Lappeenranta University of Technology
Faculty of Technology Management
Department of Industrial Management

Master's Thesis

Private Home Care in Municipal Service Systems

– A Case Study among

Finnish and Swedish Municipalities

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ABSTRACT

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The aim of this study is to assess the current and future preconditions for conducting private business in municipal service systems for home care in Lahti and Hyvinkää in Finland, and in Uppsala and Huddinge in Sweden. This study also aims to assess the implications of quality-related issues on the preconditions for conducting private business in the service systems in question.

The theories and the research methodologies of the study are based on the Business Model Generation and the Business Model Canvas -concepts. Also a couple of frameworks on implications of quality are applied and integrated into the study. The study is completed as a case study – with structured and identical approaches for all four municipalities. The analyses and assessments of the study are primarily qualitative, but supported by simple quantitative methodologies. The data of the study consists primarily of publicly available information, and secondarily of answers provided by the case-municipalities to multiple choice questions.

The results of the study show that the service systems for home care among the case-municipalities are, from perspective of private companies, diverse with local characteristics. Both the premises for conducting private business and the quality-issues are in many respects different in the Finnish and the Swedish case-municipalities. This is partly due to differences in the national service systems; the service voucher system versus the system of choice. Still, it appears that the current preconditions for conducting private business in the service systems for home care, including the implications of quality, would be more favorable in Uppsala and Huddinge than in Lahti and Hyvinkää. On the other hand, the service systems are subject to changes, and the most positive and significant development is here forecasted for a Finnish case-municipality (Lahti). Communication of quality is clearly more advanced in the Swedish case-municipalities.

The results of this study can be utilized in several ways, for instance by private companies interested in entering into service systems for home care, either in some of the case-municipalities, or in some other Finnish or Swedish municipalities. Also municipalities can apply the analyses of the study when designing, developing or evaluating their own service systems for home care.

TIIVISTELMÄ

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Tämän työn tavoite on arvioida nykyisiä ja tulevia edellytyksiä harjoittaa yksityistä liiketoimintaa kunnallisissa kotihoidon palvelujärjestelmissä Lahdessa ja Hyvinkäällä Suomessa, sekä Uppsalassa ja Huddingessa Ruotsissa. Lisäksi tämän työn tavoite on arvioida laatuasioiden vaikutuksia edellytyksiin harjoittaa yksityistä liiketoimintaa kyseisissä palvelujärjestelmissä.

Työn teoriat ja tutkimusmenetelmät perustuvat Business Model Generation ja Business Model Canvas -konsepteihin. Myös joitain muita viitekehyksiä laadun vaikutuksista sovelletaan ja yhdistetään työhön. Tutkimus toteutetaan tapaustutkimuksena – jäsennellyin ja yhtäläisin lähestymistavoin kaikille neljälle kunnalle. Tutkimuksen analyysit ja arviot ovat ensisijaisesti laadullisia, mutta yksinkertaisten määrällisten menetelmien tukemia. Tutkimuksen aineisto koostuu ensisijaisesti julkisesti saatavista tiedoista, ja toissijaisesti kohdekuntien toimittamista vastauksista monivalintakysymyksiin.

Tutkimusten tulokset osoittavat, että kohdekuntien kotihoidon palvelujärjestelmät ovat yksityisten yritysten näkökulmasta moninaisia ja paikallisilla piirteitä omaavia. Sekä edellytykset yksityisen liiketoiminnan harjoittamiselle että laatuasiat ovat monessa suhteessa erilaisia suomalaisissa ja ruotsalaisissa kohdekunnissa. Tämä johtuu osittain eroavaisuuksista kansallisissa palvelujärjestelmissä; palvelusetelijärjestelmä vasten vapaavalintajärjestelmä. Vaikuttaa kuitenkin siltä, että nykyiset edellytykset yksityisen liiketoiminnan harjoittamiselle kotihoidon palvelujärjestelmissä, laadun vaikutukset mukaan lukien, olisivat suotuisampia Uppsalassa ja Huddingessa kuin Lahdessa ja Hyvinkäällä. Toisaalta, palvelujärjestelmät ovat muutosten kohteina, ja myönteisin sekä voimakkain kehitys on tässä ennustettu suomalaiselle kohdekunnalle (Lahti). Laadun viestiminen on selvästi kehittyneempää ruotsalaisissa kohdekunnissa.

Tämän työn tuloksia voi hyödyntää monella tavalla, esimerkiksi yksityiset yritykset joilla on kiinnostusta liittyä kunnallisiin kotihoidon palvelujärjestelmiin, joko kohdekunnissa tai joissakin muissa suomalaisissa tai ruotsalaisissa kunnissa. Myös kunnat voivat soveltaa työn analyyseja kun ne suunnittelevat, kehittävät tai arvioivat omia kotihoidon palvelujärjestelmiään.

FOREWORD

This study has involved several parties and persons, and their participation in the process has enabled the implementation of the demanding research project. I am grateful to all of you who have put time and efforts into the study, and I hope that this joint investment will yield value in the form of new perspectives on arranging, producing and providing home care. Increasing the diversity while ensuring the qualification and the conformance is a view shared by all parties in the service systems for home care – the municipalities, the external service producers and the service users themselves. The apparent but simultaneously difficult task is to reach a balance that enables a fair distribution of value and benefits among the different parties in the service systems. May this study contribute to the ongoing development of home care services and operations.

I want to thank my instructor – Professor Jouni Koivuniemi at the Department of Industrial Management – not only for his valuable support, but also for his patience throughout the course of this independent research project. The various advices helped to structure the scope and contents of the study, as well as to finalize the project. I also want to thank the Lappeenranta University of Technology Research Foundation and the Niilo Helander Foundation for supporting the study with grants.

Of all the municipal representatives that participated in the study, a couple of key persons should be mentioned here. I am very thankful to Thomaz Ohlsson (City of Uppsala) and to Paula Hevosmaa (City of Hyvinkää) for their active involvement throughout the project, and also to Pia Peltomaa (City Lahti) and to the involved officers of Huddinge Municipality for their positive stance towards participating in the study.

Additionally I want to thank all those representatives of municipalities, ministries, authorities, associations, interest groups and companies in Finland and Sweden, who have contributed to the study either directly or indirectly by submitting their views on home care. And finally I want to thank my family and friends for supporting me during my academic journey.

"Bona valetudo melior est quam maximae divitiae"

- Latin expression

Espoo, July 10th, 2012

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Kim Sandlund

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

1 INTRODUCTION

1.1 Background of the Study

The demand for wellbeing services of various kinds has increased steadily over several years in Finland and Sweden and in Western countries overall. *Home care services* – i.e. services delivered to, at or near the homes of individuals – are one type of wellbeing services that are affected by the positive trend. The demand for home care services has been reinforced by structural changes in society and economy, in particular by the aging of the population and by the aims to lower the share of institutional services within publicly arranged healthcare and social services. Also improvements of treatment practices and the evolvement of health-related technologies have enabled a better and quicker demobilization of individuals from health- and care institutions to their homes. (Ministry of Employment and the Economy 2010 c, p. 38)

Limited resources of municipalities to correspond to the growing demand have made room for companies as producers of home care services. Also the rise of income levels among citizens and the possibilities to make tax deductions from acquired home care services have created business opportunities for existing and new companies on the Finnish market. (Ministry of Employment and the Economy 2010 c, p. 38). The production of statutory social services is, despite the positive development, still mostly dominated by the public sector. In Finland this is the case especially for certain service segments such as home care, where the public sector's share of the total production is around 80-90%. (Ministry of Employment and the Economy 2009, p. 140-141). In Sweden the situation and production shares held by the public sector within care-related social services are similar (Statistiska centralbyrån 2009 a, p. 17-20). But for the service segment home care the situation is somewhat different – by 2011 the private sectors' share of provided services had already risen to 20% among elderly persons, and to 25% among disabled persons (Socialstyrelsen 2012 a, p. 5-6). The trend is nonetheless clear, the growth rates of the private companies are notable and their market share is gradually increasing both in Finland and Sweden.

The privatizations of healthcare and social services have traditionally been conducted through tender processes, with service contracts being made between the public sector entity, e.g. a municipality, and the winning private producer(s) of the process. In these cases the citizens as service users have not been able to participate in choosing the service provider(s) for themselves. However, new types of *service systems* have been taken into use in Finland and Sweden as to improve the position of the individuals receiving and using the services. This development has been enabled by new legislation and supported by guidance, initiatives and allowances from ministries and national authorities (Socialstyrelsen 2011 a, p. 20-21). The basic idea is that the municipality or other public sector entity creates the rules and requirements for the service system, and that all service producers fulfilling the requirements are allowed to enter into it. The desired outcome is that individuals would be able to choose their service provider(s) among a sufficiently large amount of alternative operators. In optimal situations these service systems, which are based on *customer choice*, lead to higher amounts of service producers and thereby to open competition – for the benefit of both service users and service producers. Nevertheless, the features and functionalities of the service systems are to certain extent different in Finland and Sweden. In Finland these service systems are named *service voucher systems*, whereas they in Sweden are referred to as *systems of choice*. Service voucher systems and systems of choice have been established particularly for statutory home care services by municipalities.

The growth of privately produced home care in Finland has in recent years also been stimulated by the utilization of service vouchers, which have enabled a customer-oriented development of the privatized markets. The service vouchers have allowed citizens to choose their own service producers among private companies and on equal terms. There are several municipal initiatives across the country for acquiring wellbeing services from private companies with service vouchers, but so far the volumes have been low. (Ministry of Employment and the Economy 2011, p. 17). In Sweden the systems of choice have become increasingly popular. In 2010 systems of choice were applied to primary healthcare in all 20 county councils, and nearly 100,000 inhabitants were part of municipal systems of choice for different social services. In October 2010 a total of 153 (out of 290) municipalities had decided to implement systems of choice, and 68 of these had already taken systems of choice into use. In 2010 most municipalities and county councils were still in a starting- or

establishing phase with the systems of choice. (Socialstyrelsen 2011 a, p. 20-22). A large part of the service systems are concentrated to larger cities with solid population bases and attractive business environments with multiple companies.

The group of private companies producing wellbeing services such as home care is heterogeneous in both Finland and Sweden. The vast majority of the companies are micro-firms with only few employees. On the other hand there are a handful of large companies that possess significant shares of the private markets and their different service segments. (Ministry of Employment and the Economy 2009, p. 143-144; Tillväxtverket 2010 a, p. 7). The largest companies are often hybrids in the sense that they offer a variety of both healthcare and care-related social services (Ambea 2010, p. 7). Despite the polarized character of the private markets for wellbeing services, the amount of companies has increased notably in both countries and over many years due to active establishment of new businesses (Ministry of Employment and the Economy 2009, p. 131-142; Tillväxtverket 2010 b, p. 1-2). This together with the prevailing market growth indicates that the private sector and the companies therein are dynamic, and they adapt to the rapidly evolving conditions.

Going forward the demand for privately produced healthcare and social services is expected to grow further. This trend requires a more intense cooperation between the public sector and the private sector. (Ministry of Employment and the Economy 2009, p. 129). The need for cooperation is evident. Public entities have to take the private company perspective into account when ordering private services, as to attract desired types or/and sufficient amounts of service producers. Private companies, in turn, need to understand the terms and conditions and the overall preconditions for providing services as prescribed by the public entities. Each healthcare service or social service arranged and ordered by a public sector entity is unique, whereby private companies need to assess each business opportunity separately. In optimal situations all parties benefit from a privately produced service – the public sector entities, the private companies and the service users themselves. In sub-optimal situations one or several of the parties suffer from the private arrangement – ultimately the service users – whereby these will likely not hold in the long run. Sound terms and conditions combined with a healthy operating environment is the optimal and sustainable outcome for wellbeing services arranged through private companies – for all parties.

The increasing popularity of service systems for home care based on customer choice – service voucher systems in Finland and systems of choice in Sweden – offer business potential for private companies interested in expanding their operations. Given that the tender processes are replaced with specific qualification requirements for the service systems, the decisions about operating in the predefined service markets (Yes/No) are eventually made by the private companies themselves. And as all service systems are unique, the private companies need to make these Yes/No -decisions separately each time. A good Yes -decision by a private company incurs revenues and profits, while a good No -decision saves unnecessary costs. A bad Yes -decision incurs unnecessary cost, while a bad No -decision means lost revenues and profits for a private company. A reliable and simultaneously structured assessment to support the decision-making process of private home care companies regarding public service systems would thus be useful and valuable.

In parallel with creating a structured assessment for municipal service systems for home care from a private company perspective, it would be interesting to gain a thorough understanding of some existing service systems in Finland and Sweden. More precisely, it would be interesting to assess what the preconditions are for conducting private business in these service systems. In addition it would be interesting to comprehend how the requirements of the service systems link to quality, and what the implications of these quality-issues are for operators therein. And given that the service systems in both countries are fairly new and still evolving, it would also be good to know into what directions the service systems will develop in the future.

Based on the above, it seems justified to focus on more established municipal service systems for home care services. There are many differences in how established the municipal service systems are in terms of privatization levels, customer amounts, operator amounts etc. One simple measure is the size of the municipality. Restricting to mid-sized and large municipalities in terms of population appears rational, as they by definition have a larger customer base and supply of producers compared to small municipalities. *Lahti* (*Lahtis* in Swedish) and *Hyvinkää* (*Hyvinge* in Swedish) are two municipalities in Southern Finland that can be regarded as mid-sized or large, both of which have service voucher systems for home care services in use. *Uppsala* and *Huddinge* in turn are two large or mid-sized municipalities

in the Mälaren Valley (Mälardalen in Swedish) in Sweden, and both of them have established systems of choice for either home care services or for home help services.

1.2 Research Questions and Objectives of the Study

The first and primary *aim* of this study is to *(1) assess the current preconditions for conducting private business in municipal service systems for home care in Finland and in Sweden*. More precisely, this study aims to assess the situations separately for the municipalities Lahti and Hyvinkää in Finland, and for the municipalities Uppsala and Huddinge in Sweden. Secondly, this study also aims to *(2) identify and assess the implications of quality-related issues* on the preconditions for conducting private business in the service systems in question. Thirdly and finally, this study aims to *(3) clarify the future development (future situation)* of the service systems in question, regarding both preconditions for conducting private business and implications of quality-related issues.

The aforementioned three aims simultaneously form the research questions of this study. Moreover, because of the descriptive and exploratory type of research, this study does *not* present any *hypotheses* (Hirsjärvi & Remes & Sajavaara 1997, p. 157).

The *assessments* of this study should *as such* form a structured approach for analyzing preconditions for conducting private business in municipal service systems for home care services in Finland and Sweden. The assessments should thus constitute universal tools that can be applied or adapted more widely for aforementioned purposes in Finland and Sweden.

The *results* of this study should disclose what the current preconditions are for conducting private business in the municipal service systems for home care services in Lahti, Hyvinkää, Uppsala and Huddinge – currently and in the future. The results should in other words contain relevant findings and accurate conclusions from perspective of private companies seeking incremental business opportunities. The results should further give an overview of what the implications of quality-related issues in practice are on the preconditions for conducting private business in the four municipal service systems. The results should thereby also contain

relevant findings and accurate conclusions on quality as such, and again from perspective of private companies.

The combined results of this study should help primarily private home care companies with managing their operations and developing their businesses. This study and its results thereby comprise both operational and strategic perspectives. The combined results might help other parties as well, such as municipalities in the development of their own service systems for home care or similar types of services. Municipalities might be able to improve their cooperation with private companies. Even service companies in other sectors, where municipal service systems prevail, might utilize or adapt parts of this study.

This study is made as an independent research project, where the subject, the aims and the investigations are originated and managed by the author himself. No companies or municipalities have influenced the course of the study. The Department of Industrial Management at Lappeenranta University of Technology has provided background support in the form of perspectives and advises related to the subject, as the department itself is conducting various research projects in the healthcare sector. The Lappeenranta University of Technology Research Foundation and the Niilo Helander Foundation have provided grants for the study.

1.3 Restrictions of the Study

As already mentioned, this study encompasses four separate municipalities, Lahti and Hyvinkää in Finland and Uppsala and Huddinge in Sweden. Two municipalities from each country are enough as to compare the outcomes both inside the countries and between the countries. The municipalities participating in the study also reflect a restriction with respect to the size of the population. The populations of the four municipalities range between approximately 45,000 and 200,000, which implies that this study concentrates on mid-sized and large municipalities and excludes small municipalities. Another feature of the four municipalities in this study is that they are all forerunners in customer-based service systems for home care services. Their service systems are well-established in their own countries in terms of either *size* (privatization level) or *time* (operational years).

This study is restricted to those municipal service systems for home care that are based on *customer choice*, i.e. where the individuals themselves choose their service producers among qualified ones. This study does thereby exclude conventional service arrangements, where e.g. municipalities acquire services through *tender processes* and only from a limited amount of service producers. This study also excludes the *private market* for home care, where individuals voluntarily acquire non-statutory home care services directly from private service producers, and at their own expense.

This study is further restricted to cover only home care services. It thereby excludes other healthcare and social services arranged (ordered and financed) by municipalities or other public sector entities. As the definition of home care services is not entirely uniform, they do in this study imply services that relate to i) healthcare, ii) personal care and iii) domestic care – and where the services are a) delivered home, b) provided at home or c) provided near the home. Property management services and pure passenger transportation services are not included in this study. However, this study does to some extent bring out other healthcare and social services related to home care. This is because of the strong interconnection between home care services and other services, whereby home care in certain cases needs to be reviewed in a broader context.

The time perspective of this study stretches from autumn 2011 until approximately 2014-2016. The underlying data and the assessments concerning the *current situations* of the municipal service systems relate to the situations in autumn 2011. The terms and conditions of the four service systems in the study are mostly valid for full calendar years, so the current situation analyses do in principle apply to year 2011 as a whole. The underlying data and the assessments concerning the *future situations* of the municipal service systems have been collected and made in April-May 2012, and their outcomes refer to the next 2-4 years (from 2012 until 2014-2016).

1.4 Implementation of the Study and Research Methodology

The implementation of this study – i.e. the answering of the research questions through analyses and assessments listed earlier in this chapter – is based on the following *general guidelines*;

- Completing the study as a *case study*, where the analyses and assessments are made *separately* and *independently* for each municipality.
- Striving for a *structured approach*, where the analyses and assessments are *identical* for all municipalities.
- Applying *suitable theoretical frameworks* for performing the analyses and assessments.
- The analyses and assessments of the study are *qualitative*. The quantitative methodologies being applied are of supportive character and their results are primarily indicative.
- The data utilized in the study consists primarily of *publicly available information* and material, and secondarily of data provided by the municipalities.

1.4.1 Applied Theories and Methodologies

A main feature of this study is that it is conducted entirely as a *case study*. A case study can be defined as *"an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident"* (Yin 2003, p. 13). Case studies are suitable in research i) that aims to answer the questions "how" or "why", ii) where the focus is on contemporary events, and iii) where the investigator has little or no control over the events (Yin 2003, p. 5-9). This is largely the situation in this study. Also, this study corresponds well with the typical characteristics of case studies; a small group of similar research objects, diverse and detailed information, focus on larger communities, focus on processes, accounting for the environment, and description of phenomena (Hirsjärvi et al. 1997, p. 130). Case study methodologies aim for reflecting the empirical results not only on the main theoretical framework(s) of the study, but also on other

available frameworks (Yin 2003, p. 31-33). Here and in this context the case study approach implies *separate* and *independent* approaches for each of the four municipalities involved, and also assessment of the results from a somewhat wider theoretical perspective. Furthermore, the case study approach also means *structured procedures* accomplished through *identical* analyses and assessments for all four municipalities.

The main theoretical framework for this study is formed by the *Business Model Canvas* - concept ("*Canvas*") and a couple of other concepts derived thereof. The Business Model Canvas is an elementary framework for structuring, assessing and designing business models among companies. The framework is presented in Business Model Generation, a guidebook on business models by A. Osterwalder and Y. Pigneur. (Osterwalder & Pigneur 2010). The other theoretical frameworks relate to quality – to benefits and costs of quality to be more precise. Although the literature on quality is diverse, a couple of applicable theoretical views can be mentioned here. Two separate frameworks for the *benefits of quality* are utilized, where the benefits refer to impacts on revenues and profits. One is presented by R. Rust, A. Zahorik and T. Keiningham (1994), and another by J. L. Heskett, T. O. Jones, G. W. Loweman, J. W. E. Sasser, and L. A. Schlesinger (2008). Also the *costs of quality* are included into the theory of the study, and the relevant frameworks are primarily those outlined by W. E. Deming (1982) and those based on Six Sigma by M. Harry and R. Schroeder (1999).

The aforementioned theories have a direct and strong impact on the research methodologies applied in this study. All analyses and assessments in the study utilize the Business Model Canvas and the nine components therein (*Value Propositions, Customer Segments, Customer Relationships, Channels, Revenue Streams, Key Resources, Key Activities, Key Partners and Cost Structure*). The various issues of the municipal service systems for home care services, which are identified in the research data, are being allocated among the different components of the Canvas. The issues are then assessed in writing and/or with scoring points. Scoring points are given in all separate analyses and for all municipal service systems. Combined scoring points are then received for the separate analyses, and these allow for comparison of outcomes between municipalities. The issues identified in the research data and the written and/or numerical (scoring points) assessments related thereto are all made from the perspective of private companies.

It should be noted that the analyses on the *current situation* of the municipal service systems – preconditions for conducting private business, and implications of quality-related issues – are based on two key things; i) publicly available information and material, and on ii) subjective assessments by the author of the study. On the other hand, the analyses on the *future situation* of the municipal service systems – preconditions for conducting private business, and implications of quality-related issues – are based on; i) answers provided by municipal representatives to multiple choice questions, and thus also on ii) subjective assessments (by the municipal representatives).

This case study is by nature very qualitative, where the written assessments and discussions form the essence. The quantitative analyses in the study are important for the wholeness, but they are nonetheless more indicative than definitive. The scoring points and especially the combined numerical outcomes are not very informative *as such*, but they are more useful for *comparing* the situations between municipalities. Also, the fact that all numerical assessments are subjective affects the overall reliability of the quantitative analyses. The numerical assessments and combinations of scoring points are still useful, as they enable structured approaches to the different analyses. Apart from calculating average values and sums for different scoring points, no statistical methods have been applied in the study.

The results of this study are presented separately for all four municipalities, but also on an aggregated level for comparison purposes. The conclusions on the results are likewise discussed on municipal levels, and to some extent also on country levels and on an aggregated level. However, certain differences between municipalities and between Finland and Sweden affect the comparability of the service systems.

1.4.2 Applied Data

The data applied in this study can be divided into two categories, as the separate analyses utilize different sources of data. The analyses of the current situation of the municipal service systems are primarily based on publicly available information and material. This data category consists much of municipal documents on the service systems that act as instructions for potential service producers. Other municipal information and contents of municipal web-

pages belong to this data category too, together with other external information relating to the municipalities and their service systems. Also regulations, recommendations, market reports, public statistics and survey data issued by public authorities and interest groups are publicly available information that is used in the analyses on the current situation. A limited amount of complementary information has been requested and provided by the municipalities, as to achieve uniform analyses. Based on the above it can be said that the data for the analyses on the current situation is mostly qualitative and of diverse content.

The analyses on the future situation of the municipal service systems are based on multiple choice questions regarding the service systems, and on answers related thereto. Municipal representatives with key responsibilities for home care services and/or for the associated service systems have been contacted and supplied with questionnaires. All four municipalities have received and provided answers to identical questionnaires – or more precisely to Finnish and Swedish translations of an original English version. The questionnaires contain 18 multiple choice questions, which relate to preconditions for conducting private business and to implications of quality-related issues – in the future. The answers to the multiple choice questions have been given as scoring points, and these points constitute the data for this second category of analyses. The data is thereby qualitative also for these analyses, although here it is more structured by content. The municipal representatives have formed their answers either individually or collectively, and the answers are rather subjective estimations than official statements. It should also be noted that no complementary interviews have been made with the municipal representatives concerning the answers to the multiple choice questions.

1.5 Structure of the Study and the Report

The study and also the report are divided into two parts, into a *theory part* and an *empirical part*. If overlooking this Introduction- chapter, then the theory part starts by providing an overview of home care in the chapter Home Care Services and Operations (Chapter 2). Here home care is described as a service, it is defined officially for Finland and Sweden, related to other wellbeing services, divided into different service/market systems, reviewed by customer segments, assessed by its characteristics and reflected against process and design aspects. The

next chapter, Home Care in Finland (Chapter 3), aims to give an overview of the national market for home care. It contains a presentation of healthcare and social services as sectors and markets, and links down to home nursing and home help services, discusses the position of service end users, and briefly mentions some aspects on legislation. The following chapter, Home Care in Sweden (Chapter 4), is intended to be equivalent to that for Finland. Thereafter comes Applicable Theories (Chapter 5), starting with business models frameworks and the Business Model Canvas, then moving on to the themes productivity, efficiency, quality and innovations – where after linking to the concept of quality.

The empirical part of the study and the report starts with the chapter Home Care Service Systems of the Case-Municipalities (Chapter 6). This descriptive chapter provides relevant information on the separate service systems. It starts with a brief municipal description, after which it presents the service system(s), the service producers as well as other related wellbeing services, before ending with a review on quality issues. The aforementioned matters are dealt with all four municipalities. The next chapter, Assessment of the Private Home Care (Chapter 7), contains the analyses and assessments of the service systems, again separately for all municipalities. For each municipality the analyses and assessments are split into sub-parts, in line with the categorization of the research methodology described earlier in this Introduction -chapter. Then comes chapter Combined Results (Chapter 8), which compiles the aggregated results of the separate analyses for all four municipalities. After this follows chapter Conclusions (Chapter 9). Here the results of the study are assessed and discussed on municipal levels and on aggregated levels, as well as reflected against the theoretical frameworks. This chapter is concluded with discussions on the utilization of the results and on recommended future research. The report ends with Summary (Chapter 10), which wraps up the entire study and lists the main results and conclusions. The main report is followed by Appendices, which contain a significant share of all data utilized in the study.

2 HOME CARE SERVICES AND OPERATIONS

2.1 Service Definition

The Ministry of Social Affairs and Health in Finland outlines home care as a service category consisting of three separate service types; i) home nursing, ii) home help services and iii) support services (Sosiaali- ja terveysministeriö 2011). Swedish authorities refer to home care as the combined medical, rehabilitative and social efforts, which are performed at a person's home or place of living (Statens offentliga utredningar 2004, p. 332). The next sections aim to present and describe the service components of home care more thoroughly.

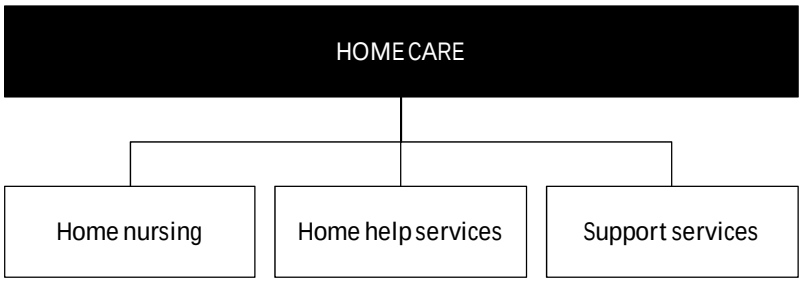

Figure 1: Categorization of home care by the Ministry of Social Affairs and Health in Finland (Sosiaali- ja terveysministeriö 2011)

2.1.1 Home Nursing

In Finland home nursing is vaguely defined. One official definition states that home nursing comprehends the performance of medical efforts that are prescribed by a doctor, such as taking samples, supervising the medication and following the condition of a patient – at a patient's home. Even specialized healthcare, such as terminal care, can be arranged at home. Supporting of close relatives is also part of home nursing. Adequate home nursing precedes an assessment of a patient's ability to function and contributes to the rehabilitation of that patient. Home nursing is conducted by specialized teams consisting of nurses at different levels, mainly of public health nurses, specialized nurses, nurses, practical nurses and of care assistants. (Sosiaali- ja terveysministeriö 2011)

Home nursing is not very uniformly or clearly defined in Sweden either. One reason is that the legislation lacks a specification of what home nursing is, what it should comprehend and

how it differs from other forms of treatment. Another reason is that authorities and other market participants have a tendency to outline home nursing from their own perspectives, resulting in plural and partly overlapping definitions. (Socialstyrelsen 2008, p. 15-16)

According to a generally accepted service definition in Sweden, home nursing comprises i) *medical efforts,* ii) *rehabilitation,* iii) *habilitation* and iv) *care* conducted by legitimate healthcare professionals or by other care personnel in patients' homes. This service definition is restricted to long-term efforts within healthcare and social services, while temporary efforts lacking predefined care- and treatment plans are excluded. In some instances the service definition also allows for efforts conducted in special housing and in centers for day activities. In this context rehabilitation refers to temporary medical, mental, social or technical efforts aimed at retrieving or maintaining persons' functionality, while simultaneously allowing for an independent living and an active social life. Habilitation in turn refers to such efforts for permanently disabled persons, which aim to develop or maintain the functionality from their own positions and needs, while simultaneously allowing for an independent living and an active social life. Habilitation efforts can be of employment-oriented, medical, mental, social or technical nature. Care refers to promoting health, preventing illness and bad health, retrieving and maintaining health, reducing suffering and giving a possibility for a dignified death. Care within healthcare denotes support and help for a shorter or longer period of time for such persons, who due to their health conditions are not capable of planning or performing activities relating to their daily life. (Socialstyrelsen 2008, p. 14-15)

Home nursing can be divided into subgroups in different ways. Home nursing is in Sweden commonly split by treatment forms into home nursing within *primary healthcare, specialized somatic healthcare* and within *specialized psychiatric healthcare.* Home nursing can also be split by the party being responsible for the services. The majority of home nursing is managed or controlled by the county councils, but there are many areas where the responsibility has been shifted partly or entirely to the local authorities ("local authority" and "municipality" are used as parallel terms in this study). In addition, it is worth noting the difference between home nursing and *home visits*. Home visits differ from home nursing in the sense that the services are temporary and unexpected of nature, such as treatment of an acute illness in a

patient's home. Home visits are e.g. not recorded in the statistics for home nursing. (Socialstyrelsen 2008, p. 30)

The practical provision of home nursing services is carried out by medical doctors and geriatricians, registered nurses, district nurses, specialized nurses, registered physiotherapists, occupational therapists, assistant nurses and care assistants. (Socialstyrelsen 2008, p. 30). It is evident that there is a wide range in medical complexity and type of activities being performed by the different home nursing professionals. Assistant nurses and care assistants on one hand perform the most basic healthcare tasks, while medical doctors are required for more demanding treatment procedures.

