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Service Specification in Home Care Of Elderly

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CONTENTS

1 INTRODUCTION

The size of elderly population in Finland is forecast to increase both as a proportion of the total population and in absolute terms in the coming decades (Statistics Finland, 2009). Given the development, need for health care services is increasing. Therefore, health care costs are estimated to increase as well (Stakes, 2006). In most cases, elderly people wish to live independently for as long as possible even when they need support and care (de Blok & Meijboom & Luijkx & Schols, 2009). Consequently, the goal of elderly care is to enable living at home for as long as possible. This leads to the need to develop the production and organization of home care services. Service delivery in home care of elderly cannot really go on before the services needed are specified. Thus, it is crucial to understand service specification before developing other parts of home care services.

While using marketing in the field of health care has received criticism (see e.g. Scrivens, 2006 in Willcocks, 2008), Willcocks (2008) argues that application of marketing in health care context may add value when its limitations and private sector origins are adequately recognized. He states that it may offer health care personnel a way to explore core aspects of organizational performance in more detail: the centrality of quality and standards in success; understanding the "customer" and "supplier" relationship; building relationships with different stakeholders; identifying the characteristics of core services; the significance of user involvement in the health service; and analyzing the nature of the health care market.

This study sheds light on service specification in home care of elderly and adopts a paradigm from marketing discipline, namely service marketing, through which the process is viewed.

1.1 Literature Review

Service marketing is an area of marketing which has gained a lot of attention in past decades (Grove & Fisk & John, 2003). Significant share of the discussion deals with

defining ‘service’. Multiple definitions have been suggested (see e.g. Judd, 1964; Lovelock, 1996; Vargo & Lusch, 2004). Yet, no commonly accepted definition of service has emerged.

Besides discussion on definition of service, the discussion in service marketing literature has focused on service marketing concepts and typologies of services, measurement of service quality, production of services, and value created by services (Bruhn & Georgi, 2006, p. 11-12). A much discussed topic of service production is service delivery or service encounter, in particular customer’s role in it (see e.g. Chase, 1978; Lovelock & Young, 1979; Kelley & Donnelly & Skinner, 1990). Yet, relatively little has been written about selecting service specifications. Cermak, File, and Prince (1994) studied customer participation in service specification and delivery, but made no difference between service specification and delivery in their analysis. Van Raaij and Pruyn (1998) studied customer control over service production one stage of which was service specification. A study focused merely on service specification in service marketing is that of Swan, Bowers, and Grover (2002). Yet, their article is highly conceptual.

De Blok, Luijkx, Meijboom, and Schols (2010) have studied specification and construction of care and service packages for independently living elderly. Yet, the theoretical foundation of their study lies in operations management discipline as they study application of modularity in elderly care. Therefore, a study from a marketing viewpoint is needed.

1.2 Research Objective and Questions

This study aims at analyzing service encounters in home care of elderly from the perspective of the service specification. In doing so, it aims at shedding light on the initiation of service specification, the actors involved in it, and the challenges affecting it. Based on these objectives, research question and sub-questions are formed:

Research question:

- How is service specification carried out for independently living elderly?

Sub-questions:

- What initiates the service specification?
- How does the service specification process proceed?
- What kind of role does the customer have in the service specification process?
- What kinds of challenges affect the service specification?

1.3 Theoretical Framework of the Study

The theoretical framework of the study is presented in figure 1. The basis of the framework is the health care context, home care of elderly to be more precise which holds certain characteristics to be taken into account in the analysis. On top of this level, customer expectations and the service concept are inputs to the service specification which takes place in service encounters. In the first service encounter, the a priori specification is carried out, i.e. a preliminary specification is formed. Then, this preliminary specification is further defined in service encounters constituting the on-the-job specification.

Once the specification is finalized, the care relationship continues in the on-going service delivery which includes service encounters. In the on-going service delivery phase, the performance is evaluated by both the customer and the service provider after each service encounter.

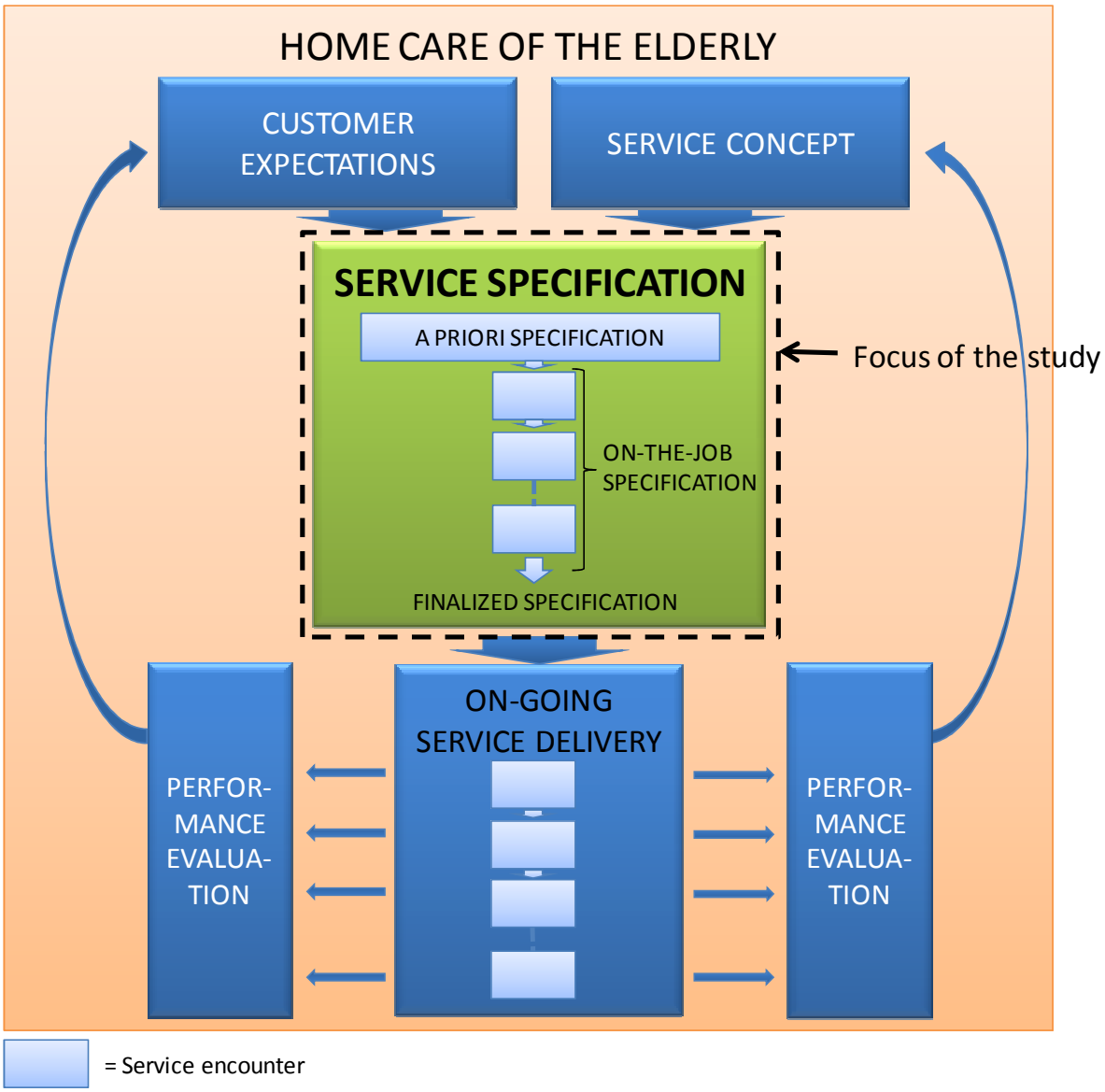

Figure 1. The theoretical framework of the study.

1.4 Delimitations of the Study

There are several delimitations for this study. First, the customer group is elderly persons who are over 75 years old. Second, the study discusses home care service specification in Southeastern Finland. Third, the context of the study is health care; care services taking place at home to be more precise, i.e. home care. Fourth, the study focuses on face-to-face service encounters. Thus, service encounters occurring through e.g. electronic distribution channels are out of the scope of the study. Fifth, the study focuses on service specification process at early stages of the

customer relationship. Service specifications may be further specified later on in the on-going service delivery phase but this part is delimited from the study.

