choose us (R7).

Regarding the home services e.g., the meals for the elderly, the food can be delivered from a restaurant that is close to their flat or they can go there and eat at the restaurant. Some elderly persons want to have the meals prepared at home, but according to the assistance administrative executive the preparation of a meal can take max 15 minutes. Thus, it is a question about good planning:

> Our personnel prepare something at the morning... If you have a plan the day before maybe it is not so complicated to cook a meal at home. The personnel know what things they have to do during a day and they can coordinate all the duties so that it works in practice. We don't have time to cook potatoes, but if you think and if you want, you can do it. I don't know how it is in the municipal home care. I can imagine that they don't want to do something extra, but it is the issue about the high quality of service for the users (Respondent 6).

Summing up, the planning, organizing and providing the home care services by the private provider seems to work in the favour of elderly. One can wonder: what hinders the public sector that their working patterns differ so much. Both organizations have followed the same regulations and directives.

4.4. Respondents about organization's environment

No one organization is working in avacuum. There are always other stakeholders within an organization's environment having some interest, wishes and pressing their own demands. The home care services independently, if they are conducted by the public or the private organization, they are political steered and have to interact and cooperate with others in their environment e.g., with care users and their families, assistance administrative executive, personnel

of municipalities, co-workers from health care and rehabilitation, contractors, suppliers, and mass media that are blowing up any accident or irregularity.

On the question *from which stakeholders within the organization's environment the first line managers felt the most pressure* the answers have varied in the public and private sector.

4.4.1. The public sector

All respondents admitted that call for efficiency has dominated their activities in the public sector. In this regard, the first line chiefs experience most pressure coming from the Municipality and its assistance administrative executive:

> Economy takes first place since the reform of 2010. It has not reduced the costs of our organization. On the contrary, the costs have increased. They count money all the time. We have got a much lower budget, it hardly covers our activities. Before when we had staff meetings, sometimes we could buy sandwiches or cake to coffee for our staff. Now it's impossible (R1).

Another respondent is critical about the public procurements signed by the politicians that essentially contributed to increasing expenditures, while in official rhetoric the emphasis is on savings, customers in centre and good quality services:

> When the coffee was cheap, I bought 10 kg but we were permitted to buy only organic coffee, very expensive, tasting no well, and s...) Why, I have to respect the agreement that increases the costs of my entity? (R3)

The same respondent told a story about a home care user who was somewhat exceptional and problematic. The district staff (10-11 persons per month) were afraid to go and meet the exceptional man. Then the first line chief asked about assistance from a private sector providing similar care services for elderly around Gothenburg. It proved that they managed the situation very well and the care user was pleased:

> I asked myself a couple of times how it was possible. They had the nurses, who hardly spoke Swedish, and they could not communicate with him, but still he was very satisfied. What do they do that makes them so good and what makes us wrong? (R3)

One can find many such examples in the collected interviews. The public procurement was perceived as a very sensitive and suspicious issue. There were some expectations that the system of free choices should be really introduced in Gothenburg.

4.4.2. The private sector

The respondents from the private organization were reasoning in a totally different way about the interaction and cooperation with other organizations in their environment. Instead of blaming the politicians for creating unjust conditions for participation in the competition for high quality services on the market or blaming the municipalities and the National Board of Health and Welfare for permanent monitoring and follow-ups, the private home care providers have accepted the institutional frame and perceived the external controls as a learning process, working in favour, to improve their activities. They keep good relations with various authorities to have them on their side:

> The municipal personnel are positive, open, willingly to cooperate. It is enough to mention our cooperation regarding the courses in which our staff can participate. We have also good cooperation regarding deviations; we have a very good relation with the contact person monitoring deviations. [...] It feels that they care about us (Respondent 6).

The same respondent is critical about the politicians' prejudices about RUT-deduction, which is the Swedish acronym for cleaning, maintenance and wash. RUT was bad interpreted by mass media:

They usually write negatively about the private care providers; they blow up the importance of profit. Profit is framed as being the only driving force behind private home care services. Mass media hardly want to see the positive side of our working methods with the elderly and what is difference between us and municipal home care services (Respondent 6).

The interactions between the social staff of private home care providers and the personnel of health care proved to be problematic in practice. The state regulations clearly explain that the nurses subordinated to the County Council have to take over some treatments, but:

> The cooperation between social assistants and nurses can be complicated and difficult. Maybe they are overworked but they are unpleasant, always lacking time [...]. They are educated in the old system and they are somewhat suspicious towards the private actors on a market with whom they have to cooperate. They just care about their own business. I think that the delegation has some weaknesses(Respondent 6).

Notably is that in the whole Gothenburg's surrounding, there is no one private company with nurses. They do exist in the Stockholm area and there, it seems to work quite well.