2.1.2 Home Help Services

Finnish authorities make, as previously mentioned, a distinction between home help services and *support services*. Home help services refer to personal help and assistance in daily routines and personal duties, and these are provided to persons with illnesses or weakened functionality. Home help includes the monitoring of clients' health and the provision of advises related to available services. Also patrols for nights are becoming more common home help services offered. Home help services are performed by homemakers, home assistants and practical nurses. The support services are seen as complementary services for the home help services, and they are less emphasized on health issues. The support services are meal service, cleaning, laundry, shopping and other running errands, transportation and accompanying (escorting), bathing and steam bathing, security services and services promoting social interaction. The support services are usually those which are being offered to customers at first, i.e. before the home help services. (Sosiaali- ja terveysministeriö 2011)

In Sweden home help services means providing people help in their own homes so, that they can continue living at home independently. Home help consists of two types of services; i) care and ii) services. Care means *personal efforts* needed to satisfy physical, psychological and social needs. In practice care means providing assistance or help with eating and drinking, bathing/showering, clothing, taking medicines, moving in or outside the house, rehabilitation/training or with socialization by providing companionship. Care also includes

the provision of personal security at home through alarm devices or patrols for evenings and nights. Services, on the other hand, mean *domestic efforts*. These are providing assistance or help with cooking/meal service, cleaning, doing laundry, shopping, running errands at the post office or bank, or with maintaining the apartment/house. (Socialstyrelsen 2007, p. 2; Socialstyrelsen 2011, web-pages)

2.2 Home Care in Relation to Other Service Forms

To gain a more thorough understanding of home care, it needs to be viewed in a broader context. Home care is one service form for providing wellbeing services to individuals being the end users. In addition to home care there are other alternatives fulfilling the same purpose. When assessing healthcare and social services for the elderly, possible alternatives for home care are typically *outpatient care, specialized housing (housing services), inpatient care (institutional care)* as well as *informal care* (Sosiaali- ja terveysministeriö 2011). Outpatient care is the service chosen method whenever possible, i.e. when a person is capable of attending health centers and social service centers himself or herself. Informal care is the closest substitute to home care, as the services are largely the same but performed by a relative or friend of the end user. Specialized housing is commonly the service method when home care is not possible, due to insufficient or decreased health condition of the end user. Inpatient care is the service method when specialized housing is not sufficient for the end user, typically in connection with a medical treatment or serious illness.

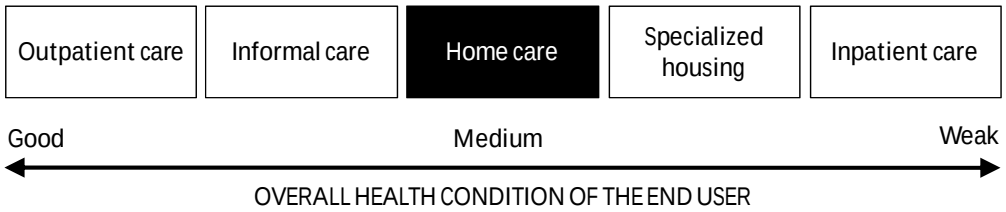

Figure 2: Home care and alternative service forms in relation to the overall health condition of the end user

2.3 Service Systems and Market Segments

Historically nearly all publicly arranged – also referred to as statutory – healthcare and social services including home care services were produced by the public sector itself (A in figure below). The deregulation of the markets has created increasing business opportunities for private companies to act as producers of these publicly arranged services. In these cases the responsibility for ordering and financing the privatized services still remains on the public sector, mainly on local authorities, healthcare districts and county councils. But here there are two possibilities for which party makes the ultimate selection of the service producer. It can either be the public entity ordering and financing the service (B in figure below), or alternatively the service end users (consumers) themselves (C in figure below). Both service systems B and C represent privatized markets of publicly arranged healthcare and social services. In addition there is a fourth service system enabled by the private market for voluntary healthcare and social services (D in figure below). Here consumers acquire services from private companies directly, at their own expense and without any influence from the public sector.

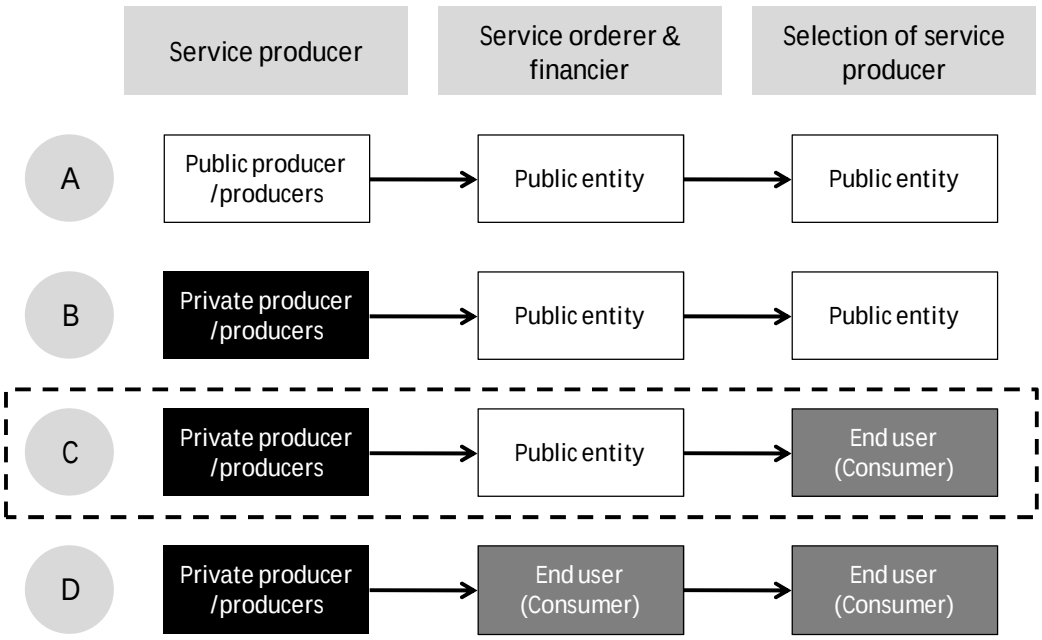

Figure 3: Alternative service systems and market segments for healthcare and social services

The rationale presented in the figure above applies to the home care services as well. The service system C and the market segment related thereto is the relevant one from perspective of this study, as the underlying material and analyses are focused on this alternative.

2.4 Service End Users

Home care can in principle be provided to everyone needing help and assistance at home. The private market for home care is operated by private companies providing home care services to all end users who have service needs and are ready to pay for them. On the other hand there is the statutory market for home care – home care services arranged (ordered and financed) by the public sector – where both the services and the end users (customers) are specified through regulations and legislation. The ministries of social affairs and health in Finland and Sweden have defined different end user segments for which services are offered. In Sweden the ministry has pointed out elderly persons and disabled persons as end user segments for home care (Socialstyrelsen 2011, web-pages). In Finland the segmentation is similar, but in addition to elderly persons and disabled persons also families with children have been identified by the ministry (Sosiaali- ja terveysministeriö 2011). In addition to these three end user segments, the private producers of home care services often target households as potential end users. Adding all end users together would result in at least four separate end user or customer segments for home care; i) elderly persons, ii) disabled persons, iii) families with children, and iv) households. This segmentation of home care end users is a rough and subjective estimation of the reality – in practice the segmentation utilized by service providers can be different and more profound.

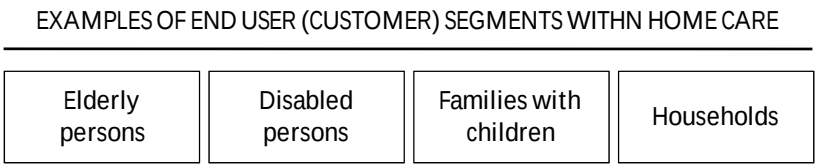

Figure 4: A rough categorization of end user segments within home care

Proper customer segmentation is important not only for identifying and gaining new end users, but also for distinguishing between the differing service needs of the segments. Home

care can be seen as services being offered at different phases in the human life-cycle. It is evident that home care for elderly persons occurs at a later on in life, whereas home care for families is needed when there are young children. However, it is fair to assume that larger home care efforts are required for elderly persons than for children, as the need for medical treatment accelerates when people grow older (Nutek 2007 a, p. 27). Persons born with a disability may need home care throughout their life, but also here the efforts needed are assumingly largest at older age. Households can in principle utilize home care during the working age, i.e. from early adulthood until retirement at seniority. For households the home care efforts typically remain at a modest level, as the services are emphasized on domestic activities and only marginally on personal care or healthcare.

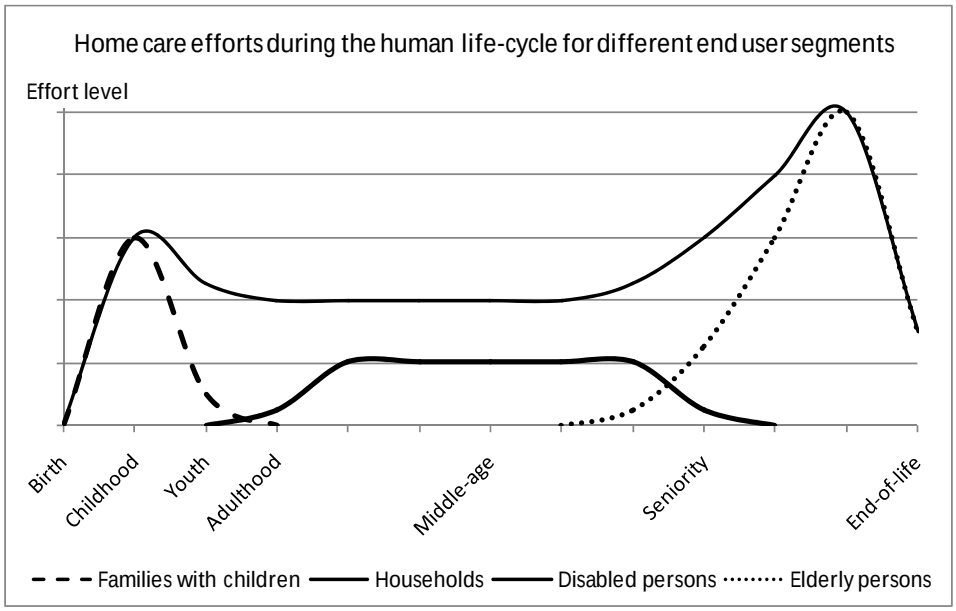

Figure 5: An illustrative description of the need for home care services among different customer segments during the human life-cycle

2.5 Characteristics of the Services and Operations

2.5.1 A Mixture of Different Services

It is important to comprehend that home care is a not single service but a *mixture* of different services. Furthermore, the *range* of the service mixture correlates positively with the complexity of managing the services, where a wide set of services is automatically more difficult to manage than a narrow one.

Given that home care is a mixture of different services, the separate services encompass different levels of complexity. A one-hour medical treatment of a seriously ill patient at home is far more challenging than an equally long session of cleaning the apartment. It can be assumed that the complexity of home nursing is relatively high, while it is somewhat lower for care-related home help services and lowest for domestic home help services. This is a simplification of reality, as e.g. performing certain home domestic home help services can be more challenging than the most basic home nursing services. The complexity of an individual home care service correlates positively with its production cost and selling price, resulting in a price range for the separate home care services. It should be noted that the cost levels of the different services are also affected by collective labor agreements, and the price levels are also affected by the general demand-supply balance on the market.

From a service production point of view, the variety of home care services requires compatible personnel for each service. Having the right types of professionals for each separate service should result in the highest quality at the lowest price. In practice this matching of right professionals with home care customers can be challenging and costly, especially for individual customers utilizing a wide range of services.

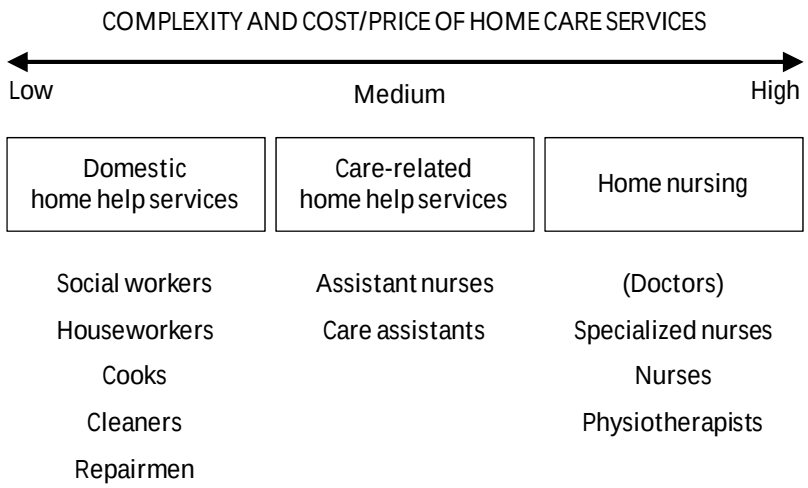

Figure 6: A simplified assessment of different home care services in terms of complexity, cost/price and service professionals

Also the differing service contents among home care services means differences in the time required to perform them. Taking a blood sample assumingly takes a shorter time than assisting in bathing. But again, there are also variations in how complex or how long it takes to perform the same service, e.g. assistance in changing clothes depends much on end users. Even the same service performed for the same end user can be different from time to time.

Comparing home help services with other healthcare and care-related social services suggests that home care services are mainly of low complexity. For instance in Sweden in 2004 the turnover per employee was the lowest for companies in the category “open social services”, clearly higher for companies in healthcare categories and the highest for companies in the dental care category (Nutek 2007 b, p. 54-55). Home help companies are grouped into the open social services -category. However, this comparison does not reflect the amount or share of non-chargeable idle time per employee. These figures are assumingly much higher for employees within home care than for stationary employees such as professionals at health centers.

Apart from the complexity there are also differences in the *frequency* for the various home care services. Within home nursing the end user demand for services is typically more infrequent, but within care-related services the demand is usually more frequent and even daily (Nutek 2007 a, p. 17). There is thus a variation in how often different home nursing services, care-related home help services and domestic home help services are offered to the end users during a given time period. It is obvious that many domestic home help services such as cleaning or doing the laundry are more infrequent than most care-related activities.

2.5.2 Mobile Service Locations

Healthcare and care-related activities encompass the typical service characteristics in the sense that they normally require a *physical encounter* between the producer and end user of the service (Nutek 2007 a, p. 17). The service locations are normally fixed while the end users are mobile. Patients visiting hospitals or health centers situated near their homes are typical examples. However, in home care the rationale is the opposite, as the services are either

brought to or performed at the end users' homes. This is the main characteristic of home care and simultaneously the main difference to other healthcare and care-related services.

As home care services are brought to the home, the geographical locations of the end user homes and the distances in between play a crucial role in performing the services. When the end users are geographically concentrated to a small area, planning the route to the end users is fairly straight-forward and the transportation times between the locations remain short. But when the end users are spread over a large area, the planning the route becomes more complex and transportation times increase. The transportation of home care services to end users is a non-productive event that consumes time and generates costs, whereby it is evident that a service provider aims to minimize the transportation distances. Grouping of end users located nearby is one way of reducing transportation distances on an aggregated level. An optimal placing of the home care service hub(s) – the place(s) from where the services are transported to the end users – is another way of reducing transportation distances.

Not all healthcare and care-related services require a physical encounter between the producer and end user of the service. Some services relate to provision or exchange of information, and these can performed using technology such as the phone or the internet (Nutek 2007 a, p. 17). This applies to home care as well, and examples of these information-based services are medical consultation, reporting and monitoring of personal health issues and mental therapy.

2.5.3 High Level of Locality

Home care is a *local business* where geographical presence is an important factor for the companies in the competition. The *width and depth* of the companies' service offering in the geographical area in question is of major importance for succeeding in the operations.

The locality of home care also incurs challenges for service providers. The locality implies that every public sector customer and customer agreement is unique. Each public sector customer has individual needs, whereby home care companies have to *customize* their service offerings separately for each service acquirer. A recent study in Sweden suggested that those local authorities, which acquire healthcare and care-related services from private companies,

take varying stands to the private services not only on between themselves, but also internally. In many cases the opinions on the private services acquired differed within a local authority depending on which person was interviewed. Overall the opinions of the local authorities tended to correlate with their political orientation and size. (Nutek 2008 b, p. 3-4)

2.5.4 High Labor-Intensity and Low Capital-Intensity

Home care, like healthcare and social services in general, is very labor-intensive. The execution of home care services predominantly requires a *human input* or *human presence* from one or several home care professionals. The services performed by the professionals are of either physical or mental nature. Examples of physical services are medical treatment, personal care and assistance, household activities, maintenance of the apartment or house, shopping, running errands, security solutions, transportation and accompanying (escorting). The mental services are partly overlapping with the physical services, and they include e.g. socialization, consultation, personal care and assistance, security solutions and accompanying.

For some of the services – both of physical and mental nature – the human element can be downscaled through utilization of *technology*, especially *automation* or *digitalization*. Automated services are for instance prefilled medicine portions, domestic meal automats and recurring deliveries of standard groceries. Digitalized services are monitoring and reporting of the health condition, the provision of essential information, ordering or cancelling services, personal alarms and social media solutions.

IT offers possibilities to improve operational performance through safety systems for the care processes within healthcare and care-related services, where a single malpractice can have fatal consequences for a patient. Apart from making the processes more effective, IT also creates new means for communication between parties in the service system. However, common sense is recommended with IT and technology, especially if they do not correspond to overall needs or behavior of customer. Excess use of IT or technology can in fact undermine the effects of treatment if the persons receiving it are not sufficiently capable of utilizing it. (Socialstyrelsen 2009 c, p. 435-436)

Home care companies are on average not very capital-intensive (Nutek 2007 b, p. 59). The reason is simple, major facilities are not needed as the service locations are the homes of the end users. Transportation vehicles and IT-systems, on the other hand, are necessary, and these require investments and capital from the home care companies.

2.5.5 Varying Service Demand

Home care services, like healthcare and social services in general, are primarily financed by public sector resources, while the client fees paid by the end users are only marginal. The low prices paid by the end users tend to accelerate the demand for the services more than would be necessary. As a result of this phenomenon, the public sector has established different kinds of mechanisms to control and restrict the provision of home care services to end users. Home care services are granted to end users based on so-called *needs assessments*. Due to limited resources within the public sector the services offered are often restricted to i) the most critical services and ii) those people needing them the most. (Nutek 2007 a, p. 17, 26)

It is believed that services within healthcare and care-related social services have a positive income elasticity (Nutek 2007 a, p. 12). In other words end users with higher income are willing to consume more home care services, while those with lower income prefer to consume less. This applies to the private market of home care, where the end users themselves pay the full price of the services.

The prioritization of publicly enabled home care services is believed to boost the market for *additional services* paid fully by the end users themselves. This means that persons who are being granted certain home care services are increasingly acquiring additional services, which they both choose and finance themselves. (Nutek 2007 a, p. 29)

Efforts in home help services have in reality been cut down in many places in Sweden, due to limitations in public resources. Interestingly, this reduction in services offered on behalf of the public sector has not resulted in an equal increase in demand for services offered by private sector companies. One reason is that end users of home care services are to a large extent persons with a low income level. (Nutek 2007 a, p. 26-27)

2.5.6 Few Customers is Normal

For companies within home care – both home nursing and home help services – it is common to have only one or just a few customers (Nutek 2007 b, p. 27). This is because the customer relationships are often tied with public sector customers such as local authorities, county councils or healthcare districts. The amount of public sector customers of a home care company does not reveal the amount of end users or individuals it is serving. A service contract for one large city may generate more end users than many service contracts for small towns. However, many companies operate either partly or entirely on the private market for home care, whereby they make service contracts directly with the end users. Also, the rising popularity of service systems, where the end users choose their service providers among several qualified operators, increases the amount and the role of direct customer relationships between home care companies and end users.

2.6 Service Process and Service Design Aspects

Services can be classified with the Service Process Matrix frequently used in services literature. The matrix groups services based on two dimensions relating to the service delivery process, degree of labor intensity and degree of interaction and customization. Healthcare services such as a medical treatment by a doctor, is characterized by close interaction between the doctor and the patient as to ensure good care. The care also needs to be customized for the specific needs of each patient. The close interaction combined with high level of customization creates challenges for managing the service delivery process successfully. Medical services can be classified as a *professional service* in the matrix, given the high competence level of doctors and the customized treatments. Cleaning or meal services on the other hand are characterized by being labor-intensive in production but fairly standardized in delivery. These *mass services* require a low competence level by persons producing them, and they are typically produced in large volumes with low levels of differentiation. (Fitzsimmons & Fitzsimmons 2006, p. 18-19). Home services have elements of both professional services and mass services, where the care-related services belong to the first group and domestic services belong to the second group.

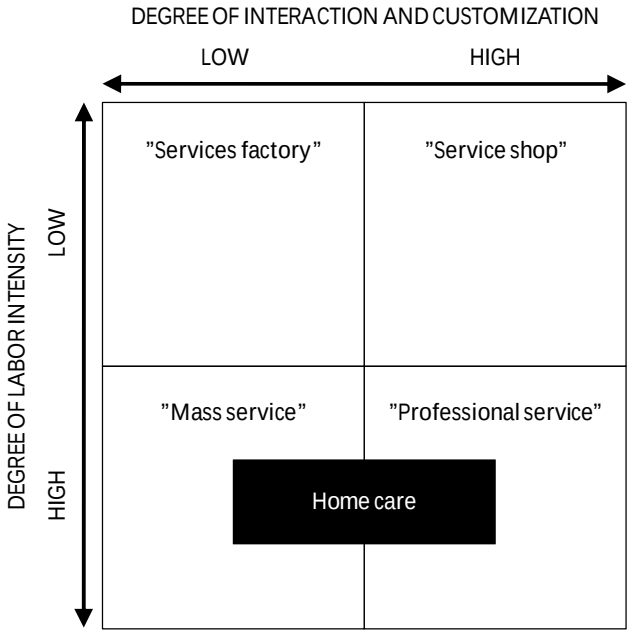

Figure 7: Home care in the Service Process Matrix (Fitzsimmons et al. 2006, p. 19)

In the design of services or service systems two types of approaches are used. The first service design is the *production-line approach*, and it is common for routine services produced efficiently in controlled environments. The production-line service design, when possible to implement, is generally the most cost-efficient alternative. Here the entire service system and all processes are predefined and detailed. For individual employees this means standardized work routines with a narrow scope. Other features of this service design are replacing personnel with technology solutions and limiting the service offering. A service design which shifts activities onto the customers makes them *service co-producers*. This solution usually improves overall efficiency and the possibilities for offering customized services. The second service design is the *customer contact approach*, which is suitable for services where service production cannot be separated from service delivery. In customer contact services the customers need to participate in the production and delivery of the services, whereby they determine the timing, demand and contents of the services. Services of the customer contact type are labor-intensive with limited possibilities for rationalization. Nonetheless, one solution is to divide the services into groups of high- versus low customer contact. For low-contact services or so-called *back-office* services the production-line approach is applied in order to reach efficiency. Low-contact services are those that can be produced separated from

the delivery, and they are typically standardized and produced in large volumes. High-contact services are also referred to as *front-office* services. (Fitzsimmons et al. 2006, p. 88-93)

Table 1: Design considerations for services with high versus low customer contact (Fitzsimmons et al. 2006, p. 93)

SERVICE DESIGN FACTOR	HIGH-CONTACT SERVICE (FRONT-OFFICE SERVICE)	LOW-CONTACT SERVICE (BACK-OFFICE SERVICE)
Service facility location	Near the customer	Near supply, transportation or labor
Service facility layout	Focus on customer needs	Focus on efficiency
Process design	Production process has a direct impact on the customer	Customer is not involved in most of the process
Scheduling	Customer is in the procution schedule	Customer is concerned mainly with completion dates
Production planning	Orders can not be stored	Order backlogging and production smooting is possible
Worker skills	Requires also good social skills	Technical skills most importants
Quality control	Quality is often subjective and thus variable	Quality standards are usually measurable and fixed
Forecasting	Short-term, time-oriented	Long-term, output-oriented

As for the design of home care services, both high-contact and low-contact alternatives are needed. In fact, it seems that most of the services are not explicitly high-contact (professional service) or low-contact (mass service), but hybrids containing elements of both. A home nursing procedure with a customer involves several back-office routines related to administration and monitoring of customer health. Even a basic meal service provided by a centralized catering unit may require a service person at the customer assisting with consuming the meal. Laundry service is another example of a home care service comprising both service designs. It can be assumed that home care companies focusing on efficiency convert an increasing amount of service processes from high-contact to low-contact categories, and also look for opportunities to conduct professional services like mass services. All in all, the design of home care services assumingly depends much on the scope of services provided. A large number of different home care services makes designing of an optimal service system a complex task.

Table 2: Examples of home help services grouped by types of service process and service design

SERVICE DESIGN TYPE	SERVICE PROCESS TYPE: PROFESSIONAL SERVICE	SERVICE PROCESS TYPE: MASS SERVICE
HIGH-CONTACT SERVICE	Health assessments, providing medication, making medical tests	Providing meals, cleaning, picking-up & delivering laundry
LOW-CONTACT SERVICE	Updating patient journals, dosing medicines, evaluating medical tests, administration	Processing medical tests, cooking of meals, purchasing supplies and medicines, washing laundry, IT-systems

In both professional services and mass services the skills, the motivation and the job routines of the personnel are critical for the performance of the service processes. Moreover, the level of service customization has an impact on the possibilities to control the service quality, and also on how the service is perceived by customers. (Fitzsimmons et al. 2006, p. 19). Home care companies do not make an exception, personnel issues and levels of service customization are important aspects in managing the operations. A generic list of the main challenges for companies in the classes Mass services and Professional services are the following table.

Table 3: Generic challenges for managers of mass services and professional services (Fitzsimmons et al. 2006, p. 20)

Mass services:	Professional services:
• Hiring • Training • Methods for development and control • Employee welfare • Scheduling workforces • Control of far-flung geographical locations • Start-up of new units • Managing growth	• Fighting cost increases • Maintaining quality • Reacting to consumer intervention in process • Managing advancement of people delivering service • Managing flat hierarchy with loose subordinate-superior relatioships • Gaining employee loyalty

Although the challenges outlined in the table are generic, they appear plausible also for companies offering home care services. While some level of customization is required for nearly all healthcare and care-related activities, sustaining a sufficient service quality can be difficult. Even domestic home help services such as cleaning or cooking are to some extent case-specific, as all homes are and service situations are unique.

3 HOME CARE IN FINLAND

3.1 Healthcare and Social Services

In Finland the responsibility of *arranging* statutory healthcare and social services is mainly placed on local authorities ("local authority" and "municipality" are used as parallel terms in this study). The law does not, however, define the content or extent of the services to be produced in detail. In addition, the local authorities are able to choose their service providers for those services that they decide not to produce themselves, but to acquire externally. Being obliged to arrange statutory healthcare and social services brings responsibilities and obligations to the local authorities through various laws and regulations. (Ministry of Employment and the Economy 2010 a, p. 15-18).

As a general rule the local authorities have the freedom to choose how they arrange the statutory healthcare and social services, except for certain specialized and complex services. Apart from arranging the healthcare and social services, local authorities also carry the responsibility for *financing* them. The majority of the financing is covered by municipal taxes, government transfers and end user payments. The planning, monitoring and supervision of statutory healthcare and social services is conducted on a national level by the Ministry of Social Affairs and Health and on a regional level by the Regional State Administrative Agencies. (Ministry of Social Affairs and Health 2006, p. 18-19).

A commonly used solution for arranging statutory healthcare and social services is the so-called *orderer-producer model*. In this model the arranging, financing and control of the services (the orderer) is separated from the production of the services (the producer). Thus, the public sector, most often local authorities, acts as the orderer, while private companies, NGOs or the local authorities themselves act as producers of the services in question. Citizens as private individuals are the end users of the services. (Ministry of Employment and the Economy 2010 a, p. 18).

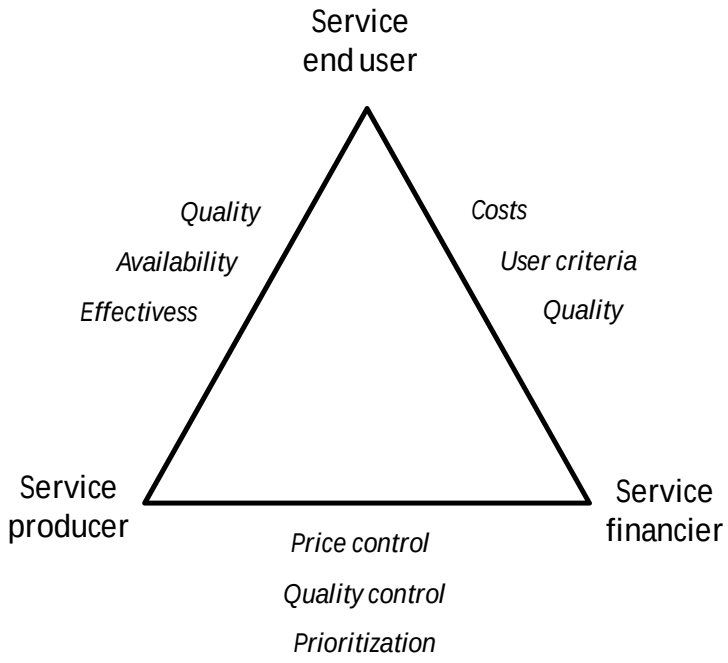

Figure 8: The orderer-producer model for publicly-financed services, which includes the financier, the producer and the end user of the services (Sosiaali- ja terveysministeriö 2002, p. 80)

Healthcare services are in Finland offered by both the public sector and the private sector. Public sector actors include the government, local and regional authorities, whereas the private sector refers to private companies, practitioners and non-governmental organizations "NGOs" (Ministry of Employment and the Economy 2009, p. 129).