1.5 Research Methodology

Research that combines home care with concepts from marketing is an emerging area. In particular, there is little research studying service specification in home care from a marketing point-of-view. Therefore, a descriptive case research approach is appropriate (Eisenhardt, 1989; Yin, 1994, p. 1).

The home care service specification is analyzed in two municipalities in Southeastern Finland. Multiple sources of evidence were used for data collection in order to facilitate triangulation (Eisenhardt, 1989). In both cases, the head nurse of home care was interviewed in April 2010. The interviews were thematic and were recorded with the permission of the interviewee. In addition, an internal report on elderly care and a questionnaire for preventive home visits were analyzed.

1.6 Key Concepts

Key concepts in this study are ‘service’, ‘service encounter’, and ‘service specification’.

In the literature, there are several definitions for a service. Judd (1964) defined marketed services as “a market transaction by an enterprise or entrepreneur where the object of the market transaction is other than the transfer of ownership (and title, if any) of a tangible commodity”. Lovelock (1996) defined service as “a process or performance rather than a thing”. Vargo and Lusch (2004) defined service as “the application of specialized competences (skills and knowledge), through deeds, processes, and performances for the benefit of another entity or the entity itself (self-service)”. Fitzsimmons & Fitzsimmons (2006, p. 4) include the customer as an active actor in their definition of service; “a service is a time-perishable, intangible experience performed for a customer acting in the role of co-producer”. Edvardsson, Gustafsson and Roos (2005) claim that the definitions are too narrow and argue that

service ought to be used as a perspective. For the purposes of this study, the definition proposed by Vargo and Lusch (2004) is adopted.

There are several definitions for a service encounter. Whereas Solomon, Surprenant, Czepiel, and Gutman (1985) rule out any services that are based on equipment by defining service encounter as “face-to-face interactions between a buyer and a seller in a service setting”, Lovelock, Wirtz, and Chew (2009, p. 43) take a wider view by defining it as “ a period of time when the customer interacts with a service provider”. Grönroos (2000, p. 6-7) sees service encounter as a process in which “the service provider is always present, interacting with the customer on a broad base …, or providing the process infrastructure”. For the purposes of this study, service encounter refers to interactions described by Solomon et al. (1985).

According to Swan et al. (2002), service specification occurs “when either the customer or provider selects specifications from possible alternatives during the service encounter” suggesting the service is specified from ready-made alternatives. Van Raaij & Pruyn (1998) see that the service may be customized and define service specification as “the agreement between the customer and the service provider about the type of service, service characteristics, and how the service will be provided”. De Blok et al. (2010) define the specification process of home care services as “the specification and construction of a package of required care and related service components” implying that the components are standard but may be customized once the service delivery has started. This study adopts the view of de Blok et al. (2010).

2 SERVICE SPECIFICATION

In order to understand service specification in home care of elderly, several aspects need to be considered. Services, in general, have characteristics that differentiate them from products and, therefore, affect the specification process. In addition, health care services are stated to differ from other services in some aspects. Moreover, the nature of service encounters affects service specification as it takes place in service encounters. Furthermore, service specification needs to be considered on a general level. Next, these aspects affecting service specification in home care of elderly are discussed in more detail. Also, literature on service specification in the context of home care of elderly is examined.

2.1 Nature and Characteristics of Services

Services, in general, have been characterized in multiple ways. Health care services have been stated to have both similarities and dissimilarities in comparison to other services. Next, these characteristics will be discussed further.

2.1.1 General Characteristics of Services

In the literature, services have been characterized in multiple ways. Typically, services are characterized by comparing them to physical goods. Lovelock and Gummesson (2004) trace a regular use in the service management literature of “the IHIP characteristics”; intangibility, inseparability (simultaneous production and consumption), heterogeneity, and perishability (therefore non-storable). These characteristics have been criticized of overgeneralization and are often recognized not being applicable to all services (Lovelock, 1996, p. 16). Lovelock and Gummesson (2004) note that significantly longer lists of differences are used in service management text books as well. Grönroos’ (2000) list of differences between goods and services acts as an example (see table 1).

Table 1. Differences between services and physical goods. (Grönroos, 2000, p. 47)

Physical goods	Services
Tangible	Intangible
Homogeneous	Heterogeneous
Production and distribution separated from consumption	Production, distribution, and consumption simultaneous processes
A thing	An activity or process
Core value produced in factory	Core value produced in buyer-seller interactions
Customers do not (normally) participate in the production process	Customers participate in production
Can be kept in stock	Cannot be kept in stock
Transfer of ownership	No transfer of ownership

Grönroos (2000, p. 47) notes that there are three basic characteristics for most services. Firstly, they are processes which consist of activities rather than things. In these processes, different kinds of resources are used often in collaboration with the customer in order to solve the customer's problem (Grönroos, 2000, p. 48). When a service is viewed as a performance, a theatrical metaphor can be used for service management; service delivery functions as the stating of a play with customers as the audience and the service personnel as actors (Lovelock, 1996, p. 16).

Secondly, services are produced and consumed simultaneously – at least to some extent. This characteristic refers to the 'inseparability' characteristic of the IHIP. Due to the simultaneous production and consumption, quality control is difficult manage and marketing in the conventional sense is difficult to do as the quality only realizes at the moment of production and consumption. (Grönroos, 2000, p. 48)

Thirdly, the customer is a participant in the service production process – at least to some extent. The customer is not just a passive receiver of the service but participates in the production process. Therefore, services cannot be kept in storage the way goods can be. (Grönroos, 2000, p. 48)

2.1.2 Characteristics of Health Care Services

Health care services have both several similarities and dissimilarities with other services (see table 2).

Table 2. Similarities and dissimilarities of health care with other services. (adapted from Berry & Bendapudi, 2007)

Similarities between health care and other services	Dissimilarities with other services
Intangible	Customers are reluctant
Variable, labor and skill intensive	Customers relinquish privacy
Inseparable	Customers need “whole person” service
Perishable	Customers are at risk
Asymmetric information	Doctors are stressed
	Supply increases demand
	High costs

Health care services have several similar characteristics as other services. Berry and Bendapudi (2007), see the IHIP characteristics discussed in chapter 2.1.1 applicable to health care services. Firstly, they are essentially intangible as the core benefits originate above all from performances and customers do not, therefore, obtain tangible assets but incur an expense. Consequently, it is not straightforward to make the potential benefits visible to the customer (Boonekamp, 1994). Secondly, health care services are variable (i.e. heterogeneous) as they are labor and skill intensive. The variability arises not only from different service styles and communication skills of doctors but also from their variable technical skills. Thirdly, health care services are inseparable as they are provided for people and not for people’s property. Therefore, the customer needs to be present where the service is provided which may be difficult for elderly customer or for customers who are inconveniently located. Fourthly, health care services are perishable as the potential value to be created perishes if staff time and expertise or equipment and physical space are not utilized. (Berry & Bendapudi, 2007)

Another characteristic of health care services is asymmetric information, i.e. customers are at a substantial knowledge disadvantage. New options in treatment made possible by advances in technology increase the asymmetry even further (Kay, 2007). Berry and Bendapudi (2007) and Lillrank and Venesmaa (2010, p. 36) see the linkage to professional services such as repair or appraisal services, while Kay (2007) fails to make the connection and argues that this is distinctive to health care services. The information asymmetry has two repercussions. Firstly, it is difficult for the customer to assess the possible treatment options (Kay, 2007; Lillrank & Venesmaa, 2010, p. 36). Secondly, it is hard to evaluate the result of the service even after it is performed (Berry & Bendapudi, 2007).