5. CONCLUSIONS

The purpose of this study was to compare the public and private home care services for elderly in two municipalities (Gothenburg and Molndal) in the Gothenburg Region in order to identify the model of home services working in favour for the elderly when both municipalities have been constrained by economic limitations. Three questions were crucial: *What do the public and private home care providers have in common? What differences can be observed in their understanding of home care services for elderly and working methods? What lessons can be learned from the implementation of the state delegation of home care for elderly to the municipal authorities?*

This study argued that the delegation of care services for elderly delivery into municipality has some unexpected effects. Whereas the public service providers struggle with regulations and goal-displacement, meaning that procedures and processes become more important than outcomes for the clients, this seems to be much less the case for private service providers. They have the client in mind; they are much less bureaucratized and seem to organize their work in a smarter way. They do employ workers on the hours, but on a monthly basis, if anyone wants that, they take care that elderly are assisted by a minimum of personnel. Pfeffer and Salancink (2003) have emphasised the importance of social context, strategy and power. When analysing the interviews and internal policy documents, the private companies seem to have worked out a strategy to keep good relations between their own personnel and the municipal staff. They are willing and open to any interaction and cooperation with other organizations, even the private companies – their competition – providing similar activities. The last ones are perceived as potential partners to cooperate with, because each organization has its profile and provides unique care and services for seniors. The massive controls and follow-ups serve them to learning in order to develop own organization. They are dependent on the users' payment, and thus have to produce services all the time to survive, which makes the private care provider very sensitive. Their managers create opportunities to the competence development of own personnel in cooperation with the municipality or the Industry. It is important for them to develop the organizational culture that is friendly for working climate and contribute to keeping care users that would feel that they are in the centre by providing them individualized car adapted to users' needs and expectations. Respect and humility towards users, the continuity of person, time and care constitute a key concepts and successful strategy to survive on a market. The working methods within the studied private organization seem really to serve the

elderly, which manifests a respect for the older people's autonomy and integrity in their own homes.

Well now, this is not at all what was expected, given the image of private care providers as depicted in the media. How can this be explained? Did the private care providers give biased answers to the questions posed? It might be the case, but it begs the question, why only the private providers would do so? There are huge differences between the answers given by the managers in the organization of the private and the public home care services for elderly. Why would one be honest and the other not?

Another explanation can be given by the repeated controls by the municipality that especially private companies face. This may induce them to perform better. It is awkward to see that the respondents from the district were complaining about frequent controls and monitoring of their activities, although in comparison to the private care provider these controls proved to be definitely less. Their attitude towards controls is also very different from the attitude of private service providers.

A third explanation is that the public service providers suffer from being part of a larger organization, the municipality as a whole, are faced with reductions in resources because of problematic financial developments caused outside their own organization/department. The permanent pressure coming from the municipality to save money caused that the first line chiefs had to buy equipment beyond the regulations and even bought necessary services from private companies that were not contracted. The financial problems within the district negatively influenced the working climate and the personnel's motivation to work. Some care users refused cooperation with the personnel of public care providers from the district, because of lacking continuity in the care provided and the problematic number of social assistants visiting users per month. The respondents from the public sector blame the politicians for granting too small amounts of resources for activities, but also the higher administrative instances for the administrative reform of 2010. The interviewed persons from Gothenburg are talking in terms of *We – They*. Many advocate that within the investigated district the elderly not get the assistance in line with the political promise i.e., they not live independently, safely, and with respect for their autonomy and integrity in their own homes. Even the public managers and the first line chiefs responsible for planning, organizing and performing care for elderly are not pleased with their working situation. They are talking about their work with embarrassment.

The elderly seem to profit from having a choice between public and private service providers. In the Municipality of Gothenburg the system of choice

was artificial, not introduced in a right way, because it was not obligatory. The responsible for the municipal budget politicians, advocating for savings have translated the idea of free choice in a typical Gothenburg way i.e., the free choices of services but not free choices of service providers.

Thus, according to Castelfranchi and Falcone [1998: 149], the delegation of care for elderly to municipalities in Sweden represents the mild delegation and the mild adaptation with regard to the specification of tasks at any intermediate level.

We could track what strategies and working methods the middle range managers and the first line chiefs from Gothenburg have developed to keep the district budget in balance. These strategies negatively influenced the quality of the care and services provided to elderly. The first line managers, according to the regulations, could not cooperate with the cheaper suppliers who could provide the equivalent or higher quality meals for the elderly, or buy cheaper coffee for personnel, or hire the cars necessary to work that were not procured by politicians.

Within the Municipality of Molndal, the elderly have seven options to choose. The elderly people are independent in uttering their preferences. The private company has the Swedish ISO Certification and fulfils all the demands of Quality Management System (ISO 9001: 2008) and Environmental Management System (ISO 14001: 2004). This seems to be advantageous for the elderly. Thus, according to Pfeffer and Salancik (1978) the different social but also political context essentially influenced the strategies for the organization of home care services for elderly conducted by the public and private providers.

This research cannot be generalized, although in my opinion many public and private businesses experience similar situations and dilemmas. The lesson drawn from this research is first and foremost that if politicians or other authorities limit people in their right to make their own decisions about themselves and the type of care they need, this inevitably results in dissatisfaction and because of that subsequent reforms, which not always tackle the real problems.

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PRYWATYZACJA OPIEKI NAD LUDŹMI STARSZYMI: PUBLICZNE I PRYWATNE USŁUGI OPIEKUŃCZE W MIEJSCU ZAMIESZKANIA W REGIONIE ZACHODNI GOETEBORG 2013 ROKU

S t r e s z c z e n i e

Celem artykułu jest porównanie i ocena publicznych i prywatnych domowych usług opiekuńczych dla ludzi starszych w regionie Goeteborg w Szwecji po przekazaniu przez władze centralne odpowiedzialności za te usługi na poziom samorządowy. Artykuł oparty jest na analizie legislacji, dokumentów urzędowych oraz wywiadów z kierownikami instytucji samorządowych odpowiedzialnymi za usługi opiekuńcze dla ludzi starszych w miejscu zamieszkania.