Social services can be divided into two categories – *residential care activities* and *social work activities without accommodation*. The social work activities without accommodation - category includes home help services, childcare, sheltered work and rehabilitation for work. Also social services are offered by both the public sector and the private sector. (Ministry of Employment and the Economy 2009, p. 139)

Public sector customers – primarily local authorities – form the dominant customer category for private social service companies. A recent study showed that public sector customers generated on average 83% of the turnover for private social service companies in Finland. In 2007 the local authorities acquired social services for more than EUR 1.2 billion from private social service companies and NGOs. (Ministry of Employment and the Economy 2010 a, p. 28-29)

The private market, i.e. the sale of non-statutory (voluntary) social services directly to consumers or households, has so far been modest apart from childcare. Nonetheless, a large amount of small home service companies have been established across the country, for the purpose of selling home services to households that are not entitled to the local authorities' services. These activities are supported by *the tax credit for domestic costs*, which in 2009 was limited to EUR 3000 per person per year. The deduction is 30% of the salary costs and side costs. (Ministry of Employment and the Economy 2009, p. 140)

Because of the heterogeneous form of the home care services, they are somewhat difficult to separate from other healthcare services and social services in a national market. Nearly half of all local authorities in Finland had by 2007 merged their home nursing activities and home help activities into one service unit – home care services (Sosiaali- ja terveysministeriö 2007, p. 1).

3.1.1 Home Nursing

In 2008 the public sector in Finland arranged and financed home nursing for EUR 265 million, or 1.7% of total expenditures on healthcare services and products. This sum reflects home nursing produced by the public sector, whereas home nursing produced by the private sector is not reported. Public home nursing has grown rapidly during the past decades – the value of the service production in current prices (i.e. not inflation-adjusted) has doubled between 1997 and 2008. It should be noted that inflation-adjusted figures would show somewhat higher absolute values but somewhat lower growth rates for the historical figures. (National Institute for Health and Welfare 2010 a, p. 35). An additional point is that the figures presented in this section also exclude non-statutory healthcare expenditure, i.e. voluntary home nursing acquired by end users directly from private service providers.

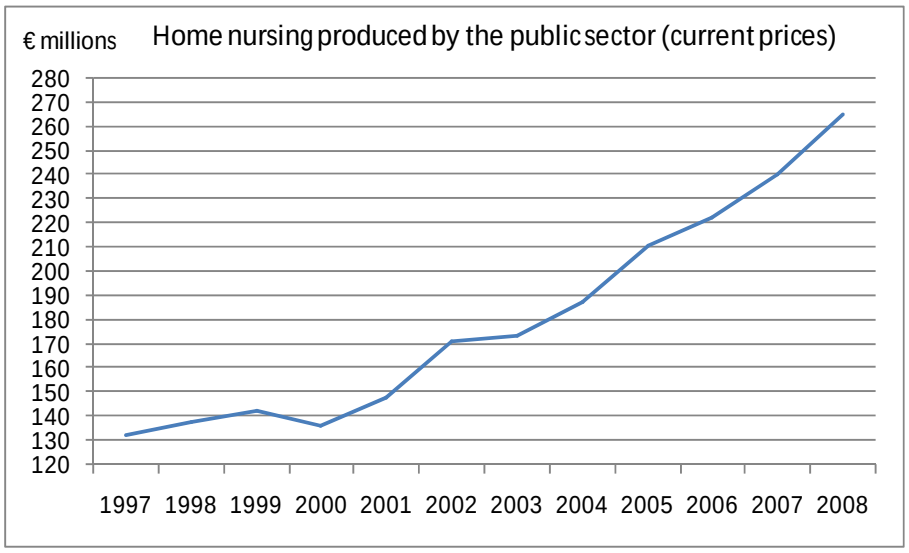

Figure 9: Total expenditure on home nursing services arranged and produced by the public sector in Finland (National Institute for Health and Welfare 2010 a)

3.1.2 Home Help Services

The public sector in Finland arranged and financed home help services for EUR 564 million in 2008. Of this service consumption 93% or EUR 522 million was produced by the public sector and 7% or EUR 42 million by the private sector. In 1997, the relative shares were 94% and 6%, suggesting that the power balance has remained stable. Yet, home help services have grown significantly during the past decades, with the value of the service production in current prices (i.e. not inflation-adjusted) increasing more than 80% between 1997 and 2008. The growth rates have been similar for the public sector and the private sector. Inflation-adjusted figures would show somewhat lower historical growth rates. (National Institute for Health and Welfare 2010 a, p. 38). The figures presented in this section do not include non-statutory home help expenditure, i.e. consumers' own expenditures on the private market.

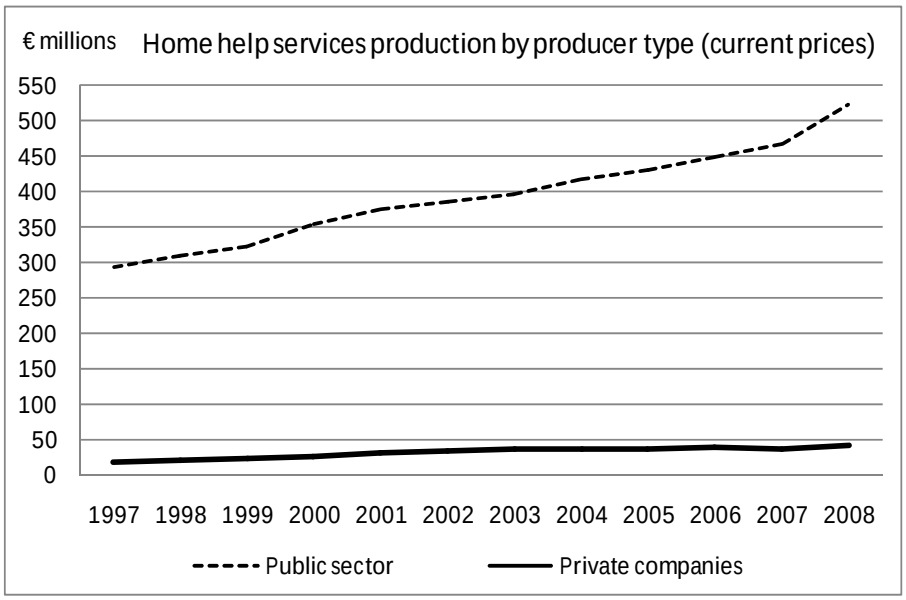

Figure 10: Total expenditure on home help services arranged and financed by the public sector in Finland by producer type (National Institute for Health and Welfare 2010 a)

The value of home help services arranged and acquired by the public sector (local and regional authorities) reached nearly EUR 650 million in 2008, when including the client fees paid by the customers. 83% of this sum was services to elderly, followed by 13% to disabled persons and 4% to families with children as the smallest customer segment. The municipalities and the state accounted for 83% of the financing of the home help services, while the customers themselves took on 17%. (National Institute for Health and Welfare 2010 b, p. 33-34)

3.2 The Position of Patients and Service End Users

3.2.1 The Rights to Receive Services

The *rights* of individuals to receive healthcare and social services vary across service types. Some services – such as emergency medical treatment and child day care – are regarded so important that legislation gives all citizens a *subjective right* to receive them. Nonetheless, a significant share of healthcare and social services are *allocation-bound*, implying that individuals have the right to these services within the boundaries of the allocated financial resources of a local authority. As a result the services can be directed to e.g. those needing

them the most. Still, the general rule is that the need for a service always has to be assessed individually. (Ministry of Social Affairs and Health 2006, p. 5)

Legislation on both healthcare and social services is divided into sub-categories based on *service types*, such as *care for substance abusers or mentally disabled persons*. But e.g. for elderly care there are no separate regulations, rather there is a range of different healthcare and social services laws and decrees that are being applied. (Ministry of Social Affairs and Health 2006, p. 6-7)

Customers can be charged for healthcare and social services provided as outlined in the Act on Decree on Client Fees in Social Welfare and Health Care. Customers are charged the same price regardless of whether the local authority produces a particular service itself or acquires it from a private company. (Ministry of Social Affairs and Health 2006, p. 16)

3.2.2 Services to the Elderly

Elderly care does overall not entail any significant rights to the associated services (home help services, residential services, institutional care, support for informal care). Nor are the preconditions for receiving these services clearly defined. The rights of individuals for elderly care can thereby be regarded as weak. The main problem with elderly care is that the factual right to receive services varies across municipalities. In addition, the right does not necessarily correlate with the service need of individuals. (Heikkilä & Kautto & Teperi 2005, p. 35 & 49). Current regulations appoint local authorities to arrange *needs assessments* of non-emergency social services for individuals at the age of 75 years or more, and for individuals on a national pension receiving special care. Similar type of needs assessments of non-emergency social services are arranged for disabled persons. Neither an age of 75 years or more nor attending a needs assessment do automatically entitle individuals to social services or healthcare. Nonetheless, the local authorities are committed to arrange services in line with the outcomes of the assessments. The needs assessments are a part the national *care guarantee* mechanism, which aims to ensure the provision of all healthcare and social services in a timely manner. (Ministry of Social Affairs and Health 2011, web-pages)

3.2.3 Services to Families with Children

The statutory social service category *child care* obligates local authorities to arrange the availability of sufficient local day care. Parents or guardians for a children under school age have the right either to a full-time day care place, or – if certain conditions are met – to financial support for child home care or private care at home. (Ministry of Social Affairs and Health 2006, p. 9). In this manner it can be said that separate regulations on home care services for families with children do exist, and that the rights to the home care services are specified.

3.2.4 Home Help Services and Home Nursing

One statutory social service category is *home services* (home help services and support services). Home services have to be provided to those persons, who due to restrictions in personal health or life situation need help to manage with the daily routines. The statutory healthcare service category *medical treatment and rehabilitation* states that medical treatments have to be arranged to municipal residents, and that the treatments can be provided as outpatient care, ward care or as home nursing. (Ministry of Social Affairs and Health 2006, p. 8). The service categories listed here are general, in the sense that they apply to all citizens and not to some specific groups or types. Still, it is apparent that they are targeted primarily for elderly people.

3.3 Relevant Legislation

There are several laws and acts with both direct and indirect impacts on home care services. There are also many alternatives for how to categorize the legislation. Here the laws and acts have been grouped by whom they primarily concern. The following sections present relevant legislation separately for the service producers and for the service users. The division is to some extent simplified – in reality single laws or acts affect several parties.

3.3.1 Legislation Concerning Service Producers

The *Public Procurement Act* was compels public entities to tender all healthcare and social sector acquisitions in excess of EUR 100,000 (Ministry of Employment and the Economy 2010 a, p. 19). Local authorities have two possibilities to tender the services to be acquired. The first one is to determine the price beforehand, and then tender for the service content. The second one is to determine the service content and quality criteria beforehand, and then choose the least expensive or economically most beneficial offer fulfilling the criteria. (Ministry of Employment and the Economy 2010 a, p. 61-62).

The production of private healthcare services, such as home nursing, is primarily subject to a license. This has been legislated in the *Private Health Care Act*, according to which the service producer needs a license from its Regional State Administrative Agency for providing healthcare services. The license is required by individuals, companies and NGOs. (Ministry of Employment and the Economy 2009, p. 129). Also the production of private social services is mostly subject to a license. A private service provider offering round-the-clock social services needs to apply for a license from the Regional State Administrative Agency before commencing or changing its operations. Other service providers (those within non-institutional social care) solely need to notify the relevant body of their local authorities about commencing or changing their operations. (Ministry of Employment and the Economy 2009, p. 139)

Legislation has been a means to ensure the quality and appropriateness of the private healthcare services. In practice this implies that the personnel, facilities and equipment have to be adequate for the operations of the actors. The personnel need to meet the same eligibility qualifications that would be required by public sector personnel in the same duties. Furthermore, a public entity acquiring healthcare services from a private service provider needs to ascertain that the acquired services correspond to the quality level being required by a public service provider. (Ministry of Employment and the Economy 2009, p. 130)

3.3.2 Legislation Concerning Service Users

Since 2004 the Finnish local authorities have been able to offer their services by granting the citizens a *service voucher*. In 2008 the use of service vouchers was extended to home nursing, and in 2009 to all those social services and healthcare services, where the citizen could genuinely choose the desired service and the service provider. (Ministry of Employment and the Economy 2009, p. 139-140). The service voucher does in theory extend to all those social and healthcare services and service providers, where the quality levels of the services offered equal those offered by the local authorities. The local authorities do in practice select both the applicable service categories and the private service providers that meet the criteria for the service vouchers. The selection methods are either to i) accept all service providers meeting the criteria without tendering, or to ii) tender the service providers according to the Public Procurement Act. (Ministry of Employment and the Economy 2009, p. 154). Local authorities can impose additional requirements on the services to be provided, and they can be related to customer needs, to service amounts or quality, or to local conditions. The citizens using service vouchers have to pay the difference between the price of service and the value of the service voucher. This difference being paid is either *equal to* or *lower than* the price to be paid for the equivalent service provided by the local authority. (Ministry of Employment and the Economy 2010 a, p. 19-20).

Different types of service voucher experiments and models are in use among the municipalities. So far service vouchers have been applied mainly in the social services without accommodation -segment, such as in home help services, in replacements for informal care and in different support services. (Ministry of Employment and the Economy 2009, p. 151-152). In 2008 the use of service vouchers was extended from home help services to include home nursing as well (Sosiaali- ja terveysministeriö 2007, p. 1).

4 HOME CARE IN SWEDEN

4.1 Healthcare and Social Services

The responsibility for the health-care system in Sweden is divided between three parties; i) the government, ii) the county councils and iii) the local authorities ("local authority" and "municipality" are used as parallel terms in this study). The government sets the principles and guidelines for the healthcare through laws and national-level agreements with the Swedish Association of Local Authorities and Regions. The responsibility for arranging healthcare services is concentrated to the counties and to some extent to the local authorities. (Swedish Institute 2009, p. 1)

The liability for the healthcare sector is placed on the county councils, while that of the social services sector is allocated to the local authorities. Here the healthcare sector refers to amongst others the arrangement of health center care, hospital care and psychiatric care. (Ekonomifakta 2010). The responsibility of the local authorities within the social services sector includes arranging of care and social services i) for elderly persons including both home care and residential care, ii) for persons with physical disabilities or mental disorders, and iii) for families and individuals. (Swedish Institute 2009, p. 2).

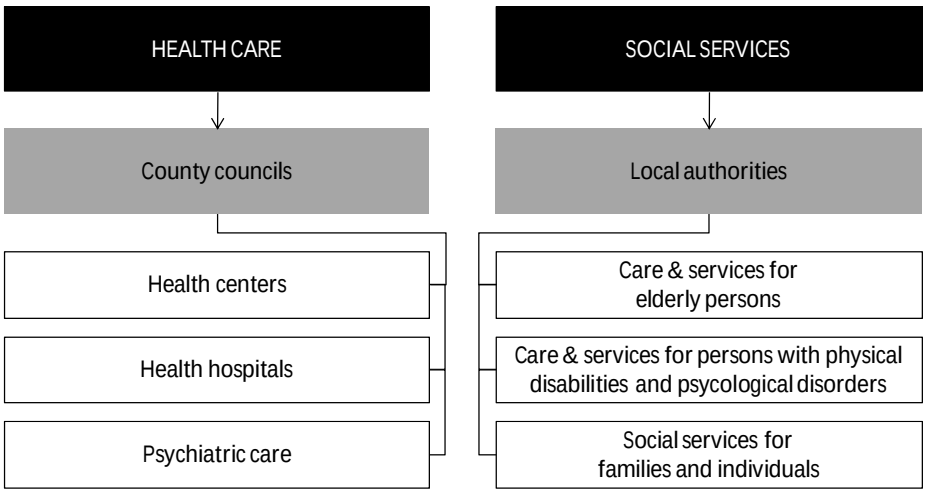

Figure 11: The roles of county councils and local authorities in arranging healthcare and social services in Sweden (Ekonomifakta 2010, Swedish Institute 2009)

County councils and local authorities can choose whether they produce the services themselves or they acquire them externally from some other service providers through a *public procurement*. Parties interested in producing the public services are required to participate in public tender processes. (Ekonomidata 2010)

County councils and local authorities have since 2009 also been able to apply the *system of choice* as an alternative to the public procurement. System of choice means that all those service providers, which fulfill certain quality and cost criteria being set, are able to offer services at a pre-determined price without attending any public tender processes. This should increase the amount of service providers of publicly arranged services, and also the level of competition – for the benefit of the citizens. The *Act on System of Choice* is applied in healthcare, elderly care and in care for disabled persons, but *not* e.g. in child care. The system of choice is compulsory in primary healthcare, i.e. county councils and certain local authorities are bound to apply the system. The service providers receive monetary compensation from the county councils or local authorities based on the amount of services provided. (Ekonomidata 2010)

Private healthcare and social services operations are managed through contracts between the county councils or the local authorities that acquire, finance and monitor the services – and the companies that produce the services in question. The most common contracts are *service contacts*, where the public sector customer acquires solely the operation of some service function from a company. The facilities and equipment associated with the services are offered to the company, but they remain in public ownership. The service contracts are typically fixed for a period of five to seven years. In other cases the public sector customer acquires the service consisting of both the service operation and of the associated facilities and equipment from a company. In these cases frame agreements are typically applied, meaning that the contracts allow for variations in the services acquired. (Ambea 2010, p. 6)

The healthcare – the vast majority of which is arranged by the county councils – is mainly financed by taxes of different kinds, i.e. by public sources (Vårdföretagarna 2011, web-pages). Also the social services arranged by the local authorities are mainly financed by taxes, local government equalization systems, and by general government allowances. Service user

fees (household fees) are applied mainly in the care of elderly persons and disabled persons, as well as in pre-school activities and school-age child care. (Statistiska centralbyrån 2009 a, p. 8-11)

The client fees for healthcare and social services are pre-determined and equal irrespective of whether the services are produced in accordance with public procurement or system of choice, or by the public sector or the private sector. Private service providers that offer *non-public* healthcare or social services to private sector customers are allowed to price these services freely. (Ekonomidata 2010)

4.1.1 Home Nursing

The basis in Sweden is that county councils carry the responsibility for arranging and financing home nursing in primary healthcare, specialized somatic healthcare and in specialized psychiatric healthcare. Local authorities *are able* to make agreements with county councils to overtake a part or the entire liability for *certain* healthcare activities affiliated with long-term care of elderly persons and disabled persons (persons with functional impairments). The treatment areas included herein are i) care, ii) rehabilitation and iii) habilitation. However, efforts requiring a medical doctors or input from specialized healthcare are outside the responsibility of the local authorities. The home nursing of local authorities also involves the provision of assistive devices. The home nursing professionals of the local authorities include nurses, physiotherapists and occupational therapists. Approximately half of the 290 local authorities in Sweden had in 2008 made agreements to conduct home nursing activities presented above, but there were internal differences in the service offerings and the patient groups. The rationale of shifting of home nursing activities from county councils to local authorities is commonly to enable a continued living at home and to improve the coordination of the public welfare services offered. (Socialstyrelsen 2008, p. 18-23)

Table 4: The responsibilities in home nursing for persons in ordinary living, i.e. living at home, in Sweden (Socialstyrelsen 2008, p. 18)

Responsible entity (Columns on right side)	County councils (Primary healthcare)	County councils (Specialized healthcare)	Local authorities
Care without doctor efforts	X	-	X
Specialized healthcare	-	X	-

4.1.2 Home Help Services

The local authorities in Sweden are obliged to arrange and finance home help services that have been prescribed in needs assessments. In other words the statutory home help services are not a clear and unified group of services for all citizens, they are rather a vast mixture of different services tailored for different people. Local authorities are also able to provide their citizens with home help services *without* any needs assessments, as additions to the statutory home help services. These *voluntary home help services* are those which aim to prevent injuries and bad health but which are *not* personal care. These services can be provided to persons at the age of 67 years or more. The local authorities have the freedom to decide the service range, the receivers of the services (among those aged 67 years or more), as well as the client fee levels for the voluntary services they arrange. The third category of home help services are those offered by private companies directly to consumers, i.e. private home help services that are neither arranged nor financed by the public sector. Private home help services are financed by the consumers themselves, but costs that relate to personal care or domestic services are tax deductible. The private home help services are thus to some extent financed also by the public sector. (Socialstyrelsen 2007, p. 2-3)

Table 5: A grouping of home help services by service type and arranger in Sweden (Socialstyrelsen 2007, p. 6)

	Statutory home help services	Voluntary home help services	Private home help services
Service arranger (and financier)	Local authorities	Local authorities	Private persons / Consumers
Service producer	Local authorities and private companies	Local authorities and private companies	Private companies
The service offering	Personal care and domestic services	Domestic services	Personal care and domestic services
Services excluded	-	Personal care	Healthcare services (by medical personnel)
Needs assesment	Yes	No	No
Client fees / Pricing	Can be income-based	Can be income-based	Market-based pricing
Client fees tax deductable	No	No	Yes
Quality standards determined	Yes	No	No

4.2 The Markets for Healthcare and Social Services

The public service producers within the Swedish healthcare system include county councils, local authorities, the state, or public companies owned by the aforementioned. The private service producers consist of private companies, NGOs and households and individuals. (Sveriges Kommuner och Landsting 2009 a, p. 74). The participants in the production of social services are the same as those in healthcare (Statistiska centralbyrån 2009 a, p. 20).

The markets for public healthcare and social services opening up for competition has been the key driver for the growing amount of private service producers since the 1990s. Outsourcings – activities shifted from the public sector to private service producers – as well as *spin-offs* – privatizations of public activities or companies – have expanded the private sector most. (Nutek 2007 a, p. 21). In both cases the arranging, financing and monitoring of the privately produced services remain at the public sector.

Even though most private healthcare and care-related social services companies are small, there are a few large companies on the market. Some of these are part of larger groups with several subsidiaries and activities in many service fields and countries. Some of the companies have been acquired by others, but their names and external profiles have been kept intact. Large private companies in healthcare are for instance Praktikertjänst AB, Capio AB and AB Previa, while Frösunda LSS AB and Assistansia AB (part of Humana AB) are large in care-related social services. Aleris AB, Attendo Group AB, Förenade Care AB (part of Forenede Service A/S), Carema Care AB and Carema Sjukvård AB (part of Ambea AB) are large conglomerates operating both in healthcare and in care-related social services. Most of the aforementioned companies have operations on a Nordic or a European scale. (Nutek 2007 b, p. 46-49)

Ambea AB, one of the largest private companies offering healthcare and care-related social services in the Nordic countries, outlined the competitive situation in Sweden in its annual report for 2009. The competitive landscape shows that the largest companies are often hybrids in the sense that they operate within both healthcare and care-related social services. (Ambea 2010, p. 7)

Table 6: The competitive landscape for the largest private companies operating in healthcare and care-related social services in Sweden (Ambea 2010, p. 7)

Company	Healthcare segment	Care segment
Ambea / Carema	X	X
Attendo / MedOne	X	X
Capio Nordic	X	-
Aleris	X	X
Praktikertjänst	X	-
Forenede / Förenade Care	-	X

4.2.1 Home Nursing

Home nursing is a growing area within Swedish healthcare. This is because county councils and local authorities have been reducing the amount of places of care in both inpatient care (hospital care) and special housing, while simultaneously shifting more patients to their homes for care and treatment. The volume of home nursing services has increased as a result of the shift, but so has also the range of services, as more complex treatments are conducted at patients' homes. (Socialstyrelsen 2008, p. 7-8)

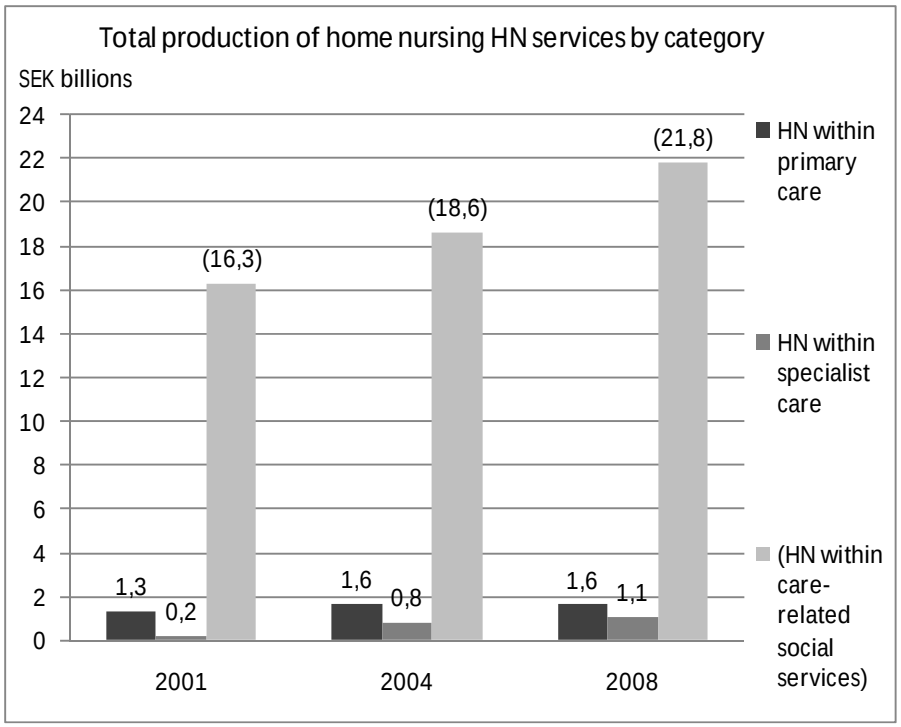

Figure 12: The total production of home nursing services arranged and financed by the public sector in Sweden in 2001, 2003 and 2008 (Sveriges Kommuner och Landsting 2009 a, p. 110; Sveriges Kommuner och Landsting 2005, p. 108; Sveriges Kommuner och Landsting 2002, p. 77, 81, 85; Statistiska centralbyrån 2011)

When examining national-level production of services arranged and financed by the public sector, it appears that home nursing within primary care grew by SEK 0.3 billion or 22% between 2001 and 2008. The equivalent home nursing within specialist care grew – from low base levels – by SEK 0.9 billion or as much as 500% during the same time period. The value of these advanced home nursing services has approached that of primary care, which denotes that home nursing overall is becoming more demanding. The third home nursing component is that conducted as a part of the care-related social services, either by or on behalf of local

authorities. Also this category shows a clear growth, but the content and quality of its figures need a clarification. They include not only home nursing, but also other healthcare activities carried out by local authorities (Socialstyrelsen 2008, p. 35-35). Thus only a part of the home nursing within care-related social services should in fact be accounted as home nursing, i.e. clearly less than the reported SEK 21.8 billion for 2008. But exactly how much less is not known for the purpose of this report. (Sveriges Kommuner och Landsting 2009 a, p. 110; Sveriges Kommuner och Landsting 2005, p. 108; Sveriges Kommuner och Landsting 2002, p. 77, 81, 85; Statistiska centralbyrån 2011)

There was no detailed information available on the volume or value of home nursing services produced by private companies. But the general rule is that in areas where the responsibility of home nursing is placed upon local authorities, their preference is to conduct the activity themselves and round-the-clock. But in areas where the liability is upon county councils, they prefer to operate the home nursing themselves during day-time, while they outsource it to external service providers for evenings, nights and weekends. (Socialstyrelsen 2008, p. 7-8). This means that the market figures for home nursing presented earlier in this section reflect primarily the service production of the public sector.

4.2.2 Home Help Services

The market for home help services has experienced steady growth rates in line with the social services sector overall, although it decreased by nearly 3% in 2008 to a total of SEK 25.0 billion. Nearly 90% of all home help services were directed to elderly persons, while disabled persons received just above 10%. The growth rates for both customer segments were almost the same from 2004 to 2008, i.e. no relative shift in the customer structure has occurred. (Statistiska centralbyrån 2009 a, p. 6)

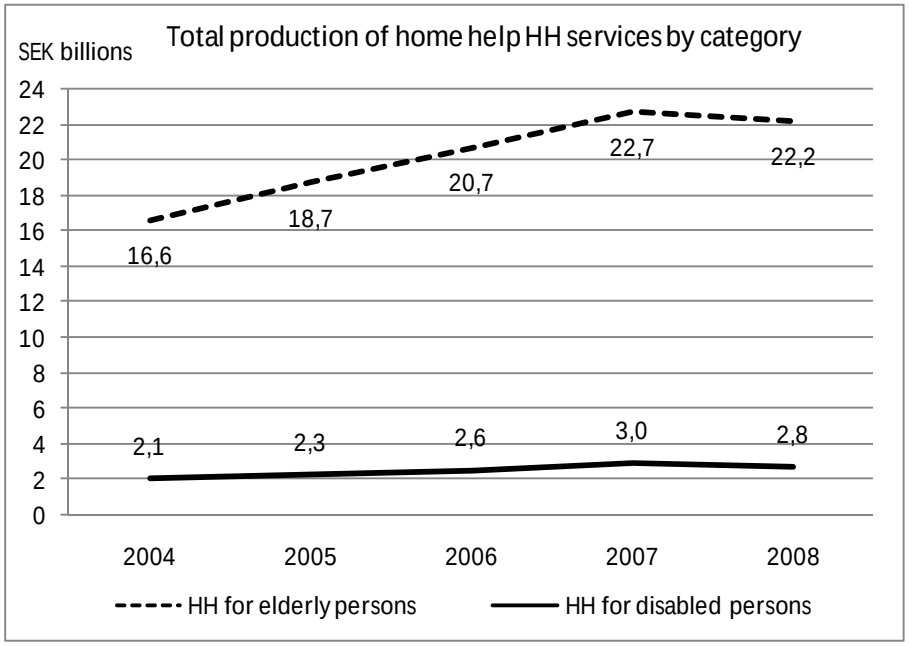

Figure 13: The total production of home help services arranged and financed by the public sector in Sweden between 2004 and 2008 (Statistiska centralbyrån 2009 a, p. 6)

Reliable assessments on the volume or the value of the private market for home help services are difficult to find from publicly available sources.