Some characteristics distinguish health care services from other services. Customers may be reluctant to use health care services due to the possibility or presence of illness which may make them feel uncomfortable. Also, customers relinquish their privacy as they may need to disrobe or discuss highly personal matters in order to receive the best care possible. In addition, health care services need to be customized based on a holistic understanding of customer needs. Not only customer's medical condition, but also his age, mental condition, personal traits, family circumstances, financial capacity, and preferences need to be considered. Furthermore, customers are at risk of e.g. hospital-acquired infections, medication errors, or mistakes caused by handwritten prescriptions. Some treatments, e.g. amputation of a limb, may have a severe impact on the customer's quality of life (Pitta & Laric, 2004). Moreover, personnel providing the service, i.e. doctors, are stressed and visibly tired. (Berry & Bendapudi, 2007)

Yet another particularity of health care services is that increase in supply increases demand. If additional resources, e.g. doctors or hospital resources, are allocated to a certain area, more medical services per capita will be used with no improvement in the overall health status of the population in the region. A related characteristic is that new health needs and desires can be created almost indefinitely through advances in medicine (Myllykangas, 2006). Consequently, health care services can be enormously expensive. In public health care services, service users, i.e. consumers, pay for only a fraction of the production costs of the service (Lillrank & Venesmaa, 2010, p. 36). Sometimes, there may not a direct may exchange relationship at all as third parties such as health insurers or regional health authorities pay for the services (Boonekamp, 1994). Furthermore, customers do not typically even know the actual costs of the service they use nor is this information easily available for those interested in it. (Berry & Bendapudi, 2007)

2.2 Service Encounters

The characteristics of services discussed above suggest that service encounters are interactive, i.e. services are produced, distributed, and consumed in an interactive process which involves the perspectives of both the service provider and the customer, i.e. the receiver of the service (Svensson, 2006). Next, management of service encounters and customer's role in them will be discussed. Also, management of services with moderate to high level of customer participation will be discussed as well as use of the 'service as theater' metaphor.

2.2.1 Service Encounters as Moments of Truth

To elaborate on the importance of effectively managing service encounters, Normann (1978 in Lovelock, 1996, p. 62) used the term "moment of truth" which he had borrowed from bullfighting. In bullfighting, the moment of truth is the moment when the matador slays the bull skillfully with his sword. The metaphor suggests that it is the life of the relationship which is at stake in the service encounter. In service encounter, the goal, however, is to keep the relationship between the customer and the service provider alive or to enable for it to grow. (Lovelock, 1996, p. 62, 64)

2.2.2 Customer Participation in Service Encounters

In order to understand the extent and nature of service encounters, it is necessary to look at the customer's role in service production (Lovelock et al., 2009, p. 43). Customers participate at some level in the production of the service and are, therefore, partly responsible for ensuring their own satisfaction (Bitner & Faranda & Hubbert & Zeithaml, 1997). Hsieh, Yen, and Chin (2004) have collected effects of customer participation from the literature; it could improve organizational productivity and efficiency, enhance service performance, have positive effects on customer satisfaction and service quality perception, as well as improve the behaviors of repurchase and referral.

The level of customer participation varies between services from low, to moderate, to high. Low level of customer participation requires the customer to be present during

service delivery. Moderate level of customer participation means that customer inputs such as information or materials are needed for service creation. At high level of customer participation, the customer co-creates the service product, i.e. has essential production roles that affect the service outcome if not fulfilled. Characteristics of each level of customer participation are illustrated in table 3. (Bitner et al., 1997)

Table 3. Levels of customer participation across different services. (Bitner et al. 1997)

***Low*: Customer presence required during service delivery**	***Moderate*: Customer inputs required for service creation**	***High*: Customer co-created the service product**
Products are standardized	Client inputs customize a standard service	Active client participation guides the customized service
Service is provided regardless of any individual purchase	Provision of service requires customer purchase	Service cannot be created apart from the customer's purchase active participation
Payment may be the only required customer input	Customer inputs (information, materials) are necessary for an adequate outcome, but the service firm provides the service	Customer inputs are mandatory and co-create the outcome

Within the levels of customer participation, the customer can play a variety of roles. Based on their literature review, Bitner et al. (1997) identified three of these roles stating the roles are not mutually exclusive. Firstly, the customer may act as a productive resource. Customers bring inputs to the service process; the quality and quantity of these inputs affect the quality of the output generated in the service process and, thus, organizational productivity (Mills & Chase & Margulies, 1983). Therefore, some suggest that direct customer contact ought to be minimized in order to reduce the uncertainty brought to the production process by customers (see e.g. Chase, 1978). Yet, others argue that organizational productivity could be increased by viewing customers as partial employees who participate in the service creation process to a high degree (see e.g. Mills et al., 1983). (Bitner et al, 1997)

Secondly, customers may act as contributors to quality, satisfaction, and value. Whereas the first role, productive resource improving organizational productivity, may not be of importance to customers, they are likely to care about whether their needs are satisfied. When customers participate in the service production process effectively, the likelihood of customer needs being satisfied can increase. In

particular, this is evident for services in which the service outcome is highly dependent on customer participation, e.g. health care, education or weight loss services. (Ibid.)

Thirdly, customers can be seen as potential competitors. For many services, customers - whether they are individuals or companies - may choose between purchasing the service in the marketplace and producing it themselves. Companies regularly make decisions on whether to outsource support services such as accounting, maintenance, or data processing. Individual consumers make similar decisions. For example, a car owner needing maintenance on his car may choose to do the maintenance tasks himself, to use a car maintenance shop for all tasks, or to do simple tasks himself and use the car maintenance shop for complex tasks. Similar examples can be considered for e.g. landscaping, child care, and home maintenance. (Ibid.)

2.2.3 Customer Participation in Health Care Services

Traditionally, the relationship between the customer and the doctor has followed a “paternalist model” in which only experts, i.e. health care workers, are qualified to diagnose and treat diseases. Thus, all decisions have been made based on the knowledge of the health care worker who has acted as a guardian of the customer’s interest. The customer has been a passive recipient of care. (Longtin & Sax & Leape & Sheridan & Donaldson & Pittet, 2010)

Today, many customers of health care services do not want to be just passive receivers of treatment (Edgren, 2006). Consequently, the paternalist model has eroded as customers wish to be better informed (Kay, 2007). Not only do customers demand information from health care workers, they also seek easy access to information on e.g. doctors and diseases online (Edgren, 2006).

According to Pitta and Laric (2004), participation of the customer in the provision of health care services affects the objective outcome, i.e. better health. Siegel (1990 in Hult & Lukas, 1995) concurs with them by arguing that it is of utmost importance that the customer participates in the decision-making process in order to achieve a level

of quality, value, and performance acceptable to all involved actors. Siegel (1990 in Hult & Lukas, 1995) has identified four different roles customers may assume in health care decision-making process; traditional, information consent, collaboration, or customer choice (see table 4). Hult & Lukas (1995) add that customer participation may also mean that the customer is encouraged to take the responsibility and an active role in caring for their particular illness and general health. Longtin et al. (2010) note that customer participation has been successfully applied to the particular aspects of care mentioned by Siegel as well as by Hult & Lukas, i.e. the decision-making process and the treatment of chronic illness.

Table 4. Customer roles in the health care decision-making process. (adapted from Siegel, 1990 in Hult & Lukas, 1995)

Customer role	Implication
Traditional	Doctor or health care provider decides. Customer trust and confidence replace the need for consent
Information consent	Doctor or health care provider decides with the customer's consent
Collaboration	Joint decisions
Customer choice	Customer decides with the doctor's or health care provider's consent

Based on their literature review, Longtin et al. (2010) have identified various factors affecting the customer's willingness to participate in health care services; acceptance of new customer role, level of health literacy and extent of knowledge, confidence in own capacities, type of decision-making required, stakes of the proposed outcome, type of illness and comorbidity, age, sex, socioeconomic level, ethnic origin, use of alternative medicine, and health care worker professional specialty. For this study, the effect of customer's age is of particular interest. According to Longtin et al. (2010), older patients are frequently less interested in the decision-making independent of their health status. Yet, they report of evidence showing that the elderly can participate in their care. Kay (2007) notes that often the decision-making and assessment of care is shifted to trusted family members when the customer ages.

2.2.4 The Servuction Model

A company has various types of interactions with its customers, particularly a company offering services with moderate to high level of customer participation. The servuction system, which is short for service production system, focuses on management of these interactions which combined make up a typical customer experience which, in turn, determines the value of the service created for the customer (see figure 2). (Lovelock et al., 2009, p. 43, 46)

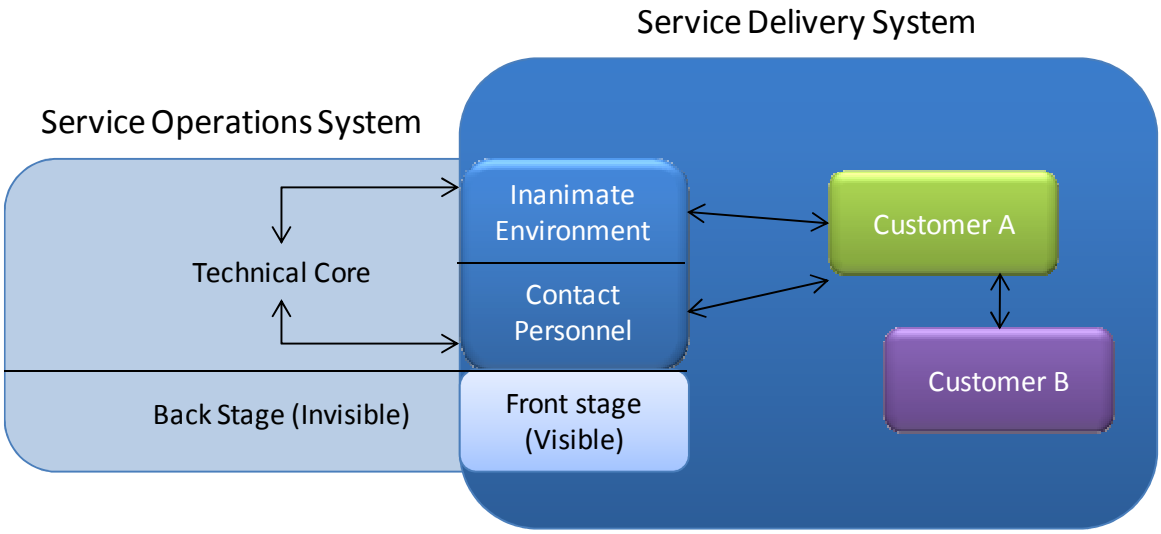

Figure 2. The Servuction System. (Eiglier & Langeard, 1977 in Lovelock et al., 2009, p. 46)

During a service encounter, the customer interacts not only with service employees but also with the service environment. In addition, the customer may interact even with other customers who are present during the service encounter. On the one hand, each interaction may create value through e.g. kind and skilled employees or a pleasing environment. On the other hand, each interaction may also destroy value through e.g. a cell phone ringing in a movie theatre or another customer speaking loudly. Thus, the service provider needs to coordinate the interactions in order for the customers to get the service experiences they came for. (Eiglier & Langeard, 1977 in Lovelock et al., 2009, p. 46)

The servuction system consists of the service operations system, i.e. the technical core and the service delivery system. In the technical core, the inputs are processed.

In addition, the elements of the service product are formed there. Typically, the technical core is invisible to the customer and located in the “back-stage”. In the service delivery system, the service is “assembled” and delivered to the customer. This part is visible to the customer and, therefore, the “front-stage”. (Eiglier & Langeard, 1977 in Lovelock et al., 2009, p. 46, 47)

2.2.5 Service Encounters as Theater

It has been proposed that service employees and customers play certain roles in a service encounter (see. e.g. Solomon et al., 1985; Broderick, 1998; Johnston & Clark, 2005, p. 226). Adding to that the division of the servuction system to the back-stage and the front-stage, theater has been suggested as a metaphor for services and their creation through the servuction system (see. e.g. Goodwin, 1996; Harris & Harris & Baron, 2003; Williams & Anderson, 2005; Lovelock et al., 2009, p. 43)

Service facilities are a stage on which the drama takes place. Sometimes, the stage is changed from one act to another, e.g. airline passengers start a service encounter at a check-in desk and, then, move on to a boarding lounge. (Lovelock et al., 2009, p. 48)

Service personnel are actors in the drama. The service personnel may assume a variety of roles, some of which are part of their formal work description, while others may be unexpected, yet have to be dealt with. These roles include order taker, advice giver, image maker, service deliverer, complaint handler, therapist, trainer, and coach. (Johnston & Clark, 2005, p. 224-225) In some cases, front-stage personnel are expected to wear special costumes on the stage, i.e. uniforms. The backstage personnel represent the support production team in the play. (Lovelock et al., 2009, p. 48)

In order to provide consistency and efficiency, “scripts” may be used in a service encounter. A script specifies the sequence of behavior that the customer and the employee are expected to follow (Lovelock et al., 2009, p. 48). Use of scripts may also provide a sense of security both for customers and employees as they understand the ‘rules’ by which the service encounter will be played out. According to

Tansik and Smith (2000 in Johnston & Clark, 2005, p. 235-236), scripts may be used for following purposes in the service encounter: to assist the service employee to find out what the customer wants or needs; to control the customer; to establish historical routines that may be relevant to the service encounter; to facilitate control of workers; to legitimize organizational actions; to serve as analogies; to facilitate organized behavior; to provide guide to behavior; to buffer or exacerbate role conflict; to provide a basis for evaluating behavior; and to conserve cognitive capacity. (Johnston & Clark, 2005, p. 234)

2.3 Selecting Service Specifications

Before the service delivery can really begin, the customer's requirements have to be specified (Fließ & Kleinaltenkamp, 2004). In service specification, an agreement is reached about the type of service to be delivered (including price, quality, timing, design as well as other service specifications) based on customer's expectations (Van Raaij & Pruyn, 1998) and the service provider's service concept (Johnston & Clark, 2005, p. 40). Thus, service specification is a crucial part of the service process since it determines what service will be rendered and how well it will meet the customer's needs (Van Raaij & Pruyn, 1998; Swan et al., 2002). Next, different modes and management of service specification are discussed.

2.3.1 Typology of Service Specification

Service specification is different for different kinds of services. According to Van Raaij and Pruyn (1998), for some services, negotiations may be carried out before the service, e.g. negotiating for price when taking a taxi in some countries. For others, they argue, the specification process may itself be enjoyable for customer, e.g. planning a long vacation. Swan et al. (2002) argue that service specification varies by the extent to which a customer or a service provider determines the choice of service specification, confidence and interest of the customer in evaluating specifications, and the amount of specifications information seeking by the customers. They have identified three modes of service specification; provider-dominated, joint, and customer-dominated. Next, each of these modes will be discussed in more detail.

In provider-dominated service encounters, the confidence and interest of customers in their ability to evaluate service specifications is low. Therefore, customers seek relatively little information – which is independent from the provider – on what kinds of specifications are available and how those could be evaluated. The provider is familiar with possible specifications, and the provider shares little if any information with the customer. Therefore, customers hand over the selection of service specifications to the provider. The customer's role may be limited to just accepting the single specification recommended by the provider. (Swan et al., 2002)

In joint provider-customer specifications selection, a service provider and a customer negotiate specifications as more or less equal partners. The customer either has adequate confidence to evaluate specifications prior to the service encounter or gets confidence from interaction with the provider. Yet, the customer does not have sufficient information on the specifications available or on the likely outcomes each specification has. Therefore, the customer counts on the provider to provide appropriate information. Then, the customer and the provider work together in evaluating specifications. Many consumers prefer joint service specification since it allows input from both parties. (Ibid.)

In customer-dominated service specification, a customer chooses from specifications available. Customers are interested in evaluating the specifications and feel confident to do so. They have appropriate information on circumstances, preferences, and needs for selecting the service specifications. They may also seek for more information, if they feel they do not have all the information available. The characteristics of each of the modes discussed above are presented in table 5. (Ibid.)

Table 5. A typology of service specification modes. (adapted from Swan et al., 2002)

	Provider-dominated	Joint	Customer-dominated
Choice of option	Minimal customer choice of option Maximal provider choice of option	Negotiated choice between customer and provider	Maximal customer choice of option Minimal provider choice of option
Customer confidence in evaluating options	Low	Medium	High
Customer interest in evaluating options	Low	Medium	High
Customer options information seeking	Minimal	Maximal	Medium

The service provider enacts a mode of service specification on in the beginning of service delivery. Within the mode enacted, a process of service specification unfolds. Customers are likely to have expectations concerning the mode of specification. In addition, they are likely to compare the mode enacted to their expectations. The mode of selection of service specifications is not necessarily intrinsic to the service; it depends on the relationship between the customer and the provider. The same service may be customer-dominated, provider-dominated or joint. (Ibid.)

2.3.2 Management of Service Specifications Selection

The management of service specifications selection begins by identifying what kind of expectations customers have towards the mode of service specification. One way to do this is to recognize which of the three modes is typical for one's service. As different customers may have different kind of expectations towards the mode of service specification, it is of importance to listen to the customers for their wishes and expectations. (Swan et al., 2002)

In service delivery, the mode of service specification is enacted. Customers expect the provider both to be customer-oriented and to exchange information. Therefore, the service provider ought to fit both the type of customer-orientation and information exchange to the mode of service specification that takes place. The service personnel should be prepared to respond appropriately to the mode of service specification (see table 6). (Ibid.)