Statistical data on home help services hours show that as many as 214 or 74% of all 288 local authorities in Sweden produced all home services themselves in 2008. Only 11 or 4% of all local authorities acquired more than 50% of the home help services from external parties. This small group accounted for as much as two thirds of all home help services acquired by the public sector. This group's external acquisitions amounted to 11% of all home help services arranged and financed by the public sector. As previously mentioned, the public sector acquired in 2008 in total 16% of its home help services from external service providers. (Statistiska centralbyrån 2009 b, p. 28-34)

Table 7: Grouping of local authorities based on the share (%) of home help services acquired from external service providers (Statistiska centralbyrån 2009 b, p. 28-34)

Home help services acquired by the Swedish local authorities				
Share of home help acquired from external parties (%)	Amount of local authorities (#)	Share of local authorities (%)	Share of total home help services acquired (%)	Share of total home help services produced (%)
No external acquisitions (0 %)	214	*74 %*	*0 %*	*0 %*
< 20 %	47	*16 %*	*8 %*	*1 %*
20%-50%	16	*6 %*	*25 %*	*4 %*
> 50%	11	*4 %*	*67 %*	*11 %*
Total	288	100 %	100 %	16 %

The private market for home help services is rather polarized, with several hundreds of small companies and a few large companies. In Sweden four companies are clearly larger than the rest, and these are Attendo Care AB, Aleris Äldreomsorg AB, Carema Care AB (part of Ambea) and Förenade Care AB. Together they possessed slightly above half of the private market in 2008. (Sveriges Kommuner och Landsting 2009 b, p. 4)

4.3 The Position of Patients and Service End Users

The *Social Services Act* states that all persons who are unable to meet their personal needs have the *right* to receive aid or help in their living. The provided aid or help shall enable the receivers a fair standard of life, and they shall be modified so that they enhance the receivers' possibilities to live an independent life. All citizens have the right to undergo a needs assessment for aid or help, which is arranged by the local authorities. Decisions of the needs assessments are binding for the local authorities. Home help services constitute one part and one possible outcome of the aggregated aid or help being outlined above, but it is worth mentioning that there is no specific definition for home help services in the legislation. (Socialstyrelsen 2007, p. 2)

Local authorities have the obligation to provide service, assistance and care to elderly persons as defined in the Social Services Act and to some extent in the *Health and Medical Services Act*. The local authorities shall facilitate individuals with living at home and with being in interaction with other people through assistance at home, special transportation services and other services. The local authorities are also bound to establish forms of special housing for

elderly persons needing special support with service and care. Local authorities have according to the Social Services Act a responsibility for disabled persons, so that these integrate into society and live an ordinary life. (Statistiska centralbyrån 2009 a, p. 33)

The Act Concerning Support and Service for Persons with Certain Functional Impairments gives persons with significant and permanent functional disabilities the right to receive the assistance they need in daily life, and the right to affect which support they receive. The act gives the right to special support and services that persons may need *in addition* to the support that they receive through other legislation. (Statistiska centralbyrån 2009 a, p. 33-34)

4.4 Other Relevant Legislation

Public procurement concerns acquisitions of services and products made by the government, the county councils and the local authorities. The public procurement process is determined in the *Act on Public Procurement.* It shall involve a tender document with descriptions of the services or products to be acquired, which shall be provided to the potential service providers, who then reply with written offers. (Ekonomifakta 2010)

The provision of home help services to elderly persons is not subject to a license for private companies, in case round-the-clock housing services are not offered. However, some home help services offered to disabled persons do require a license from the service provider. The admission of licenses and the monitoring of the operations are conducted by the National Board of Health and Welfare. (Ministry of Employment and the Economy 2010 b, p. 13)

5 APPLICABLE THEORIES

As business models are cornerstones for all business operations and all companies, the theoretical review starts with frameworks and concepts related to this topic. After that the role and interconnection of a few key operational factors – productivity, efficiency, quality and innovations – is discussed from perspective of the service- and healthcare sector. And because of the strong interrelation between quality and operational success, the chapter is ended with a review of quality and its position in services, organizations and in the healthcare and care-related services sectors in Finland and Sweden.

5.1 Focusing on Business Models

Assessing companies' preconditions for conducting business implicitly means assessing their *vitality*. There are numerous different possibilities for assessing the vitality of companies, and one is to review or analyze their *business models*. Business models are according to J. Magretta *stories explaining how companies work* (Magretta 2002, p. 4). The business model describes key issues for the company, such as who the customers are, what the customers appraise, how the company generates revenues and profits, and how the company delivers value to the customers. It thereby seems appropriate that this study focuses on business models as a means to assess the vitality of private home care companies, or more precisely, to assess the preconditions for conducting private business in the four municipal service systems for home care. There are nonetheless a number of different frameworks for how to define and describe business models. A couple of generally accepted frameworks are presented next, combined with brief subjective evaluations of their pros and cons, and of their suitability for the purpose of this study.

V. Allee has outlined a framework for modeling *value networks* for organizations and business relationships therein. Here organizations and their business models are described through networks of tangible (goods, services and revenues) and intangible (knowledge and benefits) exchanges. These exchanges are critical success factors for organizations, i.e. they are all economic exchanges. The value network is in this context a web of relationships that generates tangible and intangible value through exchanges between two or several

organizations. The framework enables sketching out value network maps consisting of *representatives* (parties and roles), *deliverables* (tangible and intangible) and *transactions*/*arrows* (their location points and directions). These visual maps illustrate where and how value streams occur, and they can be extended to cover entire operations of organizations. The framework and the maps can be used for assessing the health and vitality of the value network and of the participants therein. (Allee 2002, p. 2-12). This framework is a useful tool for illustrating the operations and interrelations of knowledge-intensive organizations, such as service companies in the wellbeing sector. However, it is primarily focused on exchanges and value flows, whereas it is less frequently used *explicitly* for business modeling purposes. As the framework would require supportive approaches or tools to qualify for business modeling, it is consequently not that applicable for this study.

G. Hamel presents a framework for business models in connection with a wider framework for innovating business concepts. Here the underlying rationale is that the core of innovation is not in products, services or technologies, but in *business concepts* of companies. The business models, in turn, are formed by the individual business concepts that companies have put into effect. The business concept and the business model consists of four main building blocks; i) core strategy, ii) strategic resources, iii) customer interface and iv) value network. These building blocks are interlinked by three separate themes; a) configuration of activities, b) customer benefits, and c) company boundaries. The four building blocks and the three themes are further supported by four factors, which set the economic value potential of the organization in question. These factors are 1) efficiency, 2) uniqueness, 3) fit, and 4) profit boosters. (Hamel 2000, p. 65-71). This framework is a multidimensional and also extensive approach for sketching out business models of companies. On the other hand it is fairly complex, as it joins several concrete and abstract issues into a single wholeness. The basis for the framework is business concept innovation, where the aim is to create business models that are distinctly different from existing ones in the industry. Thereby it is perhaps not the best alternative for this study. This study is not about differentiation, it is rather about outlining and reviewing the *base* business model for companies operating in the municipal service systems.

M. W. Johnson, C. C. Christensen, and H. Kagermann have created a roadmap for assessing and developing successful business models that create and deliver value. The basis for a successful business model is that it solves certain customer problems or satisfies certain customer needs. This first element of a successful business model is thus the *customer value proposition*. The second element is the *profit formula*, which illustrates how a company creates value for itself and its customers. The profit formula encompasses i) the revenue model, ii) the cost structure, iii) the margin model and iv) the resource velocity. The third element is *key resources*, and it refers to personnel, technology, products, facilities, machinery and equipment, channels, partnerships, information and brands – those that are necessary for delivering value to the customers and the company itself. The fourth and last element of the business model is *key processes*, meaning those operational and managerial processes that enable successful value delivery, i.e. repeatable and scalable deliveries. Key processes can include e.g. processes, rules, metrics and norms. So while the customer value proposition and the profit formula specify the value being created, the key resources and the key processes illustrate how this value is delivered to the customers and to the company. The interdependency between the four elements is fundamental yet simultaneously challenging, as a shift in one element has impacts on all the others. This roadmap can be applied on existing companies and businesses, as to understand how well or poorly the business model corresponds to existing or entirely new customer value propositions, and as to know if business model changes are needed or not. (Johnson & Christensen & Kagermann 2008, p. 51-59). This framework for business models is straightforward, compact and easy to communicate. Also the customer-centric approach and the emphasis on customer value make the framework appealing. But then again it provides limited advice for the different aspects, e.g. how key resources such as people or partnerships should be assessed and dealt with, or exactly how they are interlinked with the other elements in the business model. The framework appears not to be sufficiently in-depth for providing a solid base for all separate areas and specific issues being addressed in this study.

C. Zott and R. Amit have originated a conceptual view for designing and redesigning business models. It is based on the *system of activities* performed by both companies themselves and by external parties such as suppliers, partners and customers. Interdependencies between companies and external parties need to be taken into account, given the increase in

collaboration and networking that occurs in business and economy. Activity systems capture the value created and delivered in the entire system, i.e. also that outside the companies in question. This helps companies to assess the total value of the system, together with their own share of this. Designing business models can thus be made by designing activity systems. Here there are three *design elements*; i) content (selection of activities), ii) structure (how activities are linked), and iii) governance (who performs the activities). The design of activity systems illustrates how companies conduct business, i.e. it simultaneously illustrates their business models. Activity systems can additionally be characterized by certain *design themes*, which represent the main underlying drivers for value creation in the systems, and which govern and connect the separate design elements. There are four design themes; a) novelty (adapt innovations), b) lock-in (retain stakeholders), c) complementarities (bundle activities) and d) efficiency (reduce transaction cost). Altogether the activity systems describe how companies conduct business, how they deliver value to the various stakeholders, and how they connect factor markets and product/service markets. (Zott & Amit 2010, p. 216-226). The main advantage of this framework is that it represents a comprehensive approach that covers also the network of parties outside companies, which reduces the risk of suboptimal design solutions for their own business models. But it is also highly conceptual and provides much less advice for practical implementation than it provides ideas for future theoretical development. The framework is subsequently not the best alternative for this study.

A. Osterwalder and Y. Pigneur have developed a group of concepts, methodologies and tools entirely on business models. These are presented in Business Model Generation – a guidebook for evaluating, designing and refining business models. The various frameworks on business models are based on thorough academic and empirical research, yet they are simultaneously defined and demonstrated in simple and visual formats. The separate areas dealt with have a very practical approach, as they are meant to be applied directly to real-life situations. The separate areas covered in the guidebook are; definition of business models, common types of business models, designing business models, connecting strategy with business models, and business modeling processes in practice. The basis for all the frameworks is set by the Business Model Canvas (“the Canvas”), which is a clearly defined concept and a viable tool for business modeling. (Osterwalder & Pigneur 2010). The Business Model Generation and its Business Model Canvas reflect good modularity and vast

possibilities for application in business and economy. It is therefore a natural choice for the key framework for business models in this study.

5.2 The Business Model Canvas

5.2.1 The Business Model Canvas in Brief

The Business Model Canvas constitutes a useful tool for describing and analyzing business models of companies. The Canvas consists of nine separate *building blocks*, which together illustrate the rationale of how a company generates revenues and profits. The four building blocks Customer Segments, Channels, Customer Relationships and Revenue Streams are associated with creating value for the customers. On the other hand, the four building blocks Key Resources, Key Activities, Key Partnerships and Cost Structure are associated with efficiency and costs of the company. The building block Value Propositions relates to both value and efficiency/costs. The nine building blocks are all common topics from business literature, but their selection and combination into the Canvas is the key feature of the business model tool. The Canvas can be used as a guideline for corporate development work on many levels, from determining the strategy down to executing it with structures, processes and systems in the organization. (Osterwalder et al. 2010, p. 15, 49, 227-228)

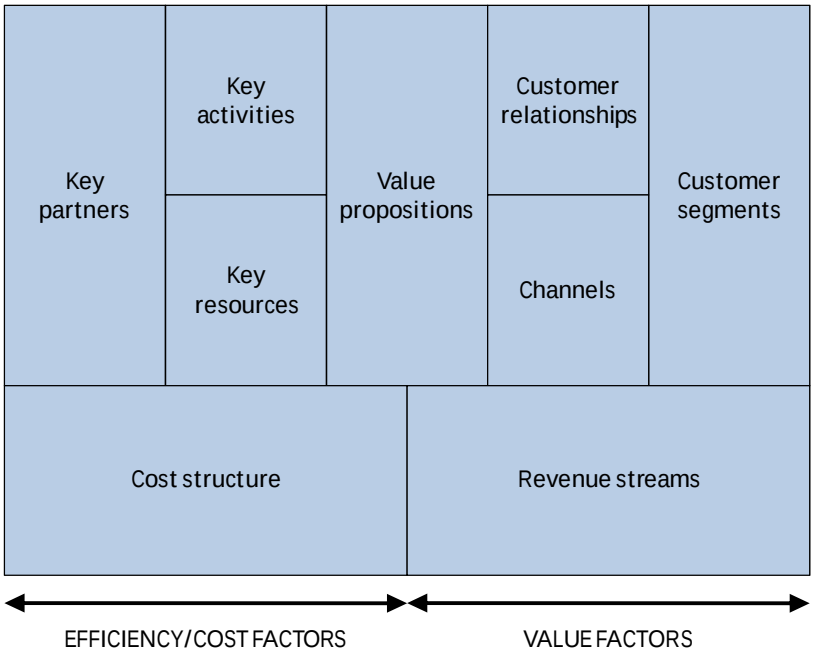

Figure 14: The Business Model Canvas (Osterwalder et al. 2010, p. 44)

A company can well operate more than one business models, in case it operates in several industries, it has a diverse offering or it serves a variety of different customer segments or geographical markets. However, according to the Business Model Generation it is not self-evident that all separate business segments require own Canvases. Similarity of the nine building blocks or synergy potential between the separate business segments speak for one uniform Canvas. Differences in the building blocks and risks of conflicts between the business segments suggest utilizing separate Canvases. (Osterwalder et al. 2010, p. 232-233)

5.2.2 The Building Blocks of the Business Model Canvas

Value Propositions

As the name suggests, Value Propositions refers to the product and/or service offering of a company. A company can by definition have one or several value propositions, where each one is being directed to a specific and predetermined customer segment. The value propositions respond to underlying customer needs, whereby they can take form in various ways. Common value proposition categories include e.g. *newness, performance, customization, "getting the job done", design, brand/status, price, cost reduction, accessibility and convenience/usability.* (Osterwalder et al. 2010, p. 22-25)

Customer Segments

According to the Business Model Canvas, Customer Segments is the component describing the parties to whom a company either offers or aims to offer its products or services. A customer segment refers to a customer group sharing certain common characteristics. A company can choose to serve one or several customer segments, but the key issue is to determine which customer segments to concentrate on and which ones to bypass. Typical customer segments are *mass market* (no customer segmentation), *niche market* (specific customer segments), *segmented* (market segments with similar characteristics), *diversified* (unrelated customer segments) and *multi-sided markets* (interdependent customer segments). (Osterwalder et al. 2010, p. 20-21)

Customer Relationships

The Business Model Canvas presents six different categories of customer relationships. These are *dedicated personal assistance, personal assistance, self-service, automated services, communities* and *co-creation.* Of these, dedicated personal assistance is the closest and most in-depth relationship, where companies typically assign key account managers for the task. (Osterwalder et al. 2010, p. 27-29)

Channels

In the Business Model Canvas -environment, Channels refer to the ways how a company communicates with and delivers products and services to its customers specified in Customer Segments. More precisely, Channels means the i) communication channels, ii) distribution channels and iii) sales channels of a company. There are two channel categories; *own channels* and *partner channels*. (Osterwalder et al. 2010, p. 26-27)

Revenue Streams

The business models determine how companies generate their revenues. Revenues of a company are formed by adding together the revenue streams for each separate customer segment. A company can thus have one or more revenue streams. Revenue streams can occur through; *asset sales, usage fees, subscription fees, lending/renting/leasing, licensing, brokerage fees* or *advertising*. The revenue streams are also linked to the pricing mechanisms, which are either *fixed* or *dynamic*. (Osterwalder et al. 2010, p. 30-33)

Key Resources

Key resources are the critical assets for the business operations of a company, and they can be split into *physical, intellectual, human* and *financial*. The key resources are usually owned, but they can also be rented or acquired from external sources. (Osterwalder et al. 2010, p. 34-35)

Key Activities

The business operations of all companies rely on certain key activities, which in turn are determined by the chosen business models and partly by the industry sector. Three categories of key activities are presented; *production, problem solving* and *platform/network*. Production

is the conventional activity where high volume and/or high quality are targeted. Problem solving calls for new and customer-specific solutions, whereby this activity is common for knowledge-intensive services. Platform/network activities are typical for companies whose business operations are built around managing platforms or networks in their control. (Osterwalder et al. 2010, p. 36-37)

Key Partnerships

Different forms of partnerships can enable or improve the business operations of companies. Partnerships can be formed in order to optimize own operations, to get access to economies of scale, to reduce exposure to risk, or to acquire some specific resources or services. The partnerships can be split into four separate categories; *strategic alliances* (between non-competitors), "*coopetition*" (between competitors), *joint ventures* (to develop new businesses), and *buyer-supplier relationships* (to assure the supply). (Osterwalder et al. 2010, p. 38-39)

Cost Structure

All components of the Business Model Canvas – starting from customer segments to revenue streams and onwards to key resources and key activities – have an impact on the cost structure of a company. The cost structures can be divided into two different categories: *cost-driven* and *value-driven*. The costs are either *fixed* or *variable*. Potential cost advantages can be the result of *economies of scale* or *economies of scope*. (Osterwalder et al. 2010, p. 40-41)

5.2.3 The Business Model Environment

No business model is detached from the specific surrounding environment of a company. Incorporating the environment into the Business Model Canvas thus enhances its value as a tool for corporate development. Major market trends such as the acceleration of the network economy, increasing uncertainty and global market chocks call for observing the environment more thoroughly. The environment may provide companies with indications for developing the business models towards new directions. Business Model Generation divides the environment into four classes: i) *market forces*, ii), *industry forces*, iii) *key trends* and iv) *macroeconomic forces*. (Osterwalder et al. 2010, p. 200)

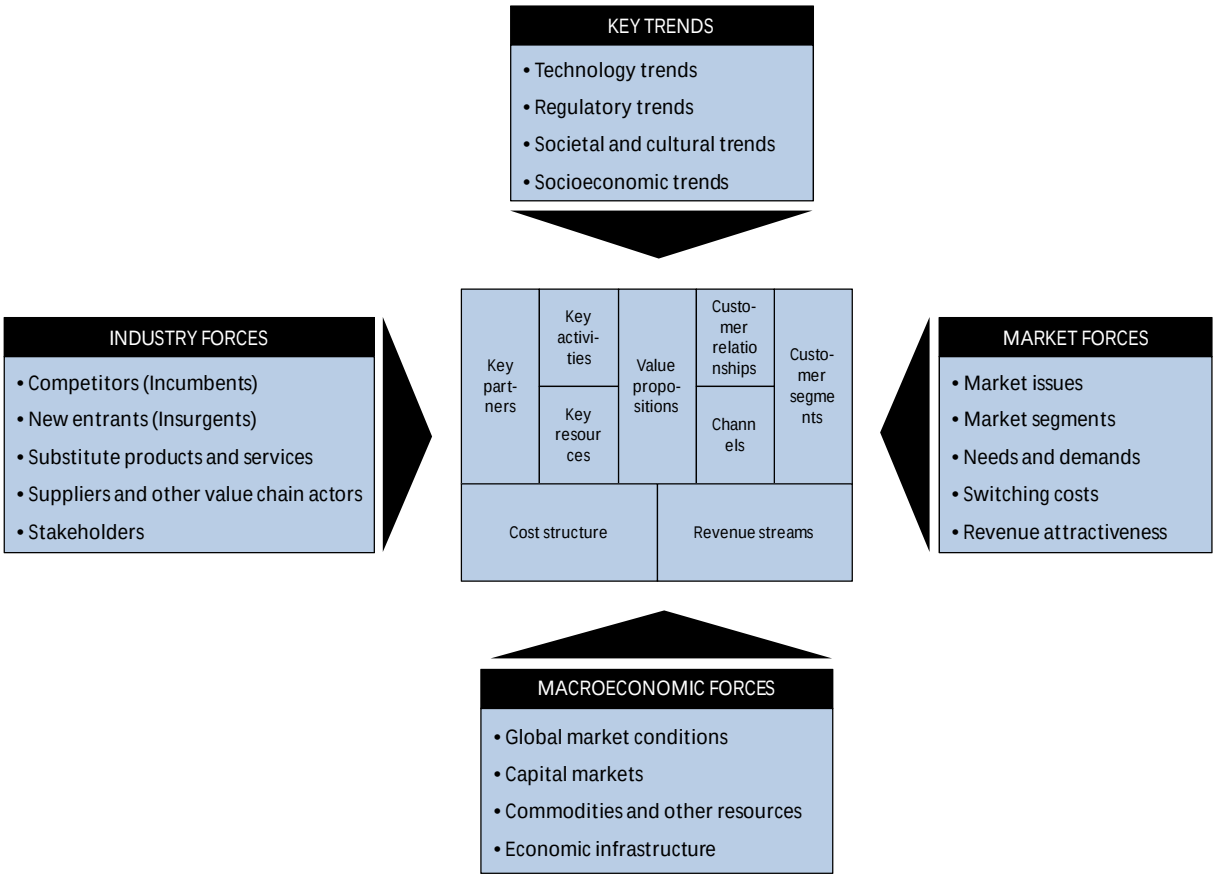

Figure 15: The Business Model Environment (Osterwalder et al. 2010, p. 200-209)

5.2.4 Evaluating Business Models

Making periodical assessments of the business model is justified for all companies, especially if the own business environment is undergoing a change. An evaluation of the business model may result in keeping it intact, making some changes or in redesigning it entirely.

There are different ways to evaluate the Business Model Canvas. The first approach is most basic. Here strengths and weaknesses of the Canvas as a whole are identified and connected to the associated building blocks. There are no rules for how many strengths or weaknesses should be identified, neither for how they should be allocated among the building blocks. The outcome gives a concise overview of the business model, but on the other hand it is not very thorough. The second approach is more analytical, as it integrates the well-known SWOT-analysis (Strengths, Weaknesses, Opportunities and Threats) into the Canvas. A comprehensive evaluation is obtained when the SWOT-analysis is projected on both the

Canvas as a whole, and on each of the nine building blocks. The outcome illustrates the internal situation of companies through strengths and weaknesses, as well as their position with respect to the environment through opportunities and threats. Expressed differently, the strengths and weaknesses illustrate the current situation of the company, while opportunities and threats can reveal paths for possible future business models. (Osterwalder et al. 2010, p. 212-224)

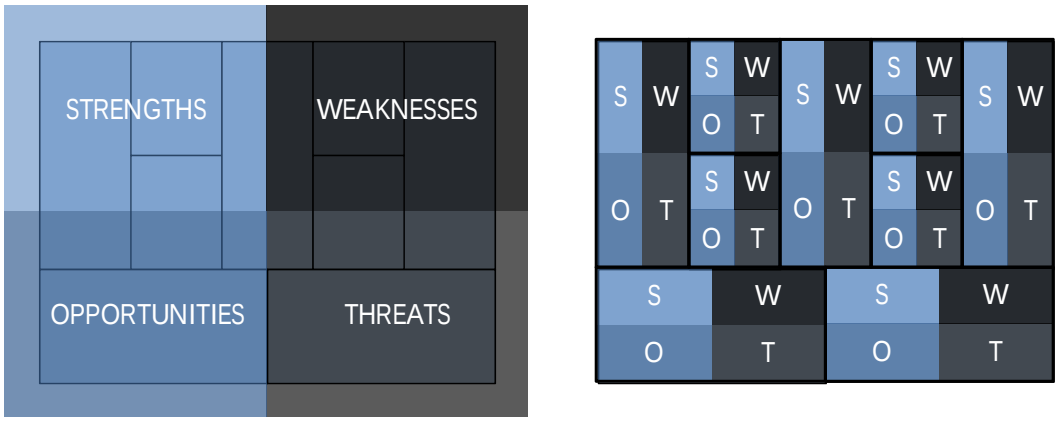

Figure 16: Evaluating the Business Model Canvas as a whole and by each building block (Osterwalder et al. 2010, p. 216)

5.3 Productivity, Efficiency, Quality and Innovations in Healthcare

Productivity refers to production results in relation to invested resources, or *output* in relation to *input*. Output is not always easy to define clearly, especially in the healthcare sector. *Efficiency* in turn is the result of efforts made. Efficiency in healthcare measures how the input factors contribute to improved health and recovery among patients. High productivity is necessary in order to achieve high efficiency, but it is not enough. Productivity has to be examined together with efficiency. While productivity measures “doing things right”, efficiency measures “doing the right things”. *Quality* arises in the area between productivity and efficiency. In industrial contexts quality improvements are regarded as productivity improvements, and this viewpoint is becoming more common in service industries as well. Quality is also a criterion for production to be efficient. Quality does, on the other hand, not make any statements about the amount of input factors needed. (Nutek 2007 c, p. 3-4)

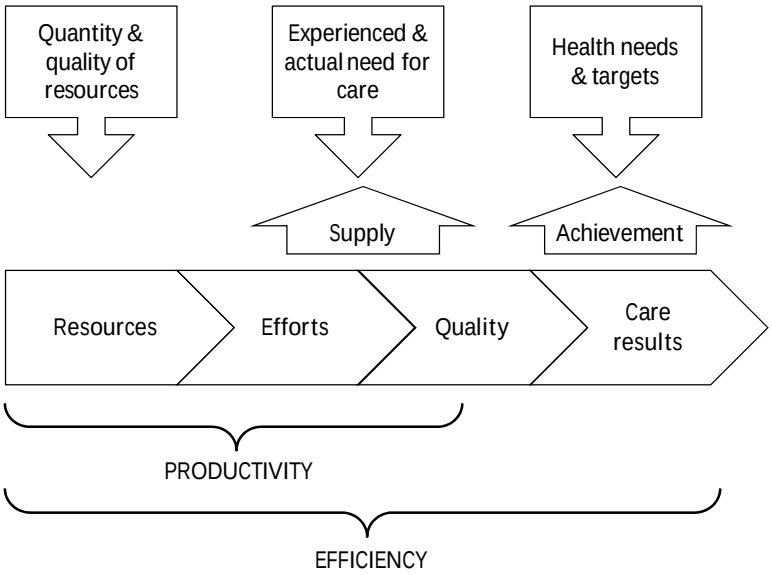

Figure 17: The roles of productivity and efficiency in the production of healthcare services (Nutek 2007 c, p. 5)

Service companies such as healthcare organizations are often characterized by low productivity. One reason for this is high labor-intensiveness of the companies, which makes is difficult to automate the operations. (Nutek 2007 c, p. 5-6)

Innovations are one possibility for improving operational productivity and efficiency. The innovations within healthcare can be divided into *medical* (such as a new medicine for dementia), *technical* (such as robotic lifting) or *organizational* (such as care chains) categories (Nutek 2008 a, p. 22). Traditionally the innovations in healthcare and care-related services have been of medical nature, such as more effective medicines or better treatment coming from advances in medical science. Many innovations are of technical nature, whereby new technology generates lower costs or higher quality for the services. Social or organizational innovations have been more popular in recent years. One example of this kind of innovation is the integration of the customers (service users) into the production of the services, or *service co-production*, which also leads to increased customer involvement. (Nutek 2007 c, p. 17-19)

The implementation of information- and communication technologies within healthcare and care-related social services constitutes technical innovation. Such technical solutions that enable people needing care to live longer at home, are believed to offer potential for

improving the operational efficiency. Solutions for managing digital patient journals are also ranked highly. (Nutek 2008 c, p. 23)

A Swedish study on innovations in the healthcare sector concluded that a significant share of innovations originate at low levels. What the personnel of healthcare organizations do during working hours, and how these activities are structured and managed, is crucial for stimulating origination of innovations. The most important innovation types are still those of organizational character, and these are typically the primary solution for significant reductions in unit costs within healthcare. Organizational innovations free resources, which enables a quicker access to treatment for a larger amount of patients – at a higher level of service quality. The quality effect here is due to improved throughput of patients and shorter lead times. (Nutek 2008 a, p. 1-2; 46-47)

A main problem in healthcare is the lack of integrated functions and the existence so-called gatekeeper functions, which lead to unnecessary controls of and actions for the patients. Another challenge is the poor co-operation and communication between different parties in the healthcare network. The outcomes of these disadvantages are inefficient utilization of resources and lowered quality. A possible solution for overcoming these problems in healthcare and – including care-related services – is to incorporate both *process* and *patient perspectives* through the implementation of predetermined service production lines. These so-called *service chains* or *treatment chains* are an example of an organizational innovation. (Nutek 2008 a, p. 28). And developing healthcare services from perspective of the patients can improve the service provision starting already from the designing phase of the service. The service provision typically offers large potential for better utilization of resources, and for higher quality. (Nutek 2008 a, p. 46-47)

The *standardization* of the most common activities within healthcare is another way of empowering the organization and steering and monitoring of the business. This is also referred to as establishing a so-called *best practice* for a certain medical treatment, an activity or a service process. In particular the best practices for medical treatments evolve over time in parallel with the evolvement of medical science. The standardization of other activities and functions in the organization is of course beneficial as well. (Nutek 2008 a, p. 58, 79)

In healthcare and care-related services the patients and service end users act as combined consumers and co-producers of the services. Thereby all parties involved – the organization and the patients and service end users – benefit from service processes of high productivity and efficiency. Active participation by the patients and service end users is in many cases a necessity for the treatments to be successful. Discontent or uninformed patients and service end users contribute to a lower efficiency for the treatments and services. Involving the patients and service end users as active co-producers is a central theme for the modern service models. In the traditional service models the patients and service end users have had a more passive role. As a result the traditional operational measures "*service results*" and "*service costs*" within healthcare and care-related services are now increasingly being complemented by "*end user experiences*" and "*service availability*". The co-production of healthcare and care-related services also increases the importance of *customer-orientation* or *customer perspective* in the design and provision of services. (Nutek 2007 c, p. 27-28).