Table 6. Actions of service provider in service specification in service delivery. (adapted from Swan et al., 2002)

Provider Actions	Provider-dominated	Joint	Customer-dominated
Customer orientation of provider	Willing listener	Consultative seller	Helpful partner
Provision of information	Outcomes and risks of specifications selected	Ask customer to voice needs	Respond to inquiries
	Verify customer needs	Explain costs, performance and limitations of specifications	Warn customer of inappropriate choice
	Seek customer agreement to specifications		Mention alternatives

In provider-dominated service specification, a customer orientation that may help prevent problems is the provider to be a willing listener. Provider-dominated services are typically professional services where the provider is an expert selecting and presenting specifications to a customer who has little or no say in consideration. Problems may rise if the provider tends to pay little attention to the customer when deciding on specifications. One problem is that customers may feel ignored. Also, the specifications may not fit the customer's situation well. The willing listener customer orientation can help prevent these problems. In addition to being a willing listener, it is important for the provider to pay attention to information exchange; the provider ought to inform customers of presumable outcomes and risks of the specifications selected, to confirm customer needs, and to seek explicit agreement to the specifications from the customer. (Ibid.)

In service encounters involving joint provider-customer service specification, consultative selling is the most appropriate customer orientation; a service provider learns from a customer of his goals, concerns, and problems. The customer will rely on the provider to present information about different specifications and about e.g. the costs, performance, and limitations of specifications. As the customer and the provider are likely to co-operate in evaluating specifications, the provider may view its role as a problem solver who is negotiating and guiding the customer to the most appropriate service specifications. Thus, the service provider needs questioning and listening skills as well as the ability to convincingly explain the service specifications. (Ibid.)

In customer-dominated service specification, the most effective customer orientation is being a helpful partner. Problems may be caused by many customers not consulting the service provider when selecting service specifications. The customer may later on find out about a service specification which he would have preferred over the ones he chose had he known about it. The service provider needs to be able to clearly respond to customer's inquiries, explaining specifications to customers. A proactive approach is important in providing information as customers may fail to ask the important questions. (Ibid.)

2.4 Service Specification in Home Care

Elderly care takes mostly place on a long-term basis. The degree, to which independently living elderly are able to take care of themselves and their households, decreases over time due to changing health conditions, while the amount and intensity of home care provided increases. Home care refers to care provided at home and includes services such as housekeeping assistance, hygienic and personal care (e.g. help with showering), technical nursing activities (e.g. wound care), meal service, and alarm systems etc. (de Blok et al., 2010)

Traditionally, the different kinds of services mentioned above are provided by different organizations (or even by different organizational departments) who work autonomously and separately from each other (de Blok et al., 2010). Yet, to an individual elderly person these services are interrelated as they all enable him to continue living at home (de Blok et al., 2009). Therefore, different service providers need to work together to create a coherent service package (de Blok et al., 2010).

In order to meet the needs of a given customer, the required care and service package needs to be specified. Professionals determine together with an elderly customer what services are to be delivered. By doing this well, some of stress and emotions related to placing one's body and living environment in the hands of a professional might be relieved. In their case studies, de Blok et al. (2010) noticed that service specification takes place in two phases (see table 7); the a priori phase

(before the start of actual care delivery) and the on-the-job phase (coincides with care delivery). (de Blok et al., 2010)

Table 7. General description of home care service specification process. (adapted from de Blok et al., 2010)

Phase	Actor	Action
A priori specification	Front-desk employee	Answer customer's phone call
		Brief clarification of needs
		Transfer of information to appropriate team
	Start-up nurse	Call customer to clarify content of need in more detail
		Plan house visit
		Pay house visit: question and observe customer
		Determine services required, construct care package
		Make arrangement on package
		Make sure key nurse is assigned and delivery is planned
Start care delivery	Key nurse	Start care delivery
On-the-job specification	Key nurse	Detail contents and planning of services in the package
		Finalize and fix package
On-going care provision	Key nurse	On-going care provision

In the a priori service specification phase, a package of relatively standard care services is formed based on a generic exploration of the customer's needs. In this preliminary package, preparations to start the care delivery are made in broad terms regarding e.g. duration and moment of delivery. The service specification process is initiated by a brief telephone call from the customer. Then, a house visit, in which the customer is questioned and his living environment is examined, is made in order to further specify needs and requirements. Consequently, the care professional can relate these needs to relevant services provided by the organization. After the house visit, care delivery can start as soon as a key nurse responsible for the delivery and adaption of the care package is assigned. (de Blok et al., 2010)

In the on-the-job phase of service specification, a detailed picture of the customer's needs and requirements is drawn based on information revealed in the delivery of care services. In this phase, problems in the elderly person's life not detected in the a priori phase may arise. Then, the services in the care package are adapted and fine-tuned accordingly with respect to content, time span, necessary aiding devices, materials used, moment and place of delivery etc. After a certain period, the care package can be finalized. Over time, changing needs of the customer may require

changes in the care package but these adjustments are out of the scope of this study. (de Blok et al., 2010)

In home care services, customer participates in service specification and in service delivery since care services are mainly targeted at the customer's body and mind (de Blok et al., 2010). Thus, service provider regularly interacts with the elderly client (de Blok et al., 2009). Customers value participation in the care process as they are taken seriously and consulted in deciding on their care services (Rijckmans & Bongers & Garretsen & Van de Goor, 2007).

Customer participates both in the a priori and in the on-the-job phase of service specification, and the participation increases over time. The care services to be included in the care package are selected mainly in the a priori phase of the specification process. There, customer participates first via telephone and then through the observation of his health and living environment. In the on-the-job phase when the care delivery has already started, the customer and the care professional can compare the outcome of the care services included in the care package and adjust them accordingly. This reduces complexity of the specification of intangible care services. (de Blok et al., 2010)

3 EMPIRICAL FINDINGS

In this section, findings from the two case home cares, A and B, are presented.

3.1 Case A

The case A is the home care of a municipality in Southeastern Finland with around 5 000 inhabitants. There are two population centers in the municipality. Home help and home nursing were in different organizations until 2005, when they were combined into one organization, i.e. home care. The interviewee has worked as the head nurse of home care for over five years. Her responsibilities include e.g. deciding on care plans and informal care allowances as well as personnel management and administrative tasks. In addition, she attends home visits in which a care plan is devised whenever possible.

Home care operates in two shifts; there is no night shift which limits the level of care that can be provided. Home care services are currently provided to about 180 customers. Approximately half of the customers live in the larger population center, some in the smaller population center, and the rest in sparsely populated areas. The distance to the furthest customers is 40 km which limits the possibilities to provide services to customers living that far from the population center.

Next, the service specification process and challenges affecting it in case A are discussed in more detail.

3.1.1 Service Specification Process in Case A

There are several ways in which new customers enter home care services. The elderly person may have been an in-patient at a health centre or at a hospital, and is to be discharged. Also, he might have visited acute care and the doctor has evaluated that home care is needed. Furthermore, the elderly person may himself call home care personnel and ask for services. Moreover, a neighbor might be the one to contact home care. In addition, there are preventive home visit for certain age

groups. Typically, however, it is the next of kin of the elderly person who contacts home care and expresses their concern.

When an elderly person is about to be discharged from a health centre or a hospital, a meeting is set for devising a care plan. The meeting may take place either at the local health centre or at the customer's home. Participants of the meeting are the elderly person himself, a nurse from home care, and a next of kin whenever that is possible. A nurse from the health centre attends the meeting as well when the meeting takes place at the health centre. When the first step is taken in some other way, a home care nurse contacts the elderly person and asks for a permission to make a home visit. The preventive home visits were introduced last year. Elderly persons turning 75 years that year are offered a home visit.

In the meeting, whether it takes place at the health centre or at the customer's home, the customer's functional capacity is discussed; how well is the elderly person able to move, is he able to wash himself, is he able to cook, or does he need help in these chores. In addition, it is discussed whether the customer remembers to do this kind of matters even if he is able to do them. One further topic to discuss is medication. Based on the discussion on customer needs, a care plan is devised. Such services which enable the customer to live at home are included in the care plan.

In the discussion, the customer needs to be listened to very carefully. Sometimes, the elderly person is used to or even submitted to someone else deciding for him. Therefore, the home care nurse has to ensure that the customer participates in the discussion. As the interviewee put it:

> "There are situations in which the nurse has to take a leading role in the conversation so that the customer really participates and is involved in the conversation. Not so, that the next of kin says or the nurse talks, and the one concerned is then quiet and listens, but that his opinion needs to be actively asked if he otherwise is afraid or does not want to express it."

The home care nurse must emphasize that it is the customer who makes the final decision on whether he wishes to have some service or not given that he is mentally in a condition to make such a decision. It is often ignored that even elderly with

memory disorders are able to decide or at least express their opinion on certain issues.

When the care plan is devised, service delivery starts. When home care personnel visit the customer, they pay attention to whether or not the services the customer receives are sufficient. Signals of insufficient services are e.g. that the customer has not taken his medication or not eaten food he has received from meal service. In particular, when a customer is discharged from a health centre or a hospital, the first few weeks are the critical determinants of whether or not he will be able to remain at home. Therefore, home care visits the customer more often during these critical weeks after which the need for services is re-evaluated.

3.1.2 Challenges Affecting Service Specification in Case A

There are several challenges affecting the service specification (see table 8). First, some neighbors or next of kin who contact home care forbid home care personnel to tell the elderly person who has expressed their concern of his well-being. In general, home care agrees with the caller that the elderly person is to be told who has expressed their concern. Yet, there are cases when e.g. the elderly person has been the one to break with the next of kin. In these situations, home care comes up with an artificial reason to contact the elderly person and to check the situation.

Table 8. Challenges affecting service specification in case A

Challenge
Person contacting home care wishes to remain anonymous
Customer declines home visit
Conflicting views between elderly person and next of kin on services needed
Misguided views on services provided by home care

Second, certain type of elderly persons sometimes decline suggested home visits and assure that they will manage on their own. Home care personnel won't make home visits against the will of the elderly person. The same applies to providing services; even though next of kin would demand services to be provided to the elderly person, no services are provided to against his wishes. In these cases,

contact information and information on services of home care are given to the elderly person in case he changes his mind.

Third, the next of kin sometimes tries to affect the decision on what services are to be provided to the elderly person. Yet, the customer is always the elderly person and the services need to be based on his needs and wishes. The interviewee gave an example:

> "…next of kin calls us and says that we need to have the emergency phone service. Okay, but the elderly person does not want it. Firstly, it costs … and then there are these that this emergency phone for instance is taken there against the elderly person's will, and it is there, it is no good as the wristband is at a table or in a dresser, so the person won't wear it. So, these things need to definitely stem from the customer himself."

Fourth, there has been an extensive change in services provided by home care during past decade. Home help used to play a larger role in home care; home help personnel baked with the customer, did the dishes, laundered etc. Today, the emphasis is more on care and nursing. The customers are activated to take care of daily chores themselves in order to maintain their functional capacity. This has taken a lot of discussion both with customers and their next of kin so that they understand the services provided by home care and the logic behind them.

3.2 Case B

The case B is home care of a municipality in Southeastern Finland with roughly 6 000 inhabitants. As in case A, home help and home nursing used to be different organizations. They were fused into home care in 1998. The interviewee has been the head nurse of home care for about five years. Her responsibilities include e.g. personnel management, deciding on informal care allowance, and participating in deciding on where to locate a person in need of care.

Home care operates in three shifts, i.e. there is a night shift as well. Home care services are provided to around 140 customers; half of them use services frequently,

i.e. from one up to even seven times a day, whereas the other half uses services typically every two weeks. About 50 customers who use services less frequently live in sparsely populated areas; the distance to the furthest of these customers is 70 km.

Next, the service specification process and challenges affecting it in case B are discussed in more detail.

3.2.1 Service Specification Process in Case B

A new customer may enter home care services in several ways. One of the most common is that the elderly person may be about to be discharged from a health centre or a hospital after being an in-patient there. Another common way is that the elderly person has had an appointment with a doctor at a health centre, and the doctor has then sent a message to home care to contact the elderly person. In addition, the elderly person might have been a patient in acute care and the doctor has assessed that home care is needed. Additionally, other authorities such as the police, social services, or pharmacy may be the ones to contact home care. There are also cases in which the elderly person has called home care personnel himself; in these cases, there have typically been problems with taking medication. Furthermore, a neighbor might be the one to contact home care. The need for home care may be detected during a preventive home visit. Yet, typically it is the next of kin of the elderly person who contacts home care and expresses their concern.

When the possibility of need of home care services is expressed, a meeting is set to devise a care plan for the elderly person. This meeting may take place at a health centre when the elderly person has been an in-patient there or at home of the elderly person. In addition to the elderly person himself and a nurse from home care, a next of kin of the elderly person often participates this meeting as does a nurse from the health centre when the meeting takes place there. If the information on the need for acute home care services is received during evening or nighttime, a practical nurse makes a preliminary visit to the customer and a nurse takes care of a more thorough specification of services the next day. If the need for home care services is not that urgent, a suitable time for a home visit is agreed with the customer.

The meeting to devise a care plan typically takes at least an hour and a half. The topics discussed are basic needs including e.g. eating, dressing, washing, and medication; household management including cleaning, shopping, and taking care of financial matters; and different allowances the elderly person may be entitled to. An example of division of tasks could be that the next of kin take care of shopping and financial matters and order cleaning from a private service provider, home care visits the customer in the mornings and in the evenings and take care of medication, breakfast and supper, and order a meal service to deliver lunch.

The discussion proceeds on the terms of the elderly person. Home care nurse tries to listen for the customer needs by chatting with the elderly person. For example, when the nurse tries to see if there is need for help with medication, she can ask the customer to show what kind of medicines he has and when he takes the medicine etc. The care plan is based on what the customer tells. As the interviewee put it:

> “It is not even appropriate on the first home visit to go and study what is there in the fridge, or how is his diet or anything like that. We have to rely on what the customer tells. And we’re no nutritional guards or anything like that.”

In addition to the meetings discussed above which respond to a need of home care services noticed for some reason, there are preventive home visits in which a physiotherapist checks what kind of home modifications might be needed and what kind of exercises might benefit the customer. These preventive home visits have been offered to elderly turning 80 or 85 years and recently to those turning 75 years as well.

After the care plan is devised, service delivery starts. Only a fraction of the actual needs of the customer can be detected during the first home visit when the care plan is devised. Once the service delivery has started, a deeper trust grows between the customer and the home care personnel. This may lead to discovery of additional needs. Usually, it takes two to three days to notice the need for change in the care plan when the customer relationship has started after the elderly person has been discharged from a health centre or a hospital. Typically, it is the customer who brings

up that there are too many home visits, e.g. it has been agreed that home care visits the customer both in the morning and in the evening, and the customer calls that he can take care of supper himself so there is no need for the evening visit. When there are too few home visits, the situation is usually the opposite; it is the home care personnel who notice that there are some things neglected, e.g. meals are not eaten. Then, more home visits are added to the care plan to ensure that the customer eats.

3.2.2 Challenges Affecting Service Specification in Case B

There are several challenges affecting the service specification (see table 9). First, the elderly person may decline an offered home visit. Some feel they are able to take care of their own business themselves and that home care is only prying into their personal matters. Often, they are elderly with memory disorders. In these cases, the nurse needs to persuade the elderly person to allow a home visit. As the interviewee put it:

> "… in our profession, one learns to come up with that kind of permissible white lies, one learns the style that we get there. So, we are fairly seldom left outside the door … We can say that a doctor has asked us to call and make a home visit."

The authority of a doctor is often enough to convince the elderly person to allow the home visit. Sometimes, when a next of kin has contacted home care and is suspecting that the elderly person won't allow a home visit, it is agreed that the next of kin will be present at the home visit and home care makes the visit with the permission of the next of kin.

Table 9. Challenges affecting service specification in case B.

Challenge
Customer declines home visit
Conflicting views between elderly person or home care personnel and next of kin on services needed
Misguided views on services provided by home care

Second, next of kin of an elderly person sometimes try to affect the decision on what services are to be provided to the elderly person. Yet, the customer of home care is the elderly person. Often, the conflict deals with the location in which the customer is to be taken care of; next of kin feel that the elderly person can no longer live at home,

and home care personnel try to convince them that the elderly person is still able to live at home with the help of home care services. This is related to the next challenge as well.

Third, there are misguided views on home care services among the elderly and their next of kin. Sometimes the next of kin do not know the level of care that can be provided at home and, therefore, demand that the elderly person ought to be taken care of in an institution. Other times, customers feel that as they pay for home visits, home care should perform tasks such as doing the dishes or taking out the trash. Yet, the customer needs to perform these tasks himself if he only is able to as that maintains his functional capacity.