5.4 The Concept of Quality

The previous section pointed out that quality is an inseparable and simultaneously fundamental element of healthcare operations and service operations overall. Good quality is a requirement for increasing the efficiency of the operations, and also for improving the effectiveness, i.e. the treatment- and care results. Quality issues are thus of great interest among both service producers and service users. Also the large amount of legislation, regulation and recommendations demonstrate the importance of quality in healthcare and social services. Against this background it is justified to present some applicable concepts and frameworks for quality as to prepare for the case studies.

5.4.1 Quality of Services

As services are generally produced and consumed simultaneously, *service quality* is experienced during the service delivery process. The service delivery is seen as a *moment of truth*, as customers at this point compare the perceived services against their expectations of the services. A generally accepted view on service quality is that it consists of five dimensions; *reliability*, *responsiveness*, *assurance*, *empathy* and *tangibles*. These dimensions

are adopted by customers when they compare actual outcomes against their expectations. Service quality is the gap between the outcome and the expectation of a service, and it ranges from unacceptable quality to quality surprise. (Fitzsimmons et al. 2006, p. 128-129). A somewhat broader view on service quality prevails for service systems. This approach divides service quality into five segments being *content*, *process*, *structure*, *outcome* and *impact*. This approach applies well for e.g. healthcare services, where the service quality impact extends from the patient itself to family/friends and to the community. (Fitzsimmons et al. 2006, p. 133-136).

Service quality is complex and difficult to define unambiguously, whereby also the assessment of service quality is challenging. Service quality is further affected by consequences reaching beyond the service delivery. One example is healthcare services where the impacts tend to occur with a lag. A number of different measures and tools have been developed for assessing service quality, such as SERVQUAL, which tracks customer satisfaction in accordance with the above-mentioned service quality gap model and its five service dimensions. SERVQUAL is usually utilized in the form of regular customer surveys for measuring trends in service quality, although it can be utilized for other quality measuring as well. (Fitzsimmons et al. 2006, p. 131-133)

Quality in healthcare, care and social services can be split into two dimensions; i) profession-based quality and ii) individual-based quality. Healthcare services are typically more affected by profession-based quality and less by individual-based quality. This is due to higher importance of science and professional competence in the treatment. Care and social services on the opposite is typically more affected by individual-based quality and less by profession-based quality. Care and social services is by nature more personal and mental, and they span over the entire service provision, whereby the individual’s subjective perception of quality becomes more important. This also means that the concept of quality in terms of definition and measuring is less clear within care and social services than within healthcare. (Nutek 2008 d, p. 26)

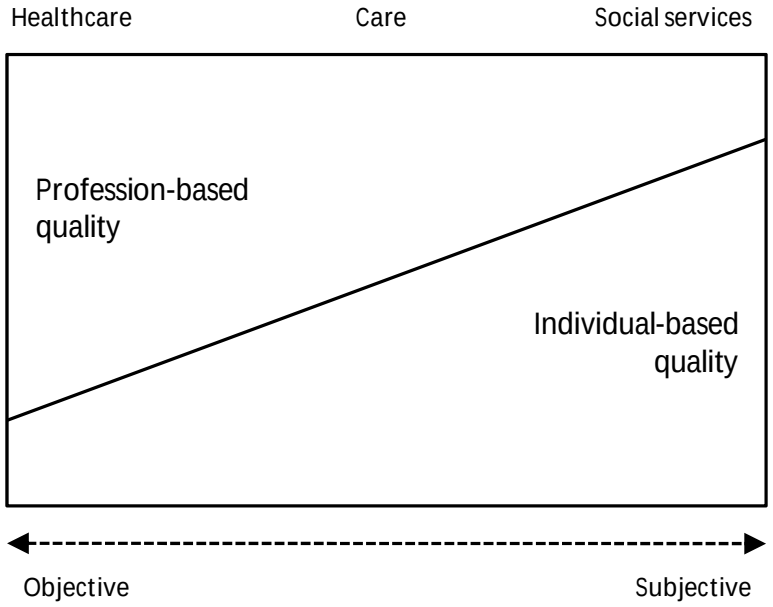

Figure 18: Quality dimensions within healthcare, care and social services (Nutek 2008 d, p. 26)

5.4.2 Quality Processes and Quality Systems

While the narrow view on service quality limits to specific services and their delivery processes, the broad view extends to entire service systems and further to nearly all corporate activities. Quality can be included already in the design of a service system, whereby it appears not only in customer contact situations, but also in supporting services, associated goods and supporting facilities (*Taguchi method).* Also simple mechanisms, such as checklists or manual procedures integrated into the service processes to prevent employees or customers from making mistakes (*Poka-Yoke methods*), are effective. A popular tool for quality in service design is the *quality function deployment (QFD)*, where products and services are designed based on customer preferences and needs. (Fitzsimmons et al. 2006, p. 136-142)

Quality issues among companies are seen as an ongoing development process. The incorporation of quality can start with single services and simple rules and gradually proceed to entire service systems and complex tools. The service quality ladder illustrates how quality concepts in companies can evolve from basic to more advanced levels. (Fitzsimmons et al. 2006, p. 157-158)

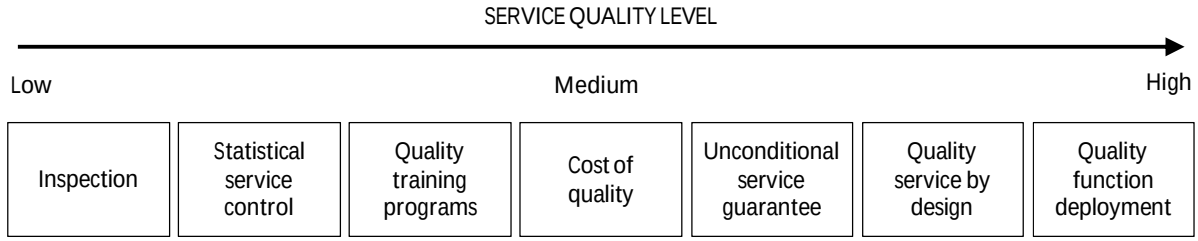

Figure 19: The service quality ladder (Fitzsimmons et al. 2006, p. 158)

Once problems related to quality have been identified, corrective actions can be taken through quality improvement programs that prevent or prepare for bad quality. Different kinds of *personnel programs* are applied for this purpose, with emphasis on e.g. training, standardization of performance or human resources planning. One of the best-known *programs for quality control* is the *ISO 9000* series of quality management system standards. The primary task of ISO 9000 is to guarantee a consistent quality of output. ISO 9000 does not specify practical measures, nor does it make any statements about the end product or end service. The focus of ISO 9000 is on the planning activities, the monitoring activities for consistent performance and on the proper documentation of activities. *Six Sigma* in turn is a method for improving quality by decreasing the variation for any given process outcome within a company. According to Six Sigma the actual outcomes of a process should always be less than or equal to six standard deviations of the targeted outcome. (Fitzsimmons et al. 2006, p. 180-187) Leading service companies have advanced from aiming for good quality at desired levels onwards to emphasizing *continuous improvement* (CI) in terms of quality and productivity. Continuous improvement is an ongoing process that affects the entire company, and its three cornerstones are i) customer satisfaction, ii) management by facts and iii) respect for people. (Fitzsimmons et al. 2006, p. 173-180)

5.4.3 The Benefits of Quality

Good customer service and high customer satisfaction are important elements for all companies, and they create one path towards high quality. This is valid in particular for service companies. High service quality is in turn associated with profits for companies. The underlying rationale is that good service performance increases customer satisfaction, which in turn raises customer retention, and this improves the market share (revenues) and thereby

also the profits. However, this classical but simplified view on the relation between quality and profits excludes that quality improvements raise companies' profits also for other reasons. Other reasons are for instance i) cost reductions due to higher efficiency, ii) new customers resulting from positive word-of mouth, and iii) companies' possibilities to set higher prices. (Metters, King-Metters & Pullman & Walton 2006, p. 190-193)

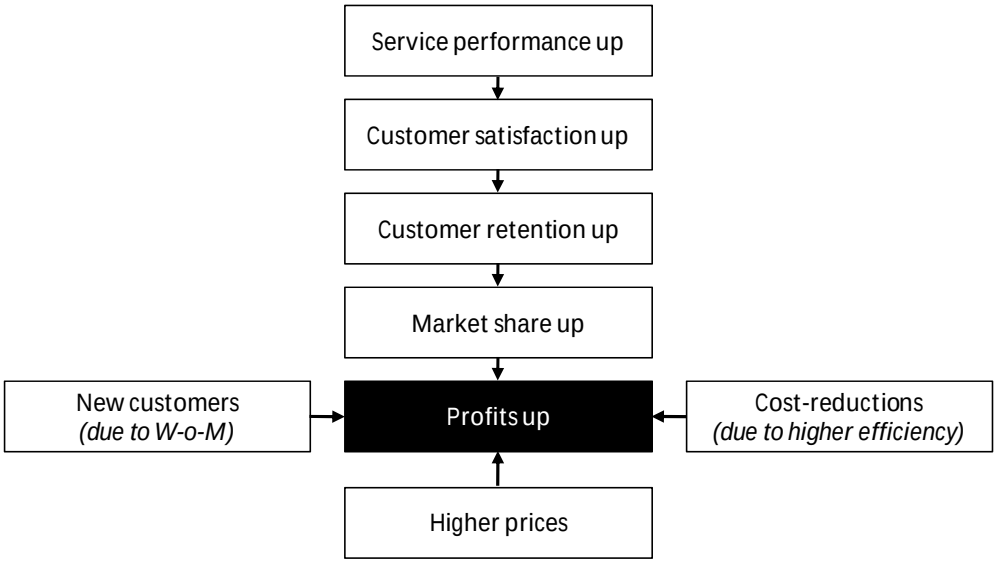

Figure 20: Impacts of high/improving service quality on profits (Metters et al. 2006, p. 190-193)

The relation between internal quality and company results can also be presented by the *service-profit chain*, which is another view on the impacts of high quality. The service-profit chain claims that companies achieve sales growth accompanied by profitability by managing their service processes successfully. Growth and profitability arise from customer loyalty, which in turn comes from customer satisfaction. Customer satisfaction is directly linked to the value of the services offered. Service value is a result of employees that are satisfied, loyal and consequently productive. Employee satisfaction is largely the consequence of high quality within the internal processes and the systems for supporting and delivering services to the customers. Internal quality forms the basis for operational success among service companies, according to this view. (Heskett, J. L., Jones, T. O., Loweman, G. W., Sasser, J. W. E, Schlesinger, L. A. 2008, p. 118-123).

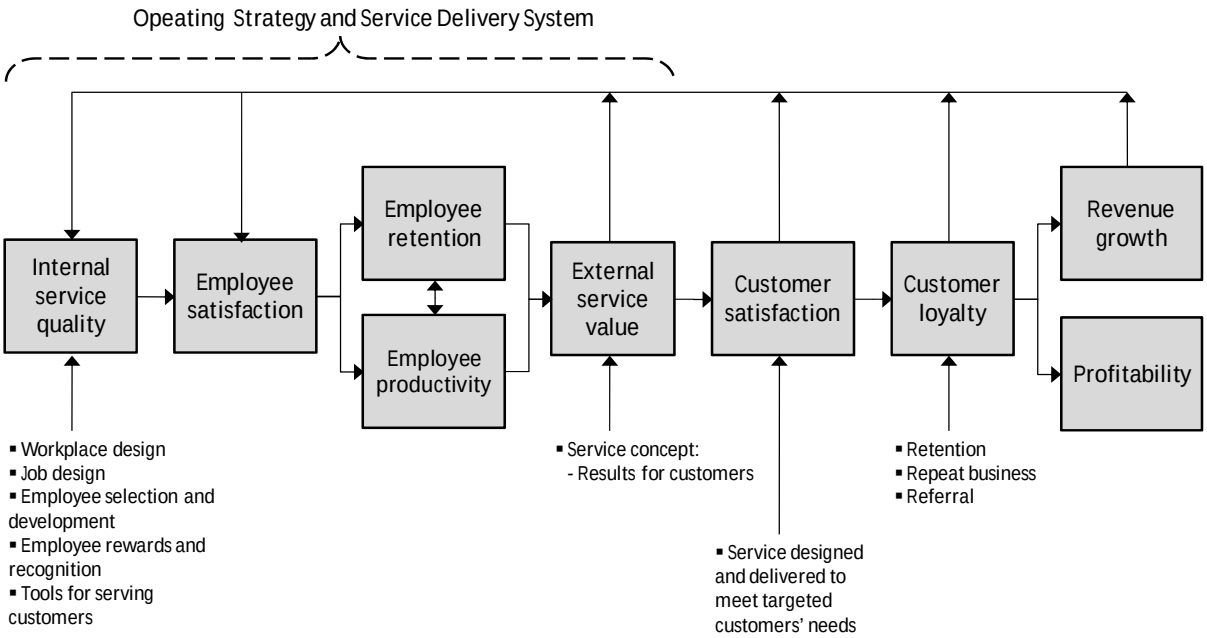

Figure 21: Linking internal quality to sales growth and profitability in the service-profit chain (Heskett et al. 2008, p. 120)

The impacts of high service quality or improving service quality do in practice vary among companies. The impacts on customers and revenues are positive, but the direct impacts on investments and costs tend to be negative at least in the short term. Companies' efforts in quality can pay off only if the customers *experience* that the service quality has improved. And also, the impacts of good or improving service quality should not be assessed solely as an isolated event. According to empirical studies it seems that in the long term the most important quality aspect for companies is how their quality performs in relation to their competitors. (Metters et al. 2006, p. 193-194)

5.4.4 The Costs of Quality

The general perception of quality costs and their contents has evolved over time. Previously the costs of quality were limited to the costs of the quality department plus a share of the R&D department, as well as to scrap costs and warranty cost. Nowadays the quality costs have been expanded to cover also i) the costs related to quality management systems and over their entire lifetime, ii) the costs associated with processes for continuous improvement, and also to iii) the direct and indirect costs due to failures or shortcomings of systems, processes, products and services. Costs of quality thus emerge from a large number of different activities

across the whole organization. The costs that relate to quality do typically constitute 5 - 25% of an organization's yearly revenues or costs, depending on the industry and the organization itself. The vast majority of the quality costs result from appraisal and failure, and these costs can often be reduced by eliminating or diminishing the causes of failures. Working with quality costs is in practice difficult for a couple of reasons. The main challenges relate to the definition of what items the quality costs comprise, to the identification and measuring of the quality costs, and to the allocation of quality costs to the right unit, function or product/service within the organization. (Dale 1999, p. 139-141)

One generally accepted theoretical framework for the cost of quality is to divide it into three categories; i) cost of prevention, ii) cost of detection/appraisal, and to iii) cost of failure. The framework is intended to identify and categorize quality components, so as to minimize the total costs of quality. The costs of prevention arise in organizations in their activities for minimizing the amounts and costs of defective products and services. Investments in physical, intangible and human resources (including know-how and skills), and also costs from quality programs, belong to this category. The costs of detection/appraisal are those that originate from testing and inspection of products and services produced by organizations. The costs of failure arise from defect products and services, and they can be divided into internal and external. The internal failure costs are those that emerge inside the organizations before the defect products and services are delivered to the customers, e.g. from scrap and rework. The external failure costs are those that are discovered outside the organizations, i.e. for the direct and indirect costs of defect products and services having been delivered to the customers. This cost category includes e.g. warranties, returned products/items, lawsuits, and lost goodwill and brand value. (Davis and Heineke 2005, p. 280-281)

Efforts and costs related to prevention can in fact generate notable drops in the costs of detection/appraisal and in the costs of failure, and thereby lower the total cost of quality. According to the strategy pioneer W. E. Deming the total cost of quality can be lowered by making the underlying processes better, because not only does this reduce the amount of defect products or services, it also reduces the costs of prevention and the costs of detection/appraisal. This differs from the traditional perception of total cost of quality,

according to which the total cost of quality increases – in particular the appraisal costs – when quality is improved. (Davis and Heineke 2005, p. 281-282)

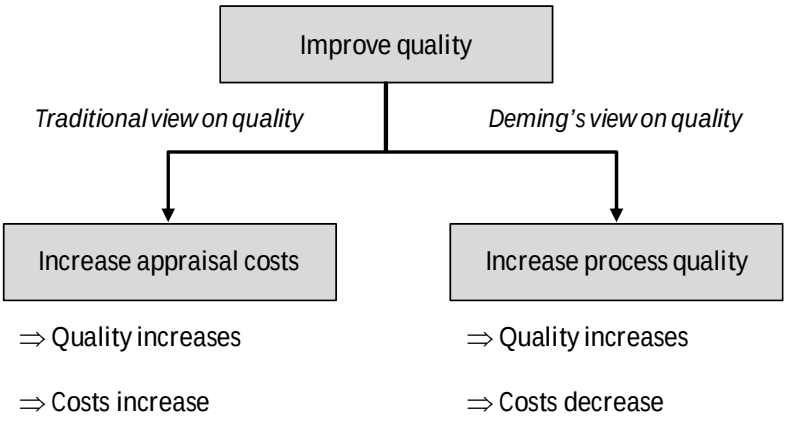

Figure 22: Two alternative views on of the cost of improved quality (Davis et al. 2005, p. 281-282)

The aforementioned brief discussion on the cost of quality can also be presented through two designated but alternative theoretical frameworks; i) a *traditional framework* and ii) a *quality improvement framework*. According to the traditional framework organizations that improve overall quality face declining failure costs but rising costs of prevention and appraisal, and they try to optimize (minimize) the total cost of quality between these. The point with the lowest cost of quality constitutes the "acceptable quality level" for organizations, and this point lies somewhere between 0-100% of defect products or services. According to the quality improvement framework the elimination of the main cause for defect products or services will lower the cost of prevention and appraisal when overall quality improves. The rationale here is that organizations should always aim for improved quality or even perfect quality (0% defect products or services), as this will result in a lower total cost of quality. (Metters et al. 2006, p. 222-223). The quality improvement framework and its view on decreasing cost of quality are connected to the Six Sigma -philosophy, i.e. to structured attempts for significant reductions in process variation (Harry and Schroeder 1999). The traditional framework has been criticized for having many weaknesses. One critical argument is that the customer requirements should determine the quality level instead of the optimal quality costs. This is because optimization of quality costs easily compromises total quality management (TQM) and overall quality improvement within organizations – which may be opposite to the customer aspirations. (Dale 1999, p. 154-155)

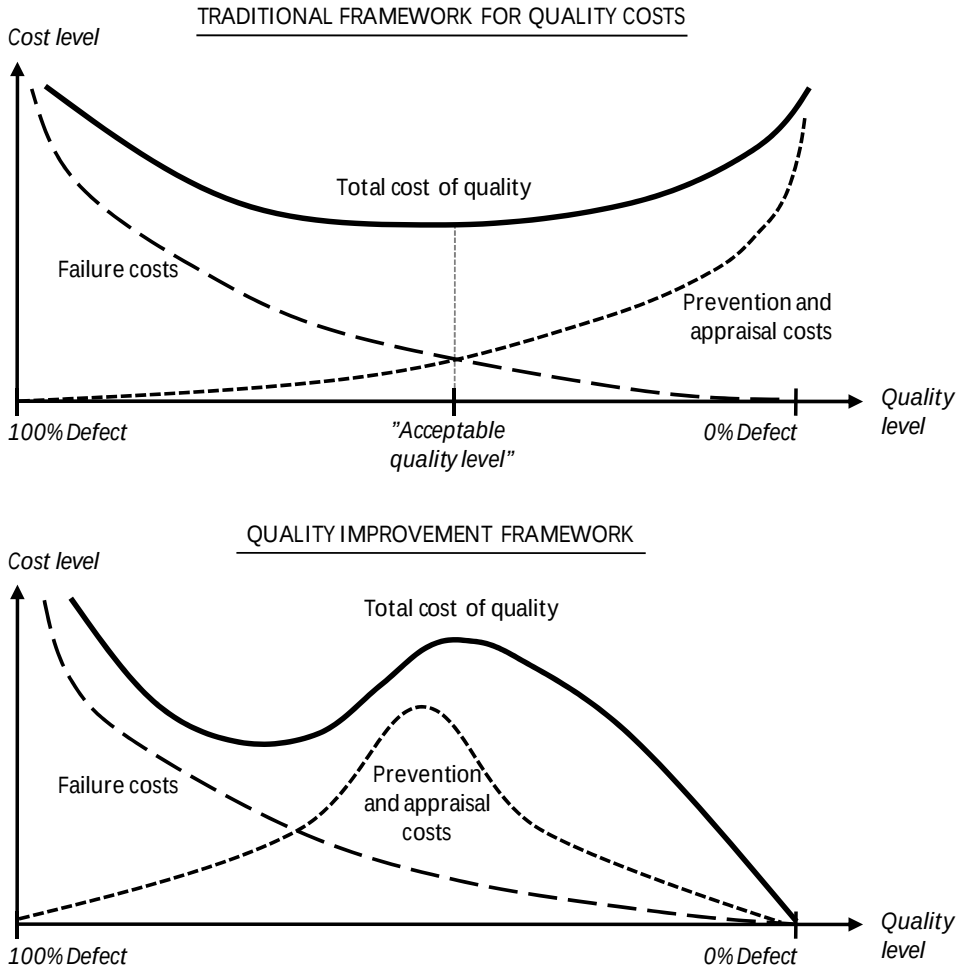

Figure 23: Two alternative theoretical frameworks for the total cost of quality (Metters et al. 2006, p. 222-223)

5.4.5 Quality in Healthcare and Care-Related Services in Finland

The quality of healthcare and social services produced by local authorities in Finland has tended not to be specified in detail. The public sector has therefore created a large amount of *national quality recommendations* to be used by local authorities, e.g. quality recommendations relating to services for the elderly and to mental health services. These quality recommendations are widely accepted as benchmarks measures, despite that they are *not* legally binding. The quality of services acquired from private companies has to be on the same level as the corresponding public services. (Ministry of Social Affairs and Health 2006, p. 17). The basis for the quality recommendations is to fulfill the needs of the service users. At the same time the quality recommendations should unify the service production, leading to equivalent services on a national level. (Raunio 2008, p. 35)

In Finland the Ministry of Social Affairs and Health together with the Association of Finnish Local and Regional Authorities determine the quality levels within healthcare and care-related services. According to the official definition quality implies the ability to systematically respond to customer service needs i) effectively, ii) by obeying regulations, and iii) cost-effectively. The quality criteria are associated with a) structural factors, b) process factors and c) results. Structural factors ensure the preconditions for the operations, such as personnel amount or management principles. Process factors relate to the entire service process from the beginning to the end. Result factors give indications about reaching the targets set, such as whether the treatment of a patient was effective or not. (Sosiaali- ja terveysministeriö 2008, p. 51)

One of the most important quality statements concerning home care in Finland is the National Framework for High-Quality Services for Elderly Persons. It is a quality *recommendation*, not a compulsory quality standard, to be applied by actors of both the public sector and the private sector. The aim of the quality recommendation is to promote the health and wellbeing of elderly persons and to improve the quality and effectiveness of the services provided. The quality recommendation is set on a national level, based on which local authorities are able to determine quality targets for their respective regions. The quality recommendations are on the whole mostly general with only few quantifiable targets. The quality recommendation includes indicators relating to the required amount of personnel, the qualification of the personnel including the management, and to the environment for living and treatment. (Sosiaali- ja terveysministeriö 2008, p. 3-4)

In the official quality recommendation for Finland, the following is stated regarding elderly persons receiving home care services: *"Good home care is proactive. It is based on a comprehensive assessment of the client's functional capacity and reacts rapidly to changes in their health and capabilities. Good home care promotes rehabilitation and responds to the client's physical, cognitive, mental and social rehabilitation needs. A rehabilitative approach means encouraging and helping clients to use their existing personal resources in their everyday life. The rehabilitation that aims to support older people to live at home emphasizes community- and outpatient services, e.g. those forms of rehabilitation that can be provided at*

home.”. In addition to these statements, a number of other targets are pointed out for the end users receiving home care services. (Sosiaali- ja terveysministeriö 2008, p. 27-28):

The Finnish quality recommendation for services for the elderly also emphasizes that qualitative and effective services require well-functioning service chains. Supporting elderly persons with living at home calls for a joint service view where the social services, primary care, specialized care and other parties producing services function and co-operate seamlessly. (Sosiaali- ja terveysministeriö 2008, p. 30). The quality recommendation also pinpoints customer-orientation as a key component of good care and service. It states that organizations providing services to elderly persons shall be customer-oriented in their operations, meaning that i) the needs of the customers receiving services (service end users) are in the center, and that ii) the customers participate in the planning, implementation and assessing the effects of the services. (Sosiaali- ja terveysministeriö 2008, p. 49)

Personnel requirements is another key area brought forth in the Finnish quality recommendation for services for the elderly. The basis for the staffing is the functionality and the need for help of the service end user. Personnel qualifications need to comply with the associated legislation, and the know-how of the personnel may have to be secured through complementary training. All employees working *directly with the wellbeing* of end users should have a vocational education in social welfare and/or healthcare, as well as know-how in gerontology. Management personnel of service producers need to be sufficient in amount, and professional in skills. Moreover, the work welfare and work safety of personnel employed by service producers has to be promoted. (Sosiaali- ja terveysministeriö 2008, p. 32).

5.4.6 Quality in Healthcare and Care-Related Services in Sweden

Quality in healthcare, care and social services in Sweden is a multidisciplinary theme that is defined in different ways and determined on several levels. Local authorities and county councils refer to several sources of quality when they arrange, produce, acquire and monitor wellbeing services being on their responsibility. Quality requirements can be divided into four separate categories reflecting their origin and character; i) legislation and regulations, ii) other

national steering documents, iii) local/regional steering documents, and iv) other quality criteria. (Nutek 2008 d, p. 16)

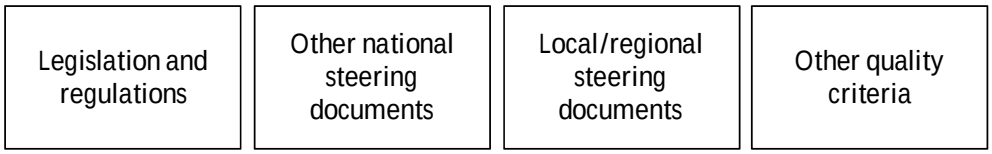

Figure 24: Categorization of quality requirements in healthcare, care and social services in Sweden (Nutek 2008 d, p. 16)

The Health and Medical Services Act and the Social Services Act both contain requirements for quality – e.g. how quality shall be maintained, secured and developed. These quality requirements also concern the provision of services, such as personnel competence, co-operation and documentation. A significant share of all regulations is issued by the National Board of Health and Welfare. The laws and regulations are usually not very detailed on quality or quality performance. The quality requirements in laws and regulations apply to both public sector actors and private sector actors, e.g. to private companies producing wellbeing services. Local/regional steering documents include quality requirements of varying kinds and amounts. These documents can contain elements from political statements, elderly plans, value statements or care programs – which have links to quality and thus determine a large part of all quality requirements for the regional or local level. The last category, other quality criteria, can be split into i) comprehensive quality targets and ii) specific quality targets. The comprehensive quality targets are often very general and contain subjective elements that are difficult to specify explicitly, e.g. respect for personal integrity. The specific quality targets vary a great deal and there are also differences between services, such as between healthcare and social services. They can also e.g. be compulsory requirements, or so-called “must-be requirements”, which service producers have to meet to be able to operate and provide services in a certain municipality. (Nutek 2008 d, p. 16-19)

The National Board of Health and Welfare has developed national-level guidelines for healthcare services provided in Sweden, as a means to ensure service quality and thereby patient security. The aim is to provide “Good Care”, and this is achieved when six separate goals or preconditions are met. The goals are based on existing and relevant healthcare legislation. The goals for Good Care within healthcare are; i) patient-focused care, ii)

healthcare within reasonable time, iii) safe healthcare, iv) knowledge-based and appropriate healthcare, v) equal healthcare and vi) efficient healthcare. (Socialstyrelsen 2011 a, p. 16-17, 198)

Apart from healthcare services also social services have their own quality guidelines, as defined by the National Board of Health and Welfare. Care and home help services belong to this category. Applicable laws and regulations form the basis for the guidelines that are meant to ensure "Good Quality" for social services, and they apply to both public and private actors. For social services Good Quality implies that; i) the efforts are built on respect for the autonomy and integrity of human beings, ii) the efforts are based on an entire view, iii) they are coordinated and characterized by continuity, iv) the efforts are knowledge-based and efficiently provided, v) the efforts are available and distributed according to demand, and that vi) public activities are characterized by law and order. In social services Good Quality also involves the establishment and maintenance of quality systems as to ensure and develop systematic quality work within the operations on an ongoing basis. The central themes within the systematic quality work are; a) guaranteeing of quality for social services, b) availability, c) cooperation, d) handling and documentation, e) faults and shortcomings in the operations, f) feedback and complaints on the operations, g) personnel- and competence maintenance, h) maintenance of products and services, and i) monitoring and evaluation of the operations. (Socialstyrelsen 2010, p. 13-21)

The basis for quality requirements for care (elderly care) is set by the Social Services Act, together with other legislation, regulations and general guidelines issued by the National Board of Health and Welfare. According to the Social Services Act all social services and thereby also elderly care shall be of good quality, and this is divided into three quality themes. First, all employees shall have knowhow and experience for the duties and for improving quality. Second, the operations shall be organized appropriately. And third, the quality of the operations shall be secured and developed systematically and on a continuous basis. The regulations and guidelines on management systems for systematic quality work have a reaffirming impact on the quality development activities, and they commit all employees to quality monitoring. There are also regulations and guidelines for the surveillance of quality. Employees are bound to report both abuses and risks of abuses in the operations, and these

obligations support also the quality development. Moreover there are regulations and guidelines stating that healthcare employees shall report to the employers in case patients become injured or sick during the medical examination or treatment. (Socialstyrelsen 2012 b, p. 124-125)