4 DISCUSSION

In this section, the empirical cases are compared both with each other and with the theoretical discussion in section 2.

4.1 Initiation of Service Specification

In the article of de Blok et al. (2010), home care service specification process is always initiated by a call from an elderly person to an organization providing home care services. In both cases studied, the initiator of the customer relationship, and thereby service specification, was rarely the elderly person himself but a health care professional, a next of kin, or a neighbor concerned of the elderly person. The initiation of service specification was described rather similarly in both cases studied. In case B, however, other authorities such as the police, social services, or pharmacy were mentioned by the interviewee as well.

The home care service providers that de Blok et al. (2010) have studied appear to be private companies, whereas the case home care organizations in this study are public service providers. This may explain the difference in the initiation of service specification. The customers in the article of de Blok et al. (2010) may already have been convinced of the need for home care services by their next of kin, while in the cases of this study, some next of kin may find it easier to let the home care professional convince the elderly person.

In both cases of this study, an additional way to start the customer relationship was preventive home visits which were suggested by the home care personnel.

4.2 Service Specification Process

The service specification processes in both cases of this study appear to follow the phases presented by de Blok et al. (2010). Next, each phase will be discussed in more detail.

4.2.1 A Priori Specification

According to de Blok et al. (2010), a priori specification takes place before the service delivery starts and includes arranging a home visit, the home visit, and making arrangements on the care package and service delivery. Similarly, a meeting takes place before the start of service delivery in both cases of this study. However, the place in which the meeting is held may vary. Some of the meetings were held at a health centre when the elderly person was an in-patient there. Yet, the goal of the meeting was the same; to specify the services needed to enable the elderly person to live independently. Otherwise, the a priori specification in both cases appears to be rather similar to that described by de Blok et al. (2010).

The topics discussed in the home visit seem to be rather similar in both cases; from basic needs to household management. In like manner, the participants are the same in both cases; a nurse from home care, the elderly person, and the next of kin of the elderly person, if only possible.

Swan et al. (2002) presented three different modes of specifications selection, namely, provider-dominated, joint, and customer-dominated. These are of relevance in the a priori specification when the care plan is being devised. The mode of specification selection in both cases appears to be twofold. Firstly, in matters related to daily chores, the customer is the expert on his own functional capacity. Yet, the home care personnel provide information on e.g. home modifications. Therefore, the mode is joint provider-customer specifications selection. Secondly, in matters related to nursing, e.g. wound care, it is the home care personnel who have adequate information and education to make decisions. Therefore, the mode is provider-dominated.

4.2.2 On-the-Job Specification

According to de Blok et al. (2010), on-the-job specification coincides with service delivery and is based on information revealed in it. In both cases of this study, there appears to be on-the-job specification as well. It is slightly more evident in case B where the growing trust between the customer and the home care personnel was

emphasized to lead to discovery of customer needs not discovered in the a priori specification phase. Yet, observation of sufficiency of services agreed upon in the care plan was mentioned in case A as well.

4.3 Customer Participation in Service Specification

Siegel (1990 in Hult & Lukas, 1995) identified four different roles a customer can play in health care decision-making process; traditional, information consent, collaboration, and customer choice. Customer participation appeared to be rather similar in both cases studied. Customers do not seem to take a traditional role in which the health care provider decides as, in both cases, it was emphasized that no services are to be provided against the customer's wishes. Customers seem to play an information consent role in relation to nursing services as the home care nurse is the one to decide on these services after receiving consent from the customer. In deciding on matters related to daily chores, customers seem to play a collaboration role as the decision is made jointly. Customers do not appear to play the customer choice role in relation to any services as is it the home care nurse who makes the final decision on which services are provided to the customer by home care, i.e. the public sector.

4.4 Challenges Affecting Service Specification

Challenges affecting service specification (summarized in table 10) were pretty similar in both cases. Yet, one challenge, namely the person contacting home care wishing to remain anonymous, was more evident in case A. Some of the challenges may arise from characteristics of health care services.

Table 10. Challenges affecting service specification in cases

Challenge	Case A	Case B
Person contacting home care wishes to remain anonymous	X	
Customer declines home visit	X	X
Conflicting views between elderly person or home care personnel and next of kin on services needed	X	X
Misguided views on services provided by home care	X	X

The challenge of the person contacting home care wishing to remain anonymous may partly be a consequence of health care services being highly personal in nature; a half-acquainted neighbor, who notices that something is wrong with an elderly person, may not be willing to question the functional capacity of the elderly person openly.

The challenge of customer declining home visit may be a result of one characteristic of health care services, namely customers being reluctant. Also, the personal nature of home care and health care services may be a reason for the second challenge. As was mentioned in case B, some elderly people may feel that home care personnel are prying into their personal matters and, therefore, decline the home visit.

The challenge of conflicting views between elderly person or home care personnel and next of kin on services needed may arise partly from asymmetric information and partly from intangibility of home care services. Information asymmetry may result in customers or their next of kin expecting daily chores to be performed by home care personnel. Customers or their next of kin may not know that the elderly person promotes his functional capacity by performing these chores himself. Intangibility of home care services may hinder an elderly person from comprehending the necessity of some service.

The challenge of misguided views on services provided by home care was mentioned to be related to the change in home care services; the emphasis has shifted from home help to care and nursing. Also, more and more services can today be provided at home.

5 CONCLUSIONS

This study aimed at analyzing service encounters in home care of elderly from the perspective of service specification. It sought out to shed light on the initiation of service specification, the actors involved in it, and the challenges affecting it. The theoretical background for the study comes from service marketing. Even though service specification is a crucial part of service delivery, it has received relatively little attention in the literature on marketing. The empirical part of the study was based on two cases of home care of elderly. The cases were studied by interviewing the head nurse of home care in both cases and by analyzing relevant documents.

In both of the cases, customer relationships, and thereby service specification, were initiated by several parties; a health care professional, next of kin of the elderly person, or a concerned neighbor. Contrary to what de Blok et al. (2010) presented, the initiator was rarely the elderly person himself in this study. Another way to enter home care services were preventive home visits.

The service specification process followed the phases presented by de Blok et al. (2010); a priori specification, which takes place before the start of service delivery, and on-the-job specification which coincides with service delivery. In the a priori specification, a preliminary care plan was devised in a meeting participants of which were a nurse from home care, the elderly person himself, and next of kin of the elderly person if only possible. If the meeting took place at a health centre, a nurse from there was also present. The topics discussed in the meeting were from basic needs to household management. On-the-job specification, where growing trust between the customer and the home care personnel leads to discovery of further needs for care, was emphasized more in case B but appeared to occur in case A as well.

Customers played two of the four roles presented by Siegel (1990 in Hult & Lukas, 1995); information consent and collaboration. In matters related to nursing services, elderly customers play an information consent role as the home care nurse is the one to decide on these services after receiving consent from the customer. In matters

related to daily chores, the decision is made collaboratively; the elderly person can best describe his functional capacity whereas the home care nurse has more information on e.g. possibilities of home modifications.

Challenges affecting service specification were rather similar in both cases; customers decline home visits, there are conflicting views between elderly person or home care personnel and next of kin on services needed, and there are misguided views on services provided by home care. An additional challenge of person contacting home care wishing to remain anonymous was more evident in case A.

Concepts of service marketing provided a good theoretical background for analyzing service specification in home care of elderly. Yet, there are some limitations in this study. There were only two cases studied. Moreover, both of the case home cares were from rather small municipalities. Had more home cares from municipalities of different sizes been included, a more complete picture could have been drawn and thus, the generalizability of the results of this study could have been improved. Also, there was only one interviewee from each case organization. By carrying out more extensive interviews among the home care personnel, a more in-depth understanding of the cases could have been achieved. Furthermore, this research could be furthered in the future by including the viewpoint of the elderly of service specification. In this research, the viewpoint of the elderly was only present through some literature. By interviewing elderly customers who have recently entered home care services, a more complete view of the service specification process could be achieved.

REFERENCES

Berry, L. L. & Bendapudi, N. (2007): “Health Care – A Fertile Field for Service Research”. *Journal of Service Research*, Vol. 10, No. 2, pp. 111-122

Bitner, M. J. & Faranda, W. T. & Hubbert, A. R. & Zeithaml, V. A. (1997): “Customer Contributions and Roles in Service Delivery”. *International Journal of Service Industry Management*, Vol. 8, No. 3, pp. 193-205

Boonekamp, L. C. M. (1994): “Marketing for Health Care Organizations: An Introduction to Network Management”. *Journal of Management in Medicine*, Vol. 8, No. 5, pp. 11-24

Broderick, A. J. (1998): “Role Theory, Role Management, and Service Performance”. *The Journal of Services Marketing*, Vol. 12, No. 5, pp. 348

Bruhn, M. & Georgi, D. (2006): *Services Marketing – Managing The Service Value Chain*. Harlow, England: Pearson Education Ltd.

Cermak, D. S. P. & File, K. M. & Prince, R. A. (1994): "Customer Participation in Service Specification and Delivery", *Journal of Applied Business Research*, Vol. 10, No. 2, pp.90-98

Chase, R. B. (1978): “Where Does the Customer Fit in a Service Operation?” *Harvard Business Review*, Vol. 56, No. 6, pp. 137-142

de Blok, C. & Luijkx, K. & Meijboom, B. & Schols, J. (2010): “Modular Care and Service Packages for Independently Living Elderly”. *International Journal of Operations & Production Management*, Vol. 30, No. 1, pp. 75-97

de Blok, C. & Meijboom, B. & Luijkx, K. & Schols, J. (2009): “Demand-Based Provision of Housing, Welfare and Care Services to Elderly Clients: From Policy to

Daily Practice Through Operations Management". *Health Care Analysis*, Vol. 17, pp. 68-84

Edgren, L. (2006): "Health Consumer Diversity and its Implications". *Journal of Systems Science and Systems Engineering*, Vol. 15, No. 1, pp. 34-47

Edvardsson, B. & Gustafsson, A. & Roos, I. (2005): "Service Portraits in Service Research: A Critical Review". *International Journal of Service Industry Management*, Vol. 16, No. 1, pp. 107-121

Eisenhardt, K. M. (1989): "Building Theories from Case Study Research". *The Academy of Management Review*, Vol. 14, No. 4, pp. 532-550

Fitzsimmons, J. A. & Fitzsimmons, M. J. (2006): *Service Management – Operations, Strategy, Information Technology*. 5th edition. New York, USA: McGraw-Hill.

Fließ, S. & Kleinaltenkamp, M. (2004): "Blueprinting the Service Company - Managing Service Processes Efficiently". *Journal of Business Research*, Vol. 57, pp. 392-404

Goodwin, C. (1996): "Moving the Drama into the Factory: the Contribution of Metaphors to Services Research". *European Journal of Marketing*, Vol. 30, No. 9, pp. 13-36

Grove, S. J. & Fisk, R. P. & John, J. (2003): "The Future of Services Marketing: Forecasts from Ten Services Experts". *The Journal of Services Marketing*, Vol. 17, No. 2, pp. 107-121

Grönroos, C. (2000): *Service Management and Marketing – A Customer Relationship Management Approach*. 2nd edition. Chichester, England: Wiley & Sons Ltd.

Harris, R. & Harris, K. & Baron, S. (2003): "Theatrical Service Experiences: Dramatic Script Development with Employees". *International Journal of Service Industry Management*, Vol. 14, No. 2, pp. 184-199

Hsieh, A. & Yen, C. & Chin, K. (2004): “Participative Customers as Partial Employees and Service Provider Workload”. *International Journal of Service Industry Management*, Vol. 15, No.2, pp. 187-199

Hult, G. T. M. & Lukas, B. A. (1995): ”Classifying Health Care Offerings to Gain Strategic Insights”. *Journal of Services Marketing”*, Vol. 9, No. 2, pp. 36-48

Johnston, R. & Clark, G. (2005): *Service Operations Management*. 2nd edition. Harlow, England: Prentice Hall

Judd, R. C. (1964): “The Case for Redefining Services”. *Journal of Marketing*, Vol. 28, pp. 58-59

Kay, M. J. (2007): “Healthcare Marketing: What is Salient?” *International Journal of Pharmaceutical and Healthcare Marketing*, Vol. 1, No. 3, pp. 247-263

Kelley, S. W. & Donnelly, J. H. & Skinner, S. J. (1990): “Customer Participation in Service Production and Delivery”. *Journal of Retailing*, Vol. 66, No. 3, pp. 315-335

Lillrank, P. & Venesmaa, J. (2010): *Terveydenhuollon alueellinen palvelujärjestelmä*. Helsinki: Talentum.

Longtin, Y. & Sax, H. & Leape, L. L. & Sheridan, S. E. & Donaldson, L. & Pittet, D. (2010): “Patient Participation: Current Knowledge and Applicability to Patient Safety”. *Mayo Clinic Proceedings*, Vol. 85, No. 1, pp. 53-62

Lovelock, C. H. (1996): *Services Marketing*. 3rd edition. Saddle River, USA: Prentice Hall

Lovelock, C. H. & Gummesson, E. (2004): “Whither Services Marketing? In Search of a New Paradigm and Fresh Perspectives”. *Journal of Service Research*, Vol. 7, No. 1, pp. 20-41

Lovelock, C. H. & Wirtz, J. & Chew, P. (2009): *Essentials of Services Marketing*. Singapore: Prentice Hall

Lovelock C. H. & Young, R. F. (1979): “Look to Consumers to Increase Productivity”. *Harvard Business Review*, Vol. 57, No. 3, pp. 168-178

Mills, P. K. & Chase, R. B. & Margulies, N. (1983): “Motivating the Client/Employee System as a Service Production Strategy”. *Academy of Management Review*, Vol. 8, No. 2, pp. 301-310

Myllykangas, 2006. Hoidon tarve lääketieteessä. ETENE:n 7. Kesäseminaari, Tarve terveydenhuollossa – kuka tai mikä määrittää? Helsinki. [Pdf-document] [Referred on 12.4.2010] Available in
http://www.etene.org/dokumentit/STM%20Etene%2007%2018%20sisus.pdf

Pitta, D. A. & Laric, M. V. (2004): ”Value Chains in Health Care”. *Journal of Consumer Marketing*, Vol. 21, No. 7, pp. 451-464

Rijckmans, M. J. N. & Bongers, I. M. B. & Garretsen, H. F. L. & Van de Goor, I. A. M. (2007): “A Client’s Perspective on Demand-Oriented and Demand-Driven Health Care”. *International Journal of Social Psychiatry*, Vol. 53, No. 1, pp. 48-62

Solomon, M. R. & Surprenant, C. & Czepiel, J. A. & Gutman, E. G. (1985): “A Role Theory Perspective on Dyadic Interactions: The Service Encounter”. *Journal of Marketing*, Vol. 49, No. 1, pp. 99-111

Stakes (2006): *Hyvinvointivaltion rajat. Hoivan ja hoidon taloudellinen kestävyys – Arvioita sosiaali- ja terveyspalveluiden kustannusten kehityksestä*. Stakes, Helsinki

Statistics Finland (2009): *Population Projection 2009-2060*.

Svensson, G. (2006): “New Aspects of Research into Service Encounters and Service Quality”. *International Journal of Service Industry Management*, Vol. 17, No. 3, pp. 245-257

Swan, J. E. & Bowers, M. R. & Grover, R. (2002): “Customer Involvement in the Selection of Service Specifications”. *The Journal of Services Marketing*, Vol. 16, No. 1, pp. 88-103

Van Raaij, W. F. & Pruyn, A. T. H. (1998): ”Customer Control and Evaluation of Service Validity and Reliability”. *Psychology & Marketing*, Vol. 15, No. 8, pp. 811-832

Vargo S. L. & Lusch R. F. (2004): “The Four Service Marketing Myths – Remnants of a Goods-Based, Manufacturing Model”. *Journal of Service Research*, Vol. 6, No. 4, pp. 324-335

Willcocks, S. (2008): “Clinical Leadership in UK Health Care: Exploring a Marketing Perspective”. *Leadership in Health Services*, Vol. 21, No. 3, pp. 158-167

Williams, J. A. & Anderson, H. H. (2005): “Engaging Customers in Service Creation: A Theater Perspective”. *The Journal of Services Marketing*, Vol. 19, No. 1, pp. 13-23

Yin, R. K. (1994): *Case Study Research – Design and Methods*. 2nd edition. Thousand Oaks, USA: Sage Publications, Inc.

Appendix 1

Interview themes

The themes discussed in the interviews with head nurses of case home cares were:

- Background information on the interviewee and the case home care
- Initiation of service specification
- Service specification process
- Customer participation in the service specification process
- Challenges affecting service specification