There are several different quality indicators in use within healthcare and social services in Sweden. Not only are there several different quality indicators across services and for different purposes, there are also parallel and thereby overlapping quality indicators upheld by different institutes. Additionally there appears to be differences in the monitoring and reporting of quality in healthcare and social services between different regions, but also between public and private actors. The entire field of quality indicators in Sweden is undergoing a development process, so the situation is by no means static. The National Board of Health and Welfare has developed and currently upholds a large number of national-level quality indicators, especially for healthcare services. It also reports so-called “open comparisons” for different services, where the indicators are presented for multiple municipalities or regions for comparison purposes. A key priority of the open comparisons is that they shall also reflect the service user perspective, which means utilization of uniform customer surveys. Also the Swedish Association of Local Authorities and Regions collects and reports several quality indicators on municipal, regional and national levels, and these include open comparisons as well. It also upholds National Quality Registries for health and medical services, and these registries contain patient data and treatment data. Also some of the county councils gather and report quality data for comparison and other purposes. (Vårdföretagarna 2008, p. 4; 11-14)

The National Board of Health and Welfare collects and reports quality indicators for home help services once a year for each municipality in Sweden. A customer satisfaction index, or “Satisfied-Customer-Index”, is the key indicator, and this is received for each municipality through feedback collected from elderly persons aged 65 years or more. The feedback is formed by a couple of questions that relate to the themes “responsiveness”, “influence”, “information” and “security”. The separate answers as well as the aggregated Satisfied-Customer-Index can vary between 0 and 100, where higher outcomes reflect higher satisfaction. The Satisfied-Customer-Index expresses the aggregated satisfaction with the

home help services. In 2011 it consisted of three sub-questions that measured i) the satisfaction with the services received, ii) how well the services correspond to the expectations, and iii) how close or far the received services are with respect to perfect home help services. The Satisfied-Customer-Index is also being criticized. One problem is that it expresses satisfaction rather than dissatisfaction. Also, it is not certain that customer satisfaction or the index reflects the actual quality of the services. Other drawbacks are the indexation, the potential inconsistencies and the interpretation of the outcomes. Most municipalities regularly conduct their own customer satisfaction surveys for the home help services in their areas, and the methodologies and questions can be either similar to or different from that of the Satisfied-Customer-Index. (Socialstyrelsen 2011 b, p. 14-15)

6 HOME CARE SERVICE SYSTEMS OF THE CASE-MUNICIPALITIES

6.1 Lahti – Finland

6.1.1 Key Facts about Lahti

With close to 102,000 inhabitants in 2010 Lahti is the eighth largest city in Finland. However, a land area of only 135 square kilometers makes Lahti one of the smallest municipalities in the country – ranking 318 of all 336 municipalities. Consequently Lahti has a relatively high population density with only seven Finnish municipalities being more concentrated. The population density is very high in the city area, but it is fairly high also in the remaining areas and districts. In 2010 some 1,400 inhabitants, implying 11 persons per square kilometer, were reported as customers of statutory home care. (Lahti 2011, web-pages; Lahti 2012 a, p. 25-26)

Table 8: Population and geographical issues in Lahti (Lahti 2011, web-pages; Lahti 2012 a, p. 25-26)

Region in Lahti municipality	Population *(inhabitants)*	*%*	Area *(km2)*	*%*	Population density *(inhabitants/km2)*
City area	20 570	*20 %*	5,0	*4 %*	4 114
Rest of municipality	81 020	*80 %*	129,9	*96 %*	624
Lahti municipality total	101 590		134,9		753
- of which home care customers *	1 411	*1,4 %*			10,5

** = 2011 figures.*

Since 2008 the customer base within statutory home care has diminished significantly. End customer amounts have declined slightly within regular home care, but drastically within temporary home care. The decline in end customer amounts within regular home care has been compensated by higher amounts of service hours per end customer, resulting in a modest growth in total amounts of service hours. The impact of the drop in temporary home care on the entire home care market is limited due to its low amount of service hours (on average 2-3 hours) per customer. 128 persons, or 9% of all those who receive regular home care, were served by private service producers in 2011. Until autumn 2010 the municipal producer, i.e. City of Lahti and its affiliates, produced all regular home care in Lahti. Temporary home care

customers, on the contrary, have in past years almost entirely been directed to private producers. In addition to the regular and temporary home care, the municipal producer has each year provided several hundreds of persons with different types of support services related to the home. This group of support services includes a meal service, a shopping service, a sauna service and a safety phone and alarm service. (Lahti 2011, web-pages; Lahti 2011 a, p. 9; Lahti 2012 a, p. 25-26)

Table 9: Key figures for home care in Lahti (Lahti 2011, web-pages; Lahti 2011 a, p. 9; Lahti 2012 a, p. 25-26)

	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
Municipal and private home care :	# of end customers:				# of service visits/month:*				# of service visits/month/person:			
Elderly persons (65 years or more)	1 266	1 290	1 199	1 238								
Other persons (0-64 years)	155	115	109	112								
Total regular home care	*1 421*	*1 405*	*1 308*	*1 350*	*30,1*	*30,3*	*32,3*	*33,7*	*21,2*	*21,6*	*24,7*	*24,9*
-of which private company customers	*-*	*-*	*62*	*128*	*-*	*-*	*n.a.*	*n.a.*	*-*	*-*	*n.a.*	*n.a.*
Yearly change (%)		*-1 %*	*-7 %*	*3 %*		*1 %*	*7 %*	*4 %*				
	# of end customers:				# of service visits/month:*				# of service visits/person:			
Temporary home care **	727	213	144	61	0,1	0,1	0,0	0,0	1,8	2,8	3,1	2,3
Total regular + temporary home care	2 148	1 618	1 452	1 411	30,2	30,4	32,4	33,7				
Yearly change (%)		*-25 %*	*-10 %*	*-3 %*		*0 %*	*7 %*	*4 %*				
Other municipal home services:	# of end customers:				# of service visits/month:*				# of service visits/month/person:			
Meal service	632	640	584	428	5,4	5,8	5,4	5,0	8,6	9,1	9,3	11,8
Shopping service	470	462	421	343	1,0	0,9	0,9	0,8	2,2	2,0	2,2	2,3
Sauna service	56	74	51	42	0,1	0,1	0,1	0,0	2,3	1,4	1,6	1,2
Safety phone/alarm service	762	833	785	801	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total other municipal home services	1 920	2 009	1 841	1 614	6,6	6,8	6,4	5,9	3,4	3,4	3,5	3,6
Yearly change (%)		*5 %*	*-8 %*	*-12 %*		*4 %*	*-6 %*	*-8 %*		*-1 %*	*2 %*	*5 %*

** = Montly amounts of service visits given in 1000s. ** = Temporary home care is dominantly produced by private companies.*

6.1.2 The Service System

City of Lahti has adopted service voucher systems for different healthcare services and social services gradually through a number of development projects. Service vouchers were taken into use within temporary home care in 2004 and within support for informal care in 2007 (Lahti 2009 a, p. 1-3). The service voucher system was extended to regular home care in September 2010 (Lahti 2011 b, p. 8).

Entering the service voucher system for home care services in Lahti is possible on a continuous basis throughout the year. The home care services include *both* home help services and home nursing as these are defined by national legislation. Potential service producers need to fulfill a number of criteria determined by the City of Lahti. Information about the

service producers is presented at City of Lahti social services offices and on an Internet-based service portal named PalveluSantra (www.palvelusantra.info). The service vouchers can be used *only* for home care services equaling those offered and produced by City of Lahti itself. And vice versa, service producers need to *fully meet* the services offered and produced by City of Lahti, which may mean serving end customers also during evenings and weekends. (Lahti 2010 a, p. 1-2)

For a citizen, utilizing the service voucher system requires a service needs assessment and a service- and care plan prepared by the City of Lahti. The related documents contain the service content, the number of home visits, the time of the day and the average time (hours) for the services. The home care services granted to a citizen and produced by a service producer can be either i) *temporary* or ii) *regular* and valid until further notice. A citizen can then choose between the municipal service producer and the qualified service producers in the service voucher system. A citizen choosing the latter alternative is provided with service vouchers for the services specified in the plan. The citizen and the service producer then make a mutual and written contract describing e.g. service fees, liabilities and duties. The contract is subject to civil laws and the Consumer Protection Act. The citizen provides documents on the municipal decisions on the service voucher and its value to the chosen service producer. The service producer charges City of Lahti and possibly also the citizen and for the services provided. The customer is able to switch service producer by cancelling a valid service contract. The service needs assessment for a citizen is made by City of Lahti social service officers on a regular basis and also if service needs change. (Lahti 2010 a, p. 1-2)

The service producers themselves determine the prices they charge the home care services they offer. The values of the service vouchers are determined by City of Lahti, and they vary for different services. If the price of a privately produced service is above the value of the corresponding service voucher, then the service producer charges the end customer (citizen) for the difference. The service producers charge City of Lahti for the collected service vouchers afterwards once a month. (Lahti 2010 a, p. 3)

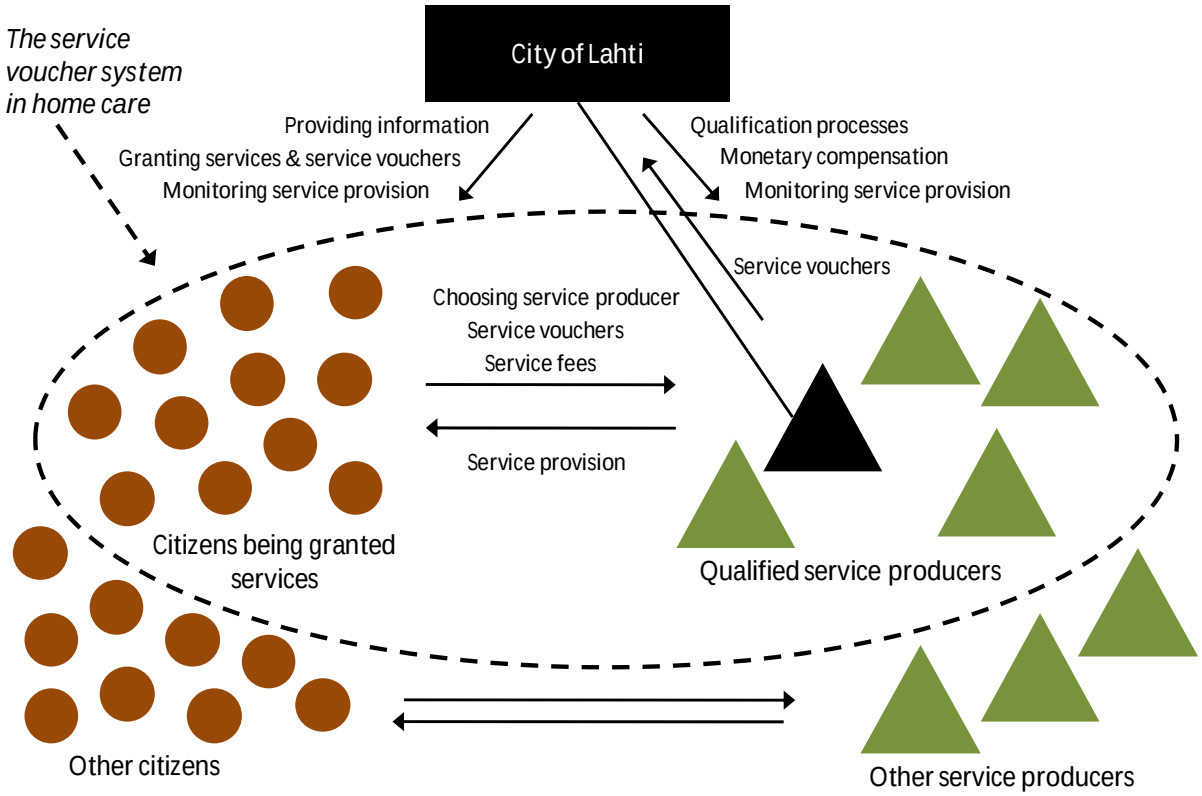

Figure 25: A simplified overview of the service voucher system for home care in Lahti

6.1.3 Overview of the Service Producers

In November 2011 the service voucher system for home care in Lahti comprised 15 qualified service producers. City of Lahti dominates the home care activities, and it is by far the largest service producer in the area with its nearly 300 home care employees. The amount of home care personnel in Lahti among the service producers is not reported publicly. What is publicly known and displayed in this study is the total personnel of the service producers reflecting *all activities* in *all areas*, of which home care and Lahti area may be only a part. The largest service producers in terms of total employees (including group- and parent companies) either offer a broader range of healthcare and care services (e.g. Mainio Vire Oy, Harjulan Settlementti Oy and Dila Diakonissalaitos Lahti), or then they operate in several locations across the country (e.g. Mainio Vire Oy, Kotipalvelu Klassikko and Akson Group Oy). On the other hand, approximately half of the service producers are small micro-firms concentrating on home care and other domestic services only in the Lahti region. The group of service producers is altogether quite varied. Apart from different sizes, among the service producers

there is also a mixture of private companies and NGOs, as well as a mixture of local and non-local entities. (PalveluSantra 2011, web-pages)

Table 10: Key facts on qualified service producers within home care in Lahti, as of November 2011 (PalveluSantra 2011, web-pages; Lahti 2011, web-pages)

	City of Lahti	Mainio Vire Oy, Vire Koti Puntari	Harjulan Settlementti ry	Dila Diakonialaitos Lahti	Kotipalvelu Klassikko	Päijät-Hämeen Hoitopalvelut Oy (part of Akson Group Oy)	Kotipalvelu Eija Bouras Ky	Lahden Lähimmäispalvelu ry	ArkiAurinko Oy	Kotihoitopalvelu Tippalita ky	Lääkäriasema Alfa Oy	Palvelukauppa KodinOnni Oy	Lahden Asukasyhdistys ry	Lähimmäispalvelu Helmi Ky	Kotipalvelu Riikka Hartikainen	Si-Ku Tmi
Non-profit organisation (NGO)	-	-	X	X	-	-	-	X	-	-	-	-	X	-	-	-
Company hometown in Lahti	X	-	X	X	-	-	-	X	X	X	-	-	X	-	X	X
Amount of operating facilities	5	39	3	15	45	24	1	1	1	1	1	3	1	1	1	1
Personnel (includes employees also in other activities and areas)	284	882	221	220	100	n.a.	16	10-20	3	2	1-4	1-4	1-4	n.a.	1	1
Regular and temporary home care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Only temporary home care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Home help services																
Mon-Fri 07:00-18:00	-	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-
Mon-Fri 07:00-22:00	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-
Mon-Fri + Sat/Sat-Sun	-	-	X	X	X	X	X	X	-	X	-	X	X	-	X	X
Mon-Sun 24 h/day	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night care	-	-	-	X	-	-	X	-	-	X	-	-	-	X	-	-
Service subcontracting (acquired)	-	-	-	-	X	-	-	X	X	-	-	-	X	X	X	-
Home nursing																
Mon-Fri 07:00-18:00	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mon-Fri 07:00-22:00	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mon-Fri + Sat/Sat-Sun	-	-	X	X	-	X	X	-	-	X	X	X	-	-	-	X
Mon-Sun 24 h/day	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Night care	-	-	-	X	-	-	-	-	-	X	X	-	-	-	-	-
Informal care (replacements)	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Additional services																
House cleaning	-	-	-	-	X	X	X	X	-	X	X	X	X	X	-	-
Transporation services	-	X	-	-	-	-	-	-	X	X	-	-	-	X	X	-
Own laundry services	-	-	X	-	-	-	X	-	-	-	-	-	-	-	-	-
Other services	-	-	X	-	-	X	X	X	-	-	X	X	-	X	-	-

In terms of service offering it is apparent that all service producers offer both regular and temporary home care, i.e. no one offers solely temporary home care. Although there is variety in the working hours regarding home help services, the majority of the service producers offer it on both weekdays and weekends, and both daytime and evenings. Some also offer night care. Six companies – both mid-sized and small ones – do not produce the home nursing

themselves, but they offer it through a partner in the same service voucher system. Home nursing is usually offered during the same hours as care and services. Nearly all service producers also offer support for informal care, i.e. they occasionally replace persons caring family members or relatives. Cleaning is the most common additional service that is offered to end customers on a voluntary basis, it is offered by over half of the service producers. Transportation of the end customer is also fairly common, as well as other services such as garden work, snowplowing, and repairing work. (PalveluSantra 2011, web-pages)

6.1.4 Home Care in Relation to Other Services

A large variety of wellbeing services related to home care are offered to elderly persons and war veterans in Lahti. City of Lahti accounts for a large proportion of the total service production, but many services have been opened up for competition. Service voucher systems are becoming more popular among the services that are privatized, and they typically comprehend both companies and NGOs as service producers. Home care, which consists of home nursing and home help services, has a key position in the serving of elderly persons. On the other hand, home care plays only a minor role in welfare services for disabled persons. Disabled persons are rather offered informal care (support for informal care) and personal assistance (support for personal assistance), which are close substitutes to home care. Among welfare services for families with children the role of home care is very limited. Home care is only a marginal service for this customer segment. Moreover, this home care is primarily produced by City of Lahti, while private service producers are only allocated with the short-term customer relationships. (Lahti 2012, web-pages). In the following sections wellbeing services related to home care are described separately for elderly persons and for disabled persons. However, a service analysis is not made for the customer segment families with children.

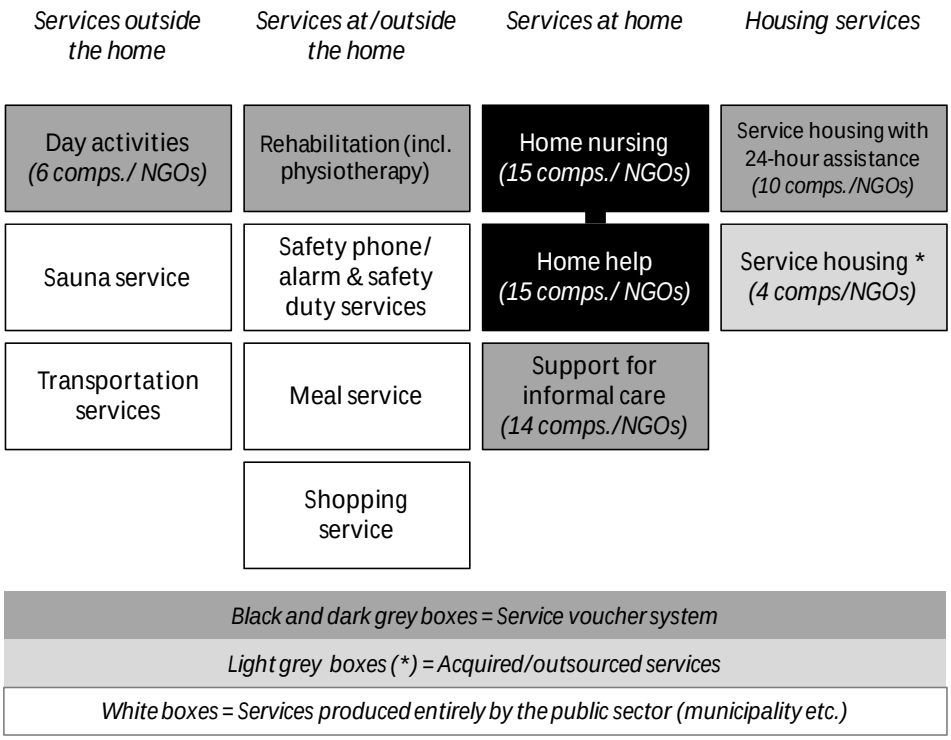

Figure 26: Wellbeing-services for elderly persons including war veterans in Lahti (Lahti 2011, web-pages)

Support for informal care is in Lahti the main alternative to home care for elderly persons and war veterans. This service has its own service voucher system with 14 companies – nearly all of the 15 companies offering home care. In addition there is a service voucher system for rehabilitation services including physiotherapy, but no service producers have entered into it yet. Day activities, a complement to services at home, is subject to an own service voucher system. Day activities is offered by three companies and three NGOs, three of which also operate in home care. City of Lahti has concentrated the production of certain services connected to home care – the safety phone/alarm service, the meal service and the shopping service – to itself. Also the sauna service and the transportation services for elderly persons are produced by the City, but taxi services are to some extent acquired externally. Housing services are widely outsourced to companies and NGOs, and a service voucher system is applied to service housing with 24-hour assistance. City of Lahti also acquires some additional service housing from two companies and two NGOs. Out of all ten producers of housing services in Lahti, only two (Dila Diakonialaitos Lahti and Mainio Vire) offer home care as well. (Lahti 2011, web-pages)

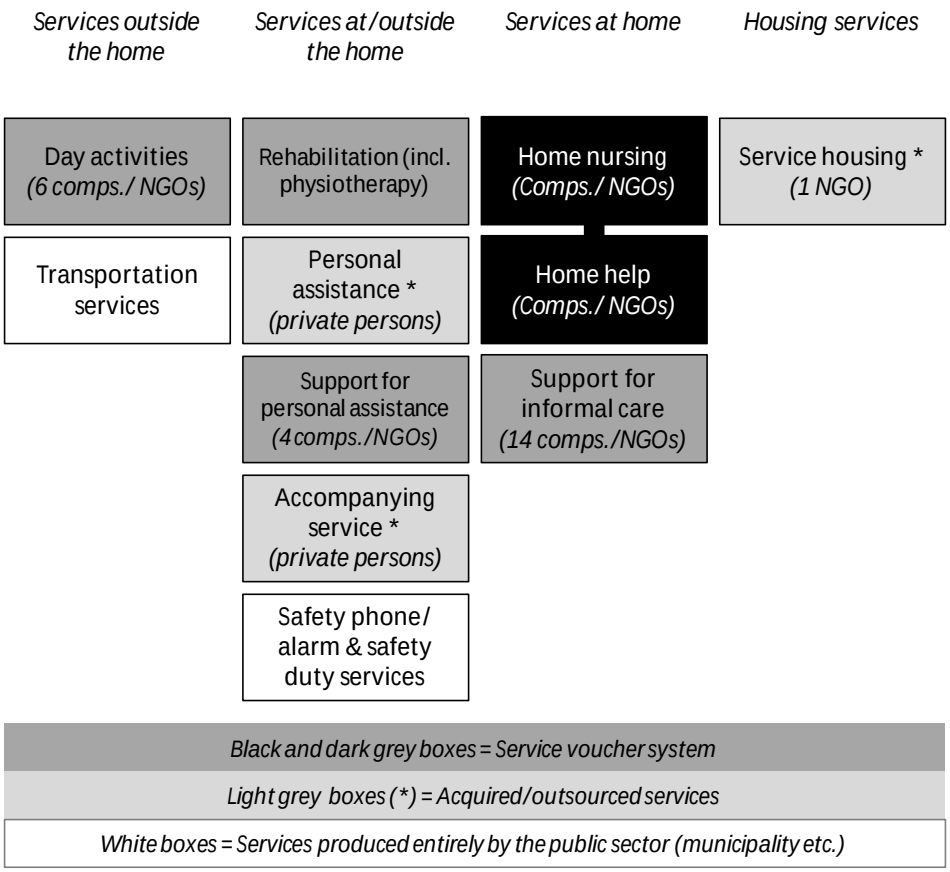

Figure 27: Wellbeing-services for disabled persons in Lahti (Lahti 2011, web-pages)

Disabled persons in Lahti are offered a number of wellbeing services, most of which occur either at home or in connection with the home. The service production is both municipal and private, but there are differences between services. The private services are mainly arranged through service voucher systems. The service voucher system for home care to elderly persons is also enabled for disabled persons, but its role and popularity is marginal. The amount of home care companies that serve this customer segment as well is apparently limited. Disabled persons are more often offered home care in an indirect form, through a service named support for personal assistance. This means temporary replacements of personal assistants for disabled persons, where the replacers then provide home care services. The service has an own service voucher system. Support for personal assistance is offered by four companies, three of which also operate in the service system for home care. Support for informal care and daily activities are produced by the same service producers that offer it to elderly persons. Personal assistance and accompanying services, in turn, are mostly arranged through direct employments of private persons. The safety alarm/phone services and the

transportation services are carried out by City of Lahti, with help from local taxi companies. Different types of service housing for disabled persons are arranged and offered in co-operation between City of Lahti and a nationwide NGO. (Lahti 2011, web-pages)

6.1.5 Terms and Conditions for Service Producers

The main requirements, duties, boundaries and available options for service producers in the service system in Lahti have been gathered and shifted to Appendix 1A. The main requirements that relate to *quality-issues* (for service producers in the service system) have been separated, and they are presented jointly in Appendix 1B.

6.1.6 Quality Issues

Quality issues can be discovered in the guidelines and qualification lists for home care producers in Lahti. City of Lahti has specified a number of different requirements for the purpose of ensuring a sufficient quality for the operations. However, quality is not visible in the service portal PalveluSantra, which means that end customers are not able to compare quality aspects for the services or operations of the service producers. Neither does City of Lahti conduct any regular and systematic customer satisfaction surveys regarding the activities of the service producers. In order to get an understanding of quality, end customers thus need to make acquaintances with web-pages or service brochures of separate service producers. (PalveluSantra 2011, web-pages)

6.2 Hyvinkää – Finland

6.2.1 Key Facts about Hyvinkää

Hyvinkää is a mid-sized city with a population of approximately 45,000 persons in 2010. This entitles to a 23rd position amongst all cities and municipalities in Finland. In terms of land area, 323 square kilometers, Hyvinkää is relatively small with a ranking of 269 out of 336. The population density is clearly higher in the city area than it is in the other less populated districts. More than 1,000 inhabitants, equivalent to over 2 persons per square kilometers, received statutory home care in 2011. (Hyvinkää 2011, web-pages; Hyvinkää 2012 a, data file)

Table 11: Population and geographical issues in Hyvinkää (Hyvinkää 2011, web-pages; Hyvinkää 2012 a, data file)

Region in Hyvinkää municipality	Population *(inhabitants)*	*%*	Area *(km2)*	*%*	Population density *(inhabitants/km2)*
City area	14 556	*32 %*	20,0	*6 %*	728
Rest of municipality	30 933	*68 %*	303,2	*94 %*	102
Hyvinkää municipality total	45 489		323,2		141
- of which home care customers *	1 044	*2,3 %*			3,2

** = 2011 figures.*

The statutory home care produced and provided municipally (by City of Hyvinkää) has remained quite stable in recent years, with end customer amounts of over 600 for regular home care and over 400 for temporary home care. Elderly persons aged 65 and more constitute nearly 90% of all end customers within regular home care. Within temporary home care around 90% of all end customers in 2011 were those receiving home nursing, while only 10% were those receiving home help services. When comparing aggregated volumes of service visits, it becomes evident that regular home care accounts for over 95% and temporary home care for less than 5%. Differences in the amounts of service visits per end customer appear when comparing the three types of home care services. End customers of regular home care received in 2011 on average 21 visits per month per person. Within temporary home nursing end customers received in 2011 on average 10 visits per person, whereas within temporary home help services the average was as much as 28 visits per person. (Hyvinkää 2011, web-pages: Hyvinkää 2012 a, data file)

Table 12: Key figures for home care in Hyvinkää (Hyvinkää 2011, web-pages; Hyvinkää 2012 a, data file)

	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
Municipal home care :	# of end customers:				# of service visits/month:*				# of service visits/month/person:			
Elderly persons (65 years or more)	562	544	553	567								
Other persons (0-64 years)	71	74	66	67								
*Total regular home care ***	*633*	*618*	*619*	*634*	*12,9*	*12,4*	*13,5*	*13,4*	*20,3*	*20,1*	*21,8*	*21,1*
Yearly change (%)		*-2 %*	*0 %*	*2 %*		*-3 %*	*9 %*	*-1 %*		*-1 %*	*8 %*	*-3 %*
	# of end customers:				# of service visits/month:*				# of service visits/person:			
Temporary home nursing	347	334	285	368	0,3	0,2	0,2	0,3	9,9	8,3	7,4	10,3
Temporary home help services	90	121	121	42	0,1	0,3	0,2	0,1	19,2	25,3	17,8	28,3
Total temporary home care	*437*	*455*	*406*	*410*	*0,4*	*0,5*	*0,4*	*0,4*	*11,9*	*12,8*	*10,5*	*12,1*
Yearly change (%)		*4 %*	*-11 %*	*1 %*		*12 %*	*-27 %*	*17 %*		*8 %*	*-18 %*	*16 %*
Total regular + temporary home care	1 070	1 073	1 025	1 044	13,3	12,9	13,8	13,8				
Yearly change (%)		*0 %*	*-4 %*	*2 %*		*-3 %*	*7 %*	*0 %*				

** = Montly amounts of service hours given in 1000s. ** = Includes war veterans.*

Also data on the amounts of end customers and service times for the privatized home care (the service voucher systems) was made available for the study. The data revealed that the amounts of end customers served by private companies have been and are still small, totaling less than 40 persons in 2011. The amount of end customers for home care services has actually been smaller than that for support for informal care. It also seems that the service hours per month per person have been clearly lower for home care services (3 hours/month/person) than for support for informal care (17 hours/month/person). The numbers presented herein are outcomes of own data processing, and they are more indicative than absolute facts.

Table 13: Key figures for the privatized market for home care in Hyvinkää (Hyvinkää 2011 h)

	2009	2010	2011*	2009	2010	2011
Private home care :	# of end customers:			# of service hours/month/person:		
Light regular home care	-	-	5	-	-	3
Temporary home care	< 5	< 5	12	n.a.	n.a.	3
Support for informal care (as home care)	18	27	19	14	20	17
Total home care + support for informal care	< 23	< 32	36			

** = January-October 2011.*

6.2.2 The Service System

In Hyvinkää systems for service vouchers have been in use since 2008. Service vouchers were then initiated within temporary home care and within support for informal care. In April 2011 service vouchers were taken into use within light regular home care and within long-term service housing with 24-hour assistance – as new areas of application. (Hyvinkää 2011 i, p. 2-16)

The service voucher system for home care in Hyvinkää is similar to that in Lahti. Home care services include both home help services and home nursing in the forms defined by national legislation. Home help services and home nursing are in fact also the service forms offered to end customers who receive support for informal care. Applicants fulfilling all predetermined conditions and criteria set by City of Hyvinkää become qualified service voucher producers. Apart from approved application forms, no separate service contracts are made between the service producers and City of Hyvinkää. A list of the approved service producers and their offering is available at web-pages and at social services offices of City of Hyvinkää. There is no dedicated web-based portal for wellbeing-services being subject to service voucher systems in the Hyvinkää area. The content and scope of the home care of service producers shall be at least on the same level as that produced by City of Hyvinkää or an appointed caregiving person. It should be pointed out that qualified home care service producers are bound to offer two varieties of home care; i) temporary home care and ii) light regular home care, whereas iii) support for informal care (replacements) is optional. (Hyvinkää 2011 a, p. 1-8). Service producers are able to enter the service voucher system for home care services throughout the year (Hyvinkää 2011 b, p. 1).

The service needs assessment and granting of statutory home care for a citizen is made by a social service officer of City of Hyvinkää. The officer makes a care and service plan together with the citizen and/or a representative of him or her. This plan specifies the contents, visit amounts, times of the day and average time of the prescribed services. Service vouchers are provided only to those citizens, who are capable of making decisions about the service producers independently, or together with a family member or relative. A citizen, who prefers a service voucher over the municipal home care, can independently choose its service producer among the qualified ones. The service vouchers are earmarked, as they can only be

used for such care and services specified in the individual care and service plans. And also, the service vouchers can only be used for home care services equaling those offered and produced by City of Hyvinkää itself. City of Hyvinkää decides the values of the service vouchers for each type of home care service. When a citizen has chosen its service producer, the two parties make an agreement on the content and price of the services to be provided. The service producer can price its services above, at par or below the values of the associated home care services. The service contract specifies the duties and responsibilities of the two parties. For short-term services the service contract are often verbal. The contract is subject to civil laws and the Consumer Protection Act. A citizen is able to cancel a valid service contract as well as switch to another service producer. The service producer collects the service voucher and charges the citizen for the possible price difference, i.e. if the service price exceeds the value of the voucher. The service producer also charges City of Hyvinkää for utilized service vouchers, afterwards on a monthly basis. Service vouchers are tax-free benefits for the citizens. (Hyvinkää 2011 b, p. 1-6)

Figure 25, which illustrates the service voucher system for home care services in Lahti, is applicable for Hyvinkää as well.

6.2.3 Overview of the Service Producers

Four service producers were part of the service voucher system for home care in November 2011. Their share of the service production is small, as City of Hyvinkää accounts for the vast majority of the home care in the area. City of Hyvinkää has around 150 employees in home care, while the equivalent amount only reaches up to some tens for the service producers. All service producers are small and mostly local private companies. One of the service producers is a small NGO. Two of the operators, Palveluneliöt Oy and Hyvinkään yksityinen kotipalvelu-sairaanhoito, have chosen to produce both home help services and home nursing. The two others, Jety Oy and Uudenmaan Tukipalvelut Oy, offer only home help services. None of the four service producers offer any kind of service housing. Palveluneliöt Oy and Uudenmaan Tukipalvelut Oy offer property management services in addition to home care. The largest operator Jety Oy also offers a variety of cleaning services, while the smallest one, Hyvinkään yksityinen kotipalvelu-sairaanhoito, offers no additional services. So most service

producers do offer additional services to the statutory home care, but there are some variations in the focus areas chosen. (Hyvinkää 2011, web-pages; company web-pages)

Table 14: Key facts on qualified service producers within home care in Hyvinkää, as of November 2011 (Hyvinkää 2011, web-pages; company web-pages)

	City of Hyvinkää	Jety Oy	Palveluneliö Oy	Uudenmaan Tukipalvelut Oy	Hyvinkään yksityinen kotipalvelu-kotisairaanhoito
Non-profit organisation (NGO)	-	-	-	X	-
Company hometown in Hyvinkää	X	X	-	X	X
Amount of operating facilities	4	1	1	1	1
Personnel (includes employees also in other activities and areas)	150	30	10	7	1
Temporary + light regular home care	X	X	X	X	X
Support for informal care	X	X	X	X	X
Home help services	X	X	X	X	X
Home nursing	X	-	X	-	X
Night care	X	-	-	-	-
Service times					
Mon-Fri 07:00-18:00	-	n.a.	n.a.	n.a.	n.a.
Mon-Sun 07:00-22:00	X	n.a.	n.a.	n.a.	n.a.
Mon-Sun 22:00-07:00 (Night care)	X	-	n.a.	-	n.a.
Related (service voucher) services					
Short-term service housing	X	-	-	-	-
Long-term service housing	X	-	-	-	-
Additional services					
House cleaning	-	X	-	X	-
Running errands	-	X	X	X	-
Transporation services	-	-	X	-	-
Other services	-	X	X	X	-

6.2.4 Home Care in Relation to Other Services

In Hyvinkää there is a very broad range of wellbeing services offered to elderly persons, including war invalids. The breadth of services ranges from those offered outside home,

onwards to those provided to/at home, unto those provided in service houses or in care institutions. Although City of Hyvinkää is a significant service producer in some of the services, most of them have been opened to competition. The majority of these are directly acquired from or outsourced to external service providers. Service voucher systems apply to home care, support for informal care and to service housing with 24-hour assistance. Both companies and NGOs act as service producers in the municipality. Also disabled persons in Hyvinkää are offered with multiple wellbeing services, where home care is one alternative. Particularly NGOs but also private companies are well represented in this segment, with acquired or outsourced services being the most popular solution. Home care for families with children is offered but only marginally, and City of Hyvinkää produces all these services itself. (Hyvinkää 2011, web-pages). In the following sections wellbeing services related to home care in Hyvinkää are described separately for elderly persons and for disabled persons.

Services outside the home	*Services at/outside the home*	*Services at home*	*Housing services*	*Institutional care services*
Day activities * *(7 NGOs)*	Rehabilitation (incl. physio-therapy)	Intensified home care	Service housing with 24-hour assistance * *(4 companies)*	Short-term care
Bathing service	Safety phone/ alarm & safety duty services *	Home nursing *(2 comps./ NGOs)*	Service housing with 24-hour assistance *(4 companies)*	Demobilization services (from institutional care)
Transportation services * *(bus + taxi companies)*	Meal service *	Home help *(4 comps./ NGOs)*	Support for informal care: SH *(4 companies)*	
	Cleaning services for poor persons *	Support for informal care: HC *(5 companies)*	Group homes	
	Laundry services *	Home care for war invalids *		

Light grey boxes (*) = Acquired/outsourced services | *Black and dark grey boxes = Service voucher system*

White boxes = Services produced entirely by the public sector (municipality etc.)

Figure 28: Wellbeing-services for elderly persons and war invalids in Hyvinkää (Hyvinkää 2011, web-pages)

For elderly persons City of Hyvinkää produces all intensified home care, rehabilitation and all services within institutional care (short-term care and demobilization services) – i.e. medical-

oriented wellbeing services that enable living at home. The City is also a significant producer of different housing services and the only provider of group homes. Nonetheless, private companies are overall quite well represented both in home care and in service housing for elderly persons. Home care and support for informal care in the form of home care are in separate service voucher systems, although they are in practice the same service(s). Service producers can thus choose whether they operate in only either service system or in both. Only one service producer has chosen to offer support for informal care in the form of home care, but not home care itself. City of Hyvinkää acquires all home care services for war invalids from a single service provider. It has also outsourced the production of most home care support services to external parties. Safety phone/alarm services, meal deliveries, cleaning services to special customers and laundry services are acquired directly from either one or a few service producers. Also those services that support living at home but occur outside the home, such as day activities and transportation services, are being produced by NGOs, bus- and taxi companies. On the accommodation side there are four service voucher producers offering support for informal care in the form of short-term service housing. They constitute the same four producers that offer long-term service housing with 24-hour assistance through service vouchers. Three of them are private companies and one is an NGO. Additionally City of Hyvinkää acquires service housing directly from four private companies, of which Esperi Care and Mainio Vire are large-scale and operate nationwide. Both companies offer home care services, but they do not provide it in the service system in Hyvinkää. (Hyvinkää 2011, web-pages)

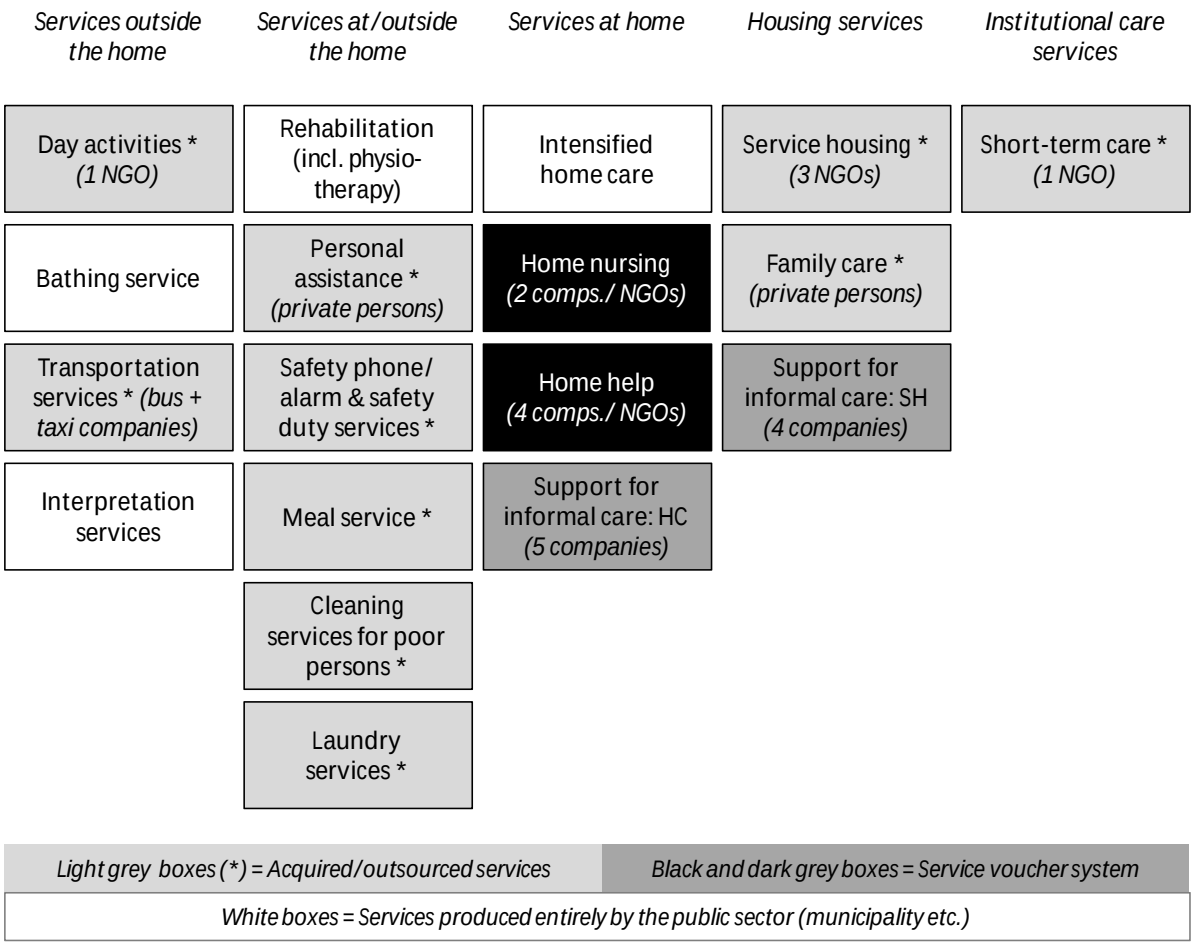

Figure 29: Wellbeing-services for disabled persons in Hyvinkää (Hyvinkää 2011, web-pages)

In Hyvinkää the wellbeing services to disabled persons have, compared to elderly persons, more emphasis on supporting services and on services occurring outside home. Furthermore, for this customer segment NGOs and private companies account for a larger share of the total service production. Acquired/outsourced services appear to be more common than service voucher systems. The service voucher systems for home care and for support for informal care – including the service producers – are the same as those for elderly persons. Also the other services provided at home and outside home are mostly the same as those for elderly persons, suggesting that services are widely co-produced for both disabled and elderly persons. Disabled persons are additionally provided with personal assistance and family care, where private persons act as service producers. Service housing and institutional care are available to some extent, with City of Hyvinkää and some NGOs being the primary service producers. (Hyvinkää 2011, web-pages)

6.2.5 Terms and Conditions for Service Producers

The main requirements, duties, boundaries and available options for service producers in the service system in Hyvinkää have been gathered and shifted to Appendix 2A. The main requirements that relate to *quality-issues* (for service producers in the service system) have been separated, and they are presented jointly in Appendix 2B.

6.2.6 Quality Issues

Issues related to quality can be extracted from the guidelines and qualification lists for home care producers in Hyvinkää. A range of service requirements have been listed by City of Hyvinkää in order to ensure a sufficient quality for the operations. It is worth mentioning that the web-pages of City of Hyvinkää do not contain any information on the quality of the operations or services of the qualified service producers. This means that potential end customers do not have direct access to public and objective quality data on the service producers – such as quality records or customer satisfaction studies. Web-pages or service brochures of the service producers are thus the primary source of information for end customers interested in quality issues. (Hyvinkää 2011, web-pages)

6.3 Uppsala – Sweden

6.3.1 Key Facts about Uppsala

In terms of population Uppsala is the fourth largest city in Sweden, with nearly 200,000 inhabitants in 2010. Its land area of nearly 2,200 square kilometers makes it the 42nd largest all 290 municipalities in Sweden. It is important to know that the population density in Uppsala varies a great deal because of the municipal structure. Three quarters of all inhabitants in Uppsala live in the geographically small city area, while one quarter is spread over a wide area accounting for 98% of the municipal region. Consequently the population density in the sparsely populated areas diminishes to only 1% of what it is in the city center. (Uppsala 2011, web-pages). In October 2011 some 2,750 end customers in Uppsala – equaling roughly 1% of the population or 1 person per square kilometer – received statutory home help services. (Socialstyrelsen 2012, web-pages)

Table 15: Population and geographical issues in Uppsala (Uppsala 2011, web-pages; Socialstyrelsen 2012, web-pages)

Region in Uppsala municipality	Population *(inhabitants)*	*%*	Area *(km2)*	*%*	Population density *(inhabitants/km2)*
City area	150 983	*76 %*	53,3	*2 %*	2 833
Sparsely populated areas	46 804	*24 %*	2 136	*98 %*	22
Uppsala municipality total	197 787		2 189		90
- of which home help service customers *	2 750	*1,4 %*			1,3

** = 2011 figures.*

In past years the development of the market for statutory home help services (i.e. home care excluding home nursing) in Uppsala has been somewhat mixed. Total amounts of end customers and service hours provided declined between 2008 and 2010 but increased in 2011. Over this period elderly persons have clearly dominated over disabled persons, when categorizing these as two separate end customer segments. The market has been quite evenly divided between the municipal producer (Uppsala City and its affiliates) and private service producers. The private producers' share of the end customers receiving home help services has declined from 52% to 43% in 2009-2011, but their share of the service hours provided has risen from 34% to 43%. In 2010 the amount of service hours provided by the municipal producer declined clearly, as did the end customer amounts for the private producers. The situation improved in 2011, as the end customer amounts and the amount of service hours provided grew by some 4-10% for both the municipal producer and the private producers. One underlying reason for the somewhat divergent trends between end customer amounts and service hours provided is the migration to a new service system for home care. Between 2008 and 2010 a number of large home care service contracts between City of Uppsala and private service producers (Attendo Care, Carema Care, Aleris Äldreomsorg and Förenade Care) expired, as a new system of choice for home care was established in late 2008. Also, from 2009 to 2011 the average amounts of service hours per month per end customer dropped by a quarter for the municipal producer, while for the private producers the service hour amounts have increased by more than half. In 2011 the average amounts of service hours per month per end customer among the private service producers were, when compared to the municipal producer, marginally higher for elderly persons (39.5 hours) but clearly lower for disabled persons (50.6 hours). Year 2011 can be summarized as a satisfactory rise in end customer amounts combined with a stabilization of amounts of service hours per end customer. (Socialstyrelsen 2012, web-pages; Uppsala 2012 a, e-mail; Uppsala 2008 a, p. 6)

Table 16: Key figures for home help services in Uppsala (Socialstyrelsen 2012, web-pages; Uppsala 2012 a, e-mail)

	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
Municipal and private home care :	# of end customers:				# of service hours/month:*				# of service hours/month/person:			
Elderly persons (65 years or more)	2 739	2 665	2 305	2 486	108,4	99,4	90,4	96,7	39,6	37,3	39,2	38,9
Disabled persons (0-64 years)	389	290	298	264	18,8	17,8	14,6	15,5	48,3	61,3	48,9	58,8
Total home care	3 128	2 955	2 603	2 750	127,2	117,2	104,9	112,3	40,7	39,6	40,3	40,8
Yearly change (%)		*-6 %*	*-12 %*	*6 %*		*-8 %*	*-10 %*	*7 %*		*-3 %*	*2 %*	*1 %*
Municipal home care:	# of end customers:				# of service hours/month:*				# of service hours/month/person:			
Elderly persons (65 years or more)		1 220	1 310	1 401	63,4	64,4	50,4	53,8		52,7	38,5	38,4
Disabled persons (0-64 years) **		201	192	163	15,8	13,4	11,0	10,4		66,4	57,3	63,9
Total municipal home care		1 421	1 502	1 564	79,2	77,7	61,4	64,3		54,7	40,9	41,1
Yearly change (%)			*6 %*	*4 %*		*-2 %*	*-21 %*	*5 %*			*-25 %*	*0 %*
Private home care:	# of end customers:				# of service hours/month:*				# of service hours/month/person:			
Elderly persons (65 years or more)		1 445	995	1 085	45,1	35,0	39,9	42,9		24,2	40,1	39,5
Disabled persons (0-64 years) **		89	106	101	3,0	4,4	3,6	5,1		49,9	33,5	50,6
Total private home care		1 534	1 101	1 186	48,1	39,5	43,5	48,0		25,7	39,5	40,5
Yearly change (%)			*-28 %*	*8 %*		*-18 %*	*10 %*	*10 %*			*54 %*	*2 %*

** = Montly amounts of service hours given in 1000s. ** = The amounts also include "young seniors" without direct disabilities.*

6.3.2 The Service System

City of Uppsala has implemented the Act on System of Choice among certain care-related services since 2008. It established systems of choice for accompanying services for disabled persons in May 2008. In November 2008 similar systems of choice were established for two other service categories: day activities for adults and home care services for elderly persons and disabled persons. (Uppsala 2008 a, p. 1-5) Currently all three systems are in parallel use (Uppsala 2011, web-pages).

Uppsala initially set the following goals for its systems of choice (Uppsala 2008 a, p. 2):

- Increased freedom of choice for individuals
- Development of quality through continuous competition
- Increased diversity of service producers
- Continuity through long-term entrepreneurship

The system of choice for home care services allows private companies, cooperatives and NGOs to apply for qualified service supplier status. Uppsala Vård & Bildning (“V&B”) is the internal service production unit of City of Uppsala, and it represents the largest qualified service provider. For qualification the applicants need to meet a number of requirements, many of which are related to quality issues. All service suppliers receive same levels of

monetary compensation from City of Uppsala, although the compensation levels vary across services. (Uppsala 2011, web-pages) Other principles of the system are e.g. that it corresponds to current legislation, the contracts are made between the municipality and the service producers, services in the system are announced continuously, *all* applicants that meet the requirements are qualified, and also that non-choice -alternatives have to exist for services in the system (Uppsala 2008 a, p. 2).

A citizen, who aspires home care services and meets the formal requirements for receiving these, shall first contact a social services handler at City of Uppsala for general consultation, which includes a home visit. City of Uppsala officers then formulate a frame decision regarding the home care services being granted, and distribute this decision both to the citizen and to the chosen service producer. To ensure that the freedom of choice materializes, the social services handlers at City of Uppsala are obliged to give sufficient and unbiased information on qualified service providers to the citizens (Uppsala 2010 a, p. 7). Based on the frame decision the citizen together with the preferred service producer then formulate a service plan. (Uppsala 2010 b, p. 3-4) Only a citizen, who applies for home care services less than 7.5 hours per month, can contact an approved service producer directly. Here the citizen together with the preferred service producer formulate a service plan, and send it back to City of Uppsala officers for consideration. The frame decision formulated and returned by City of Uppsala officers is flexible as it allows for some deviations with respect to the service plan. The service plan and the frame decision form the basis for the monitoring of the actual service provision, and this monitoring is conducted on a regular basis by the service producer itself and by City of Uppsala officers. The citizen pays predetermined fees to City of Uppsala for the services consumed. (Uppsala 2010 b, p. 3-4) A citizen who is not able to choose its service provider, will be addressed with one according to predetermined procedures derived from geographical areas. Also, a citizen is allowed to switch service providers on request, with the factual switch occurring in two weeks. And if changes occur in a citizen’s demand for home care services, then a social services handler at City of Uppsala needs to be contacted. (Uppsala 2010 a, p. 14)

The steering model that is applied by City of Uppsala for municipal services has three main parties; i) the city council as the upper and governing body, ii) client-side boards (with client-

side offices) and iii) production boards (with production administrations). The client-side boards and the client-side offices are responsible for giving commissions to both municipal production units, i.e. to the production boards and their production administrations, and also to external production units, such as private companies and NGOs. For wellbeing services, such as home care, the client-side boards are the Health and Social Welfare Board and the Senior Citizens Board, while the client-side office is the Health and Social Welfare Office. Care and Education, Uppsala Vård & Bildning (V&B) in Swedish, is the relevant production administration, as it is the municipal producer of wellbeing services in Uppsala. (Uppsala 2012 b, spreadsheet; Uppsala 2012, web-pages). For external service producers in the service system for home care, the main counterpart at City of Uppsala is the Health and Social Welfare Office.

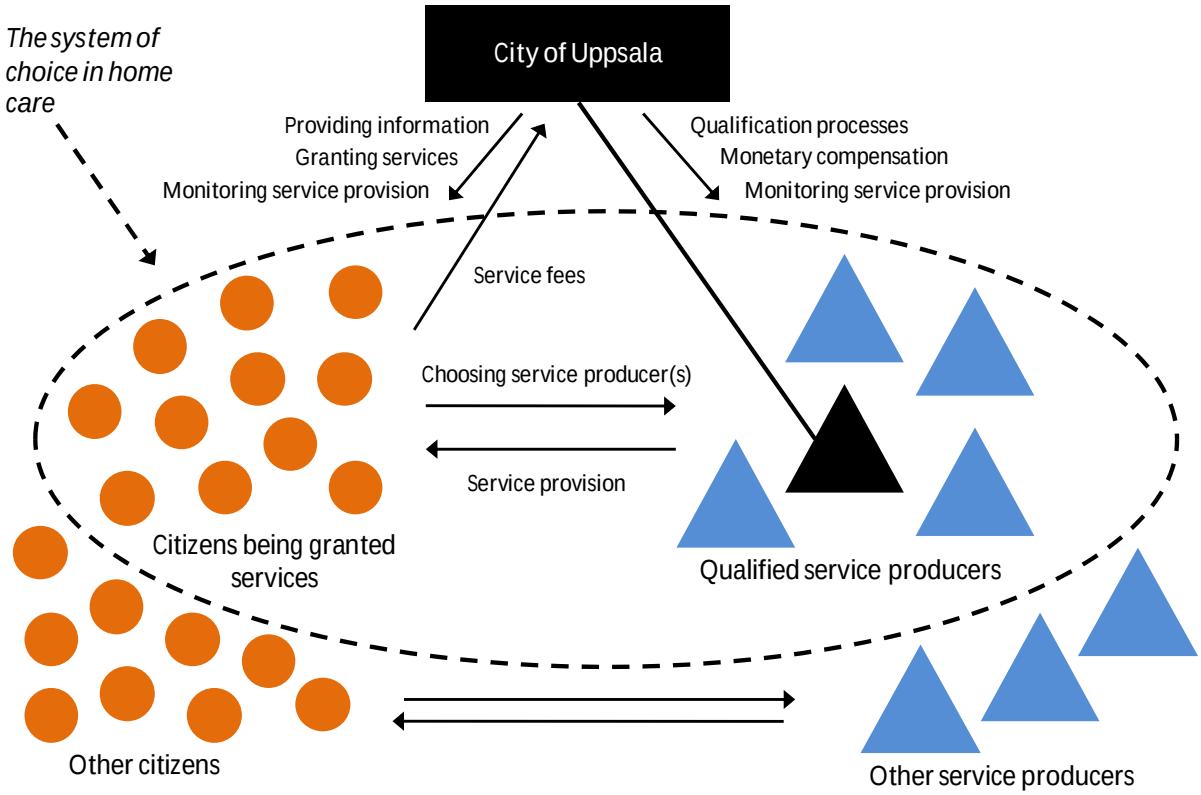

Figure 30: A simplified overview of the system of choice in home care in Uppsala

6.3.3 Overview of the Service Producers

The system of choice within home care in Uppsala included 16 qualified service producers in October 2011. V&B was clearly the largest entity with approximately 1,800 employees measured in people working full-time. It should be noted that this figures contains all employees working in all service areas, of which home care is only one. The amount of home care employees at V&B is thus clearly lower, but it is not disclosed separately. Measured by personnel size V&B is followed by Förenade Care, Aleris Äldreomsorg and Attendo Care. Together these three companies employ 338 people full-time, or 16% of the total amount. The remaining twelve service producers sum up to 45 full-time employees, or 2% of the total amount. (Uppsala 2011 a, p. 4-35)

Table 17: Key facts on qualified service producers within home care in Uppsala, as of October 2011 (Uppsala 2011 a, p. 4-35)

	Uppsala Vård & Bildning	Förenade Care	Aleris Äldreomsorg	Attendo Care	Alvis Vård & Omsorg	Konvaljens Hemvård och Städ	Omsorgshuset i Stockholm	Diakonistiftelsen Samaritthemmet	Mariatjänst	Upplands Assistans	Mångkulturell Hemtjänst	Athena Omsorg	REAL-Assistent	Uppsala Hemservice	Andreas Hemservice	Uppland Nursing Resurs
Non-profit organisation (NGO)	-	-	-	-	-	-	-	X	X	-	-	-	-	-	-	-
Company hometown in Uppsala	X	-	-	-	X	X	-	X	X	X	X	X	-	X	X	-
Personnel in Uppsala, converted to full-time employees	1800	180	84	74	8	6	6	5	5	4	3	2	2	2	1	1
Total personnel in Uppsala	2600	230	126	100	10	17	7	10	10	10	5	10	2	3	1	1
Personnel utilization rate	69 %	78 %	67 %	74 %	80 %	35 %	86 %	50 %	50 %	40 %	60 %	20 %	100 %	67 %	100 %	100 %
Personal care																
Between 07:00-22:00 (incl. home nursing)	-	-	-	-	X	-	-	X	X	-	-	-	-	-	-	-
24h (excl. home nursing between 22:00-07:00)	X	X	X	X	-	-	X	-	-	-	-	-	-	-	-	-
Services																
Cleaning, making the bed, washing	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Meal service incl. delivery	X	X	X	X	X	X	X	X	X	-	X	X	-	-	-	X
Grocery shopping, running errands	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Socializing, activities indoor and outdoor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Number of languages spoken	+++	+++	14	9	13	6	9	+++	9	3	+++	2	> 5	3	2	5
Additional services																
Related to personal care	-	-	-	X	-	X	-	-	X	-	-	-	-	-	-	-
Related to domestic services	-	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X
Other services	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-

Most of the smaller and mid-sized qualified service producers are local operators with Uppsala as their hometown. The largest private service producers – Förenade Care, Aleris Äldreomsorg and Attendo Care – are headquartered outside Uppsala, and they also operate in other parts of Sweden. The services made available for the service producers consist of personal care either daytime or full-time, and of services related to domestic activities in four separate service categories. Several languages are in general spoken among the service producers, with large producers offering a wider linguistic range than small producers. (Uppsala 2011 a, p. 4-35)

6.3.4 Home Care in Relation to Other Services

Home care services constitute a notable part of the wellbeing services being offered to elderly persons and disabled persons in Uppsala. Some of the wellbeing services related to home care are produced entirely by City of Uppsala itself (V&B), while others are open for competition and thus also produced by companies and NGOs. Both publicly tendered contracts and systems of choice are applied to the privatized services. (Uppsala, web-pages 2012). These wellbeing services, which are either substitutive or complementary services to home care, are presented next as to gain a more thorough understanding of the competitive landscape for home care services in Uppsala. The related wellbeing services are outlined separately for elderly persons and for disabled persons.

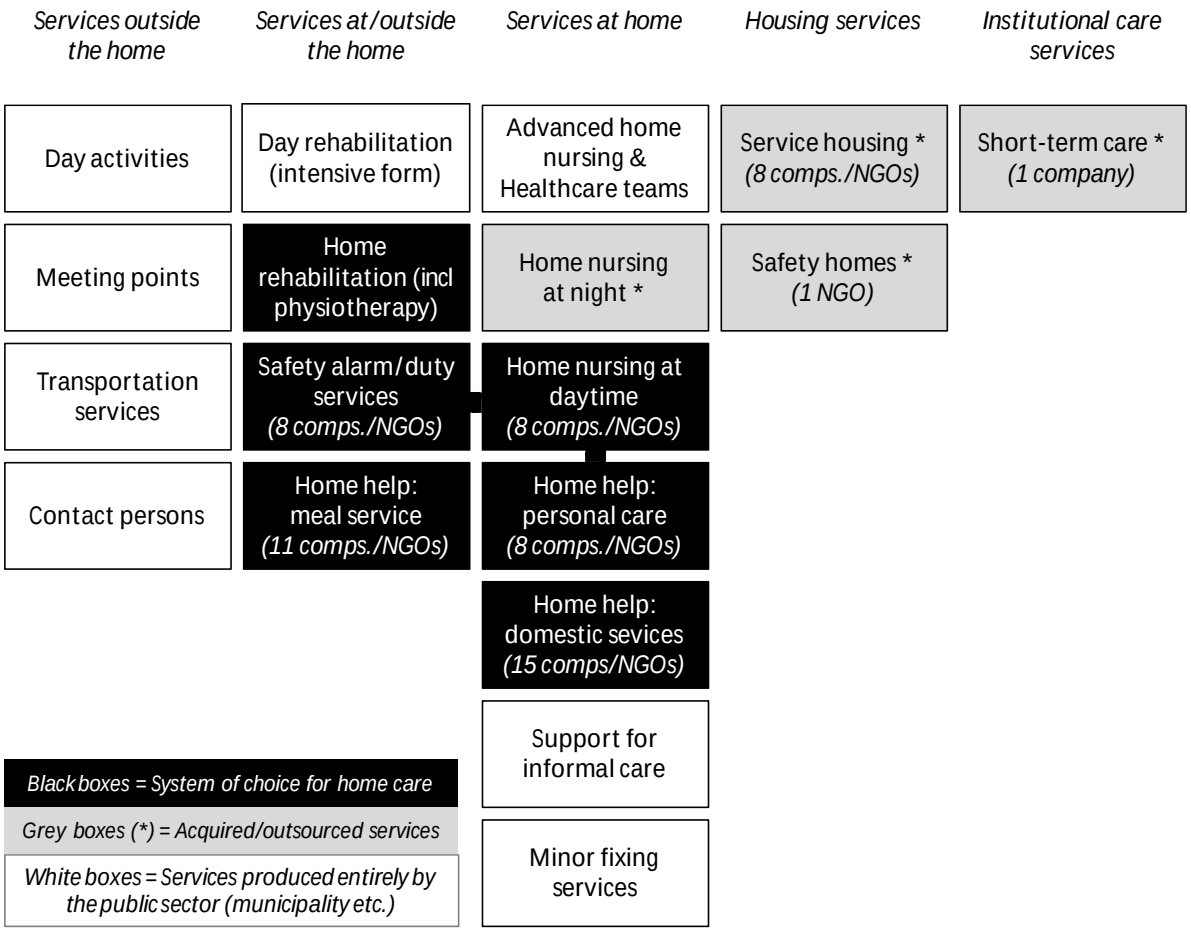

Figure 31: Wellbeing-services for elderly persons in Uppsala (Uppsala web-pages 2012)

Elderly persons in Uppsala are offered several different services connected to the home, many of which are part of the system of choice for home care. The safety alarm services have been integrated into the system of choice, and it constitutes a compulsory service for all home care producers that offer personal care and home nursing. On the other hand, home rehabilitation (part of home nursing) and meal service (part of domestic services) are both optional services for the home care producers. City of Uppsala itself produces and offers elderly persons some home-related services, such as day rehabilitation, advanced home nursing, healthcare teams, home nursing at night (acquired externally), support for informal care and minor fixing services. Furthermore, it arranges all services outside home; day activities at its activity centers, meeting points, associated transportation services, as well as contact persons. When moving from services at or outside home to housing services, it appears that City of Uppsala also acquires these from (outsources to) external parties. Apart from V&B, six companies and two NGOs offer service housing. The majority of the service housing companies also offer

home care. The list of housing services companies includes the large healthcare groups, i.e. Aleris, Attendo Care, Carema Care and Förenade Care. (Uppsala web-pages 2012)

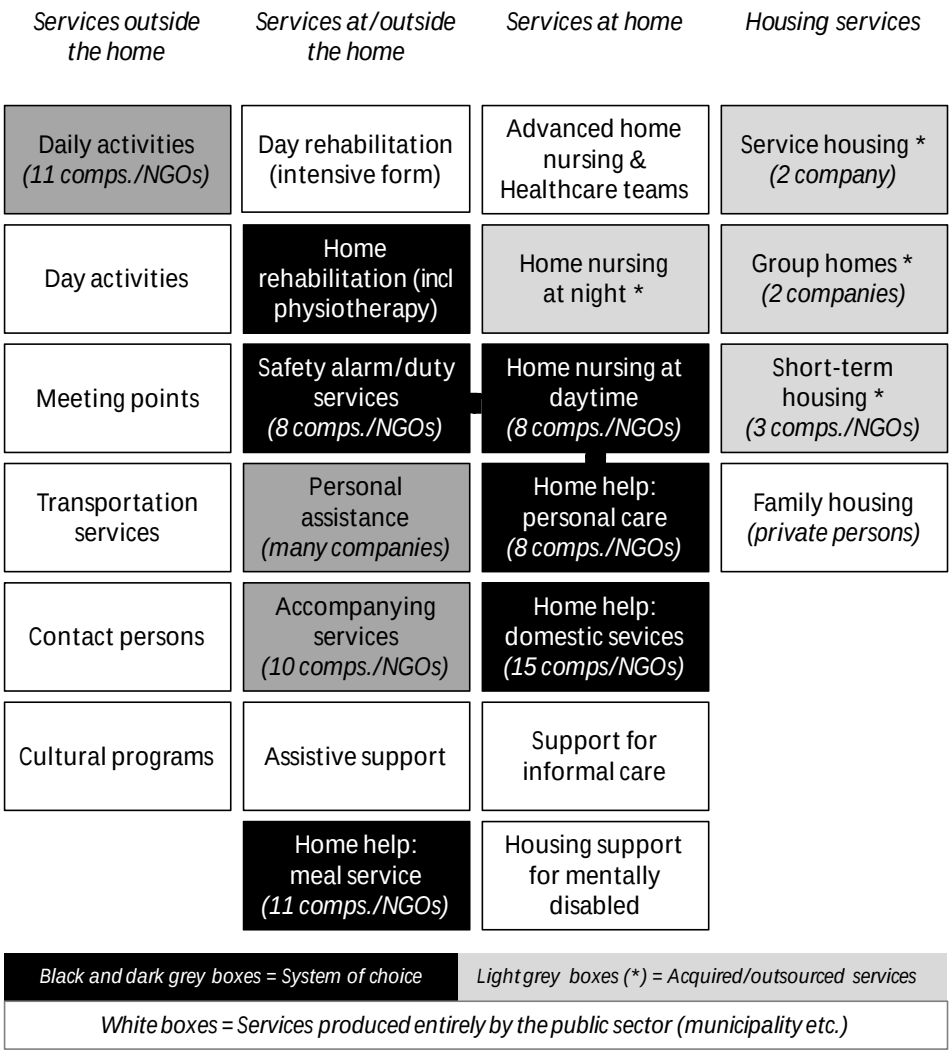

Figure 32: Wellbeing-services for disabled persons in Uppsala (Uppsala web-pages 2012)

The wellbeing services offered to disabled persons in Uppsala are somewhat more home-centered than those offered to elderly persons. The mobility of disabled persons has lead to less emphasis on housing services and more emphasis on services with a high degree of personal aid and assistance. The set-up for the available home care services – including home rehabilitation, safety alarm services and meal service – is the same as with elderly persons. Additionally there are separate systems of choice for accompanying services, personal assistance and for daily activities – services that are particularly intended for disabled persons. Accompanying services is offered by seven companies and three NGOs, of which three

companies also offer home care in Uppsala. Likewise, a few of the several personal assistance companies in the area produce home care as well. City of Uppsala produces and provides disabled persons not only with day rehabilitation, advanced home nursing, healthcare teams, home nursing at night (acquired externally) and support for informal care – it also backs up with housing support for mentally disabled and with assistive support. As with elderly persons, also for disabled persons nearly all wellbeing services outside home are produced by City of Uppsala. In housing services City of Uppsala has shifted a part of the production to external service producers – to both companies and NGOs – from which services are acquired. One of the home care producers, Carema Care, operates both service houses and group homes for disabled persons. (Uppsala web-pages 2012)

6.3.5 Terms and Conditions for Service Producers

The main requirements, duties, boundaries and available options for service producers in the service system in Uppsala have been gathered and shifted to Appendix 3A. The main requirements that relate to *quality-issues* (for service producers in the service system) have been separated, and they are presented jointly in Appendix 3B.

6.3.6 Quality Issues

Operational quality is highly important for all home care producers in Uppsala, and a number of different quality requirements are set and monitored by City of Uppsala. All qualified home care service producers in Uppsala meet the quality requisites being set, but many have extended their operational quality beyond that. The most advanced ones are the municipal V&B and the private companies Aleris and Förenade Care, as they have ISO 9001 quality certifications for their operations, including home care. Some other service producers may also have ISO 9001 quality certifications, but they do communicate it through Uppsala web-pages. Many of the producers have established their own targets, requirements or programs for managing operational quality. (Uppsala 2011 a, p. 4-35)

In November 2011 the results of the annual customer survey for home care services were published. Results were received only for the four largest service producers. Twelve service

producers were combined into one, “Other service providers”, due to statistically insufficient amounts of end customers when analyzed alone. The customer satisfaction index, which ranges from the lowest 0 to highest 100, was 71 for V&B. The index varied between 68 and 73 for all involved parties. This indicates that the differences in customer satisfaction among the service producers were quite small. (Uppsala 2011 c, p. 33)

Table 18: Quality issues among the service producers within home care in Uppsala, as of November 2011 (Uppsala 2011 c. p. 31)

	Uppsala Vård & Bildning	Förenade Care	Aleris Äldreomsorg	Attendo Care	Other service producers
Total personnel in Uppsala	2600	230	126	100	86
Customer amount in Uppsala *	780	217	154	154	44
Customer satisfaction index 2011	71	73	68	70	73

** = The figures reflect only persons answering the customer survey in 2011.*

6.4 Huddinge – Sweden

6.4.1 Key Facts about Huddinge

With more than 97,000 inhabitants in 2010, Huddinge was the 14th largest city in Sweden. On the other hand, its land area of 141 square kilometers makes places it among the smallest municipalities (269 out of 290) in the country. As a result of the concentrated geographical structure, the population density of Huddinge is relatively high. The population density between the 6-10 municipal districts varies between some 450 – 1,690 inhabitants per square kilometer, which shows that the districts are largely alike. (Huddinge 2012, web-pages). In October 2011 approximately 1,500 inhabitants in Huddinge, close to 2% of the population or 11 persons per square kilometer, were reported as end customers for statutory home care. (Socialstyrelsen 2012, web-pages)

Table 19: Population and geographical issues in Huddinge (Huddinge 2012, web-pages; Socialstyrelsen 2012, web-pages)

Region in Huddinge municipality	Population *(inhabitants)*	*%*	Area *(km2)*	*%*	Population density *(inhabitants/km2)*
Sjödalen-Fullersta-Flemingsberg-Visättra	36 322	*37 %*	80,2	*57 %*	453
Stuvsta-Snättringe	15 702	*16 %*	9,3	*7 %*	1 688
Segeltorp	11 743	*12 %*	11,2	*8 %*	1 048
Trångsund-Skogås	23 514	*24 %*	34,2	*24 %*	688
Vårby	9 910	*10 %*	6,5	*5 %*	1 525
Huddinge municipality total	97 453		141,4		689
- of which home care customers *	1 527	*1,6 %*			10,8

** = 2011 figures.*

The market for statutory home care in Huddinge has grown steadily over recent years. During this time the balance between elderly and disabled has evolved from approximately 90-10 to 85-15. A system of choice for home care was initiated in 2009, and this allowed private service producers to enter the market and grow their operations. This is the reason why the end customer amounts and also the amounts of service hours among the private producers have grown rapidly in absolute terms, but also compared to the municipal producer (Huddinge Municipality and its affiliates). In 2011 the private producers possessed already 24% of all end customers receiving home care, while their share of all service hours provided had risen to 43%. Although the municipal producer has generated higher aggregated volumes of service hours, its service hours per end customer are strikingly lower than for the private producers. In 2011 the average amounts of service hours per end customer per month among the private service producers were 47 hours for elderly persons and 37 hours for disabled persons. The corresponding hour amounts for the municipal producer were as much as 60% and 49% lower. (Socialstyrelsen 2012, web-pages)

Table 20: Key figures for home care in Huddinge (Socialstyrelsen 2012, web-pages)

	2008	2009	2010	2011	2008	2009	2010	2011	2008	2009	2010	2011
Municipal and private home care :	# of end customers:				# of service hours/month:*				# of service hours/person/month:			
Elderly persons (65 years or more)	793	1 039	1 248	1 295	23,0	28,3	31,0	32,6	29,0	27,3	24,8	25,1
Disabled persons (0-64 years)	100	126	158	232	2,8	3,1	3,9	5,7	27,9	24,2	24,9	24,4
Total home care	893	1 165	1 406	1 527	25,8	31,4	34,9	38,2	28,9	26,9	24,8	25,0
Yearly change (%)		*30 %*	*21 %*	*9 %*		*22 %*	*11 %*	*9 %*		*-7 %*	*-8 %*	*1 %*
Municipal home care:	# of end customers:				# of service hours/month:*				# of service hours/person/month:			
Elderly persons (65 years or more)		869	991	998	19,5	23,2	18,4	18,7		26,7	18,5	18,8
Disabled persons (0-64 years)		113	129	163	2,5	2,9	3,0	3,1		25,9	23,1	19,0
Total municipal home care		982	1 120	1 161	22,0	26,1	21,4	21,8		26,6	19,1	18,8
Yearly change (%)			*14 %*	*4 %*		*19 %*	*-18 %*	*2 %*			*-28 %*	*-1 %*
Private home care:	# of end customers:				# of service hours/month:*				# of service hours/person/month:			
Elderly persons (65 years or more)		170	257	297	3,5	5,1	12,6	13,8		30,1	49,2	46,6
Disabled persons (0-64 years)		13	29	69	0,3	0,1	1,0	2,6		9,1	32,8	37,1
Total private home care		183	286	366	3,8	5,2	13,6	16,4		28,6	47,5	44,8
Yearly change (%)			*56 %*	*28 %*		*37 %*	*160 %*	*21 %*			*66 %*	*-6 %*

** = Montly amounts of service hours given in 1000s.*

6.4.2 The Service System

In 2007 Huddinge Municipality initiated preparations for establishing systems of choice among home help services. In March 2009 a system of choice aligning the Act on System of Choice was launched for home help services for elderly persons. A similar service system, but for disabled persons, was launched in September the same year. Both service systems for home help services are still in parallel use. (Huddinge 2009 a, p. 1; Huddinge 2009 b, p. 1)

The systems of choice for home help services for both elderly persons and for disabled persons enable both natural persons (individuals) and legal persons (organizations) to become service producers in Huddinge (Huddinge 2011 b, p. 7). Qualified service producers in the service system compete not only with each other, but also with the home help service unit of Huddinge Municipality, which is the largest producer within the service area. The general aim of the system is to increase options, participation and influence of those elderly persons and disabled persons being end customers. Qualified service producers are not guaranteed with any customer amounts or service volumes – these issues are entirely determined by the choices made by the end customers. The qualification requirements and compensation levels are equal for all service producers in the system. All listed requirements have to be met. All qualified service producers are able to enter the service system, no upper limits apply. Huddinge Municipality assesses service producer applications on a regular basis, and

approved applications are followed by a separate signing of a service contract between these two parties. The assessment of a service producer application takes approximately eight weeks, and may require a complementary interview. (Huddinge 2011 a, p. 1-4; 10-12)

Huddinge Municipality regularly monitors the end customer satisfaction with respect to their service providers. In addition, Huddinge Municipality controls that the service producers uphold sufficient quality levels in their operations. The results of the quality studies are published on the web-pages of Huddinge Municipality to be observed by existing and new end customers of home help services. (Huddinge 2011 a, p. 4)

The system of choice for home help services to elderly persons concerns citizens aged 65 years or more, while the system of choice for home help services to disabled persons concerns citizens aged less than 65 years. Such citizens can contact social services handlers of Huddinge Municipality, who make individual service needs assessments of what home help services will be granted. Based on the municipal decisions, the citizens can freely choose their service provider. Citizens not willing or able to choose their service provider will be directed to the home help service unit of Huddinge Municipality. A service producer chosen by a citizen will receive the associated service needs assessment from Huddinge Municipality. (Huddinge 2011 a, p. 3-8). A designated contact person of the service producer will then formulate a service plan together with the citizen, where the personal aspirations of the citizen have to be taken into account. The service plan is evaluated and updated on a regular basis. (Huddinge 2012, web-pages). A dissatisfied citizen can anytime change its service provider to another one within the service system (Huddinge 2011 b, p. 3). However, elderly persons can only choose *one* service provider, they are not allowed to split the granted home help services between several providers. Disabled persons, on the contrary, are allowed to split the granted home help services between several service providers. The service fees paid by a citizen are independent of which service provider he/she has chosen, and the fees are paid directly to Huddinge Municipality. This means that citizens cannot and do not assess or choose their service providers by service fee levels. Instead citizens assess the operational quality and profile of the service producers, such as their competence areas, language skills or offering of additional services. (Huddinge 2012, web-pages)

Figure 30, which illustrates the system of choice for home care services in Uppsala, is applicable for Huddinge as well.

6.4.3 Overview of the Service Producers

In February 2012 there were 14 qualified producers within the two systems of choice for home help services in Huddinge. Huddinge Municipality with over 1,000 end customers appears to have by far the largest customer base of all producers. Huddinge Municipality also has the largest personnel of all service producers having their headquarters in Huddinge. On the other hand, there are also large non-local companies with hundreds of employees or more, for which home help services in Huddinge is only a part of the business. Attendo Care, HSB Omsorg, Omsorgshuset i Stockholm and OmsorgsCompagniet belong to this group. A clear majority (71-92%) of the privately served end customers are concentrated to 3-5 producers, which consist of both local and non-local companies. But also the smallest service producers in terms of customer amounts are a mix of local and non-local companies. The smallest service producers have only a few end customers and/or employees. Another observation is that the service system withholds only private companies and no NGOs. (Huddinge 2012, web-pages)

Table 21: Key facts on the qualified service producers of home help services for elderly persons in Huddinge, as of February 2012 (Huddinge 2012, web-pages)

	Huddinge Municipality	HSB Omsorg AB	Assistansen S&M AB	CL Assistans AB	Real Omsorg i Stor Stockholm AB	Omsorgshuset i Stockholm AB	Ekens Hemtjänst AB	AB OmsorgsCompagniet	AB Jessys Assistans	Alerta Omsorg AB	Dedicare Omsorg AB	Attendo Care AB	Eveo AB	ADA hemtjänst & personlig assistans AB
Non-profit organisation (NGO)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Company hometown in Huddinge	X	-	X	X	-	-	X	-	X	-	-	-	-	X
Personnel *(includes employees also in other activities and areas)*	120	1200	50	51	150	664	<5	600	50	80	274	7000	>10	<5
Customer amount in Huddinge *	1054	120	75	69	45	33	18	5	4	2	1	n.a.	n.a.	n.a.
Geographical service area														
Sjödalen-Fullersta-Flemingsberg-Visättra	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Stuvsta-Snättringe	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Segeltorp	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Trångsund-Skogås	X	X	-	X	X	X	X	X	X	X	X	-	X	-
Vårby	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Service times														
Every day 07:00-22:00	-	-	-	X	-	-	-	-	X	X	-	X	-	X
Every day 24h	X	X	X	-	X	X	X	X	-	-	X	-	X	-
Meal service (internal/external)	X+SP	X	X+SP	X+SP	X+SP	SP	X+SP	X	SP	X	X+SP	X+SP	X	X+SP
Home help for disabled persons														
Personal care	X	X	-	X	X	X	-	X	X	-	X	-	-	-
Domestic services	X	X	-	X	X	X	-	X	X	-	X	-	-	-
Meal service	X+SP	X	-	X+SP	X+SP	SP	-	X	-	-	X+SP	-	-	-
Corporate profile														
Special competences	X	X	X	X	X	X	-	X	-	X	X	X	X	X
Number of languages spoken	+++	9	+++	5	+++	+++	6	+++	n.a.	+++	n.a.	+++	+++	8
Additional services														
Healthcare services	-	-	-	-	X	-	-	-	-	X	X	X	-	-
House cleaning	-	X	X	X	X	X	X	X	X	X	X	X	X	X
Running errands	-	X	X	-	X	X	X	X	-	-	X	X	X	X
Other services	-	X	X	X	X	X	X	X	-	X	X	X	X	X

** = Data as of April 2012. SP = External service partner utilized.*

All 14 qualified service producers of home help services operate in the service system for elderly persons. Only three of these do not operate in all seven sub-regions of Huddinge, and all three entities have excluded the same two peripheral sub-regions. Most of the service producers serve their customers 24-hours every day, but some of the smaller ones have limited their service time to 7:00 - 22:00 every day. As the services offered for elderly persons are not optional, all service producers are obliged to offer the same service bundle comprising

personal care, domestic services, meal service, housing support, safety alarm services, accompanying services and support for informal care. Regarding the meal service there are some variations. Most service producers utilize external catering partners but also cook at homes, while some have internal catering services, and a few producers utilize catering partners only. Almost all service producers have stated that they possess some special competence areas or skills, but these are quite difficult to measure and compare objectively. Several languages are spoken among all service producers, with more than ten languages in many cases. All service producers offer various cleaning services as additional services. Also property management services such as garden work, home repair services and/or snowplowing are widely offered. Help outside the home, such as running errands and/or assistance are also offered as additional services. (Huddinge 2012, web-pages)

Of the 14 qualified service producers of home help services for elderly persons, 8 operate also in the service system for disabled persons. All of these producers except for one have chosen to offer all three sub-services available for disabled persons – personal care, domestic services and meal service. The service areas and service times for the service producers offering home help services for disabled persons are different than they are for elderly persons, but they are not specified in the previously presented table. (Huddinge 2012, web-pages)

6.4.4 Home Care in Relation to Other Services

Elderly persons in Huddinge are offered with a variety of different wellbeing services, many of which are provided either at or around home. Most of the services directly linked to the home have been opened up for competition through a system of choice. Almost all remaining wellbeing services for elderly persons are produced by Huddinge Municipality itself or by Stockholm County Council. Healthcare services are primarily a responsibility of Stockholm County Council. Direct acquisitions or outsourcing contracts have not been applied. All producers of wellbeing services for elderly persons are private companies. Three NGOs provide voluntary workers to stimulate individuals, but this is a small-scaled and free service. Disabled persons, too, are addressed with a fairly large set of wellbeing services. Also for them the services at or around home are most essential. Nonetheless, services that occur outside home, as well as housing services, are well available too. Systems of choice and

acquired or outsourced services are both applied to the services offered to disabled persons. All producers of wellbeing services for disabled persons are private companies. (Huddinge 2012, web-pages). In the following sections wellbeing services related to home care in Huddinge are described separately for elderly persons and for disabled persons.

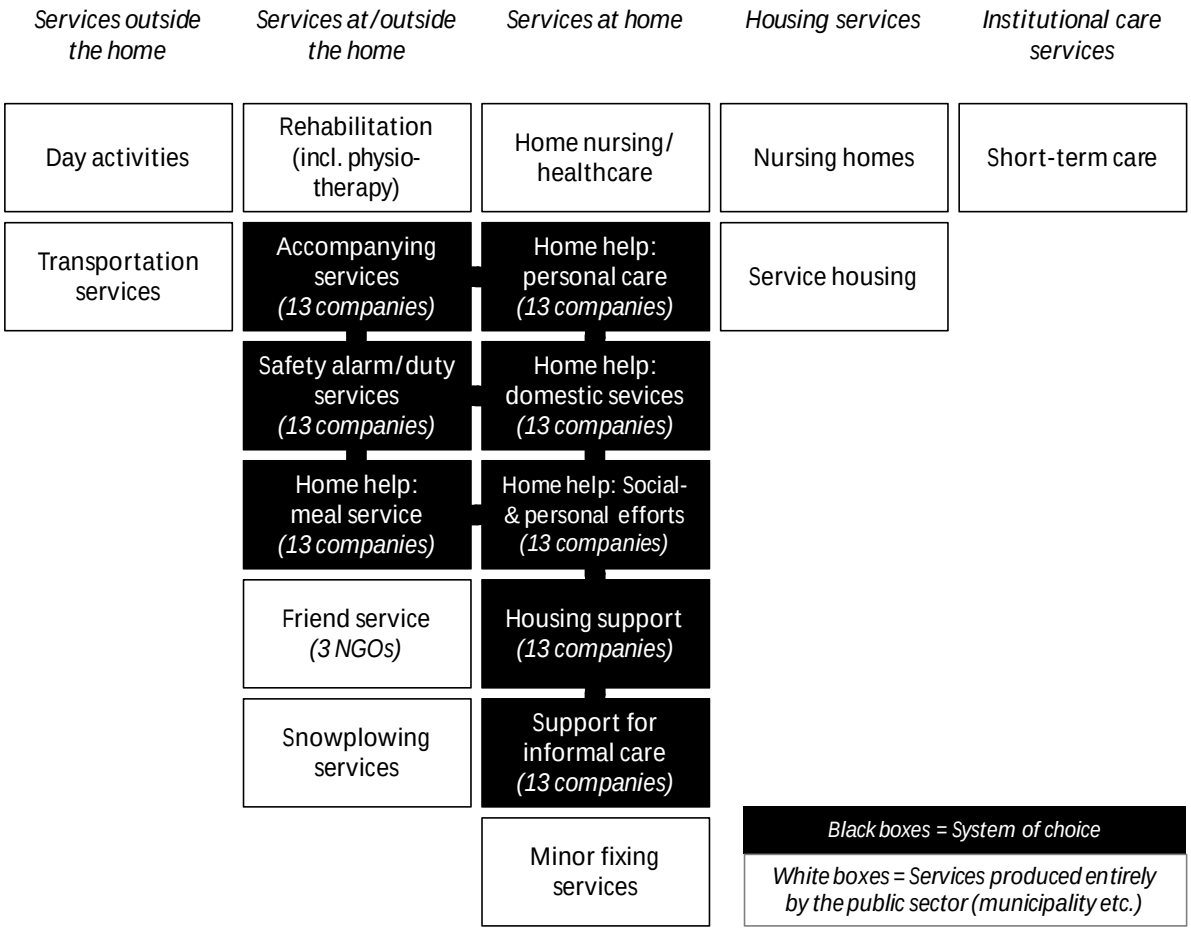

Figure 33: Wellbeing-services for elderly persons in Huddinge (Huddinge 2011, web-pages)

Stockholm County Council and partly also Huddinge Municipality produce more intense and demanding wellbeing services for elderly persons. This group of services includes short-term institutional care, nursing homes, service housing, home nursing, home healthcare and rehabilitation. This means that medical treatments remain a public sector activity. Still, most of the services at or around home are subject to a system of choice. Home help services, or its service sub-segments, have in fact been bundled together with a number of other home-related services. Home help services in Huddinge is thus a service bundle consisting of i) personal care, ii) domestic services, iii) social- and other personal efforts, and iv) meal service –

together with the other home-related services v) housing support, vi) support for informal care, vii) accompanying services and viii) safety alarm services. A total of 13 private companies – the companies presented in the previous section – offer this service package. Huddinge Municipality has kept a few supportive home help services in its own possession – minor fixing services and snowplowing services. Also day activities and transportation services remain municipally produced, although a part of the transportations is arranged through external taxi companies. (Huddinge 2012, web-pages)

Services outside the home	*Services at/outside the home*	*Services at home*	*Housing services*
Daily activities	Personal assistance * *(many companies)*	Home help: personal care *(8 companies)*	Service housing * *(1 company)*
Afternoon/ daytime clubs	Accompanying services *(9 companies)*	Home help: domestic sevices *(8 companies)*	Service homes
Transportation services	Home help: meal service *(6 companies)*	Personally formed support *(8 companies)*	Group homes * *(2 companies)*
	Safety alarm/duty services	Housing support *(8 companies)*	Short-term housing
	Contact person *(private persons)*	Support for informal care *(8 companies)*	Family housing *(private persons)*
	Snowplowing services	Home & window cleaning * *(1 company)*	

Black and dark grey boxes = System of choice | *Light grey boxes (*) = Acquired/outsourced services*

White boxes = Services produced entirely by the public sector (municipality etc.)

Figure 34: Wellbeing-services for disabled persons in Huddinge (Huddinge 2012, web-pages)

For disabled persons Huddinge Municipality produces all services that occur outside home. Housing services, on the other hand, are partly acquired from the large healthcare groups Carema Care and Attendo Care. Also family housing is utilized to some extent, and this external service is arranged through private persons and their homes. Most services provided at or around home are subject to a system of choice, and these are either the same or close to

those offered to elderly persons. Some of the individual services, such as personal assistance, personally formed support, accompanying services and support for informal care are either entirely designed or partly modified for disabled persons. Home help for disabled persons differs from home help for elderly persons in the sense that producers can choose among several separate home-related services instead of being compelled to offer one large service bundle. Between six to nine companies offer these home-related services, and nearly all of them are also represented among the 13 companies providing home help to elderly persons. Furthermore, the composition of companies is largely the same for each separate service. Huddinge Municipality has kept the production of a few home-related services by itself, such as safety alarm services, snowplowing services and the appointment of private persons to the contact person service. (Huddinge 2012, web-pages)

6.4.5 Terms and Conditions for Service Producers

The main requirements, duties, boundaries and available options for service producers in the service system in Huddinge have been gathered and shifted to Appendix 4A. The main requirements that relate to *quality-issues* (for service producers in the service system) have been separated, and they are presented jointly in Appendix 4B.

6.4.6 Quality Issues

Given the nature of the system of choice, quality is automatically an important factor for service producers in Huddinge. Minimum quality requirements are determined, listed and monitored by Huddinge Municipality. On Huddinge Municipality web-pages each service provider is allowed to present *additional quality issues* and own *quality declarations* related to the operations or services. This presentation is directed to end customers and it is instructed and controlled by Huddinge Municipality. Almost all service producers have briefly listed some quality features they possess or quality work they do. 7 of 13 service producers have created and published their own quality declarations, and these are primarily the large or mid-sized companies. (Huddinge 2011 a, p. 7-8; Huddinge 2012, web-pages)

The results of the customer survey for home help services in 2011 were published in November. Many of the service producers were excluded from the survey due to limited amounts (<10) of end customers from a statistical point of view. The customer satisfaction index, which ranges from the lowest 0 to highest 100, was on average 78 for all service producers. The index was 78 for Huddinge Municipality as well. For the other service producers the index varied between 67 and 98. No clear correlation can be observed between customer satisfaction indices and customer amounts among the service producers. (Huddinge 2012, web-pages)

Table 22: Quality issues among the service producers within home help in Huddinge, as of November 2011 (Huddinge 2012, web-pages)

	Huddinge Municipality	HSB Omsorg AB	Assistansen S&M AB	CL Assistans AB	Real Omsorg i Stor Stockholm AB	Omsorgshuset i Stockholm AB	Ekens Hemtjänst AB	AB OmsorgsCompagniet	AB Jessys Assistans	Alerta Omsorg AB	Dedicare Omsorg AB	Attendo Care AB	Eveo AB	ADA hemtjänst & personlig assistans AB
Personnel *(includes employees also in other activities and areas)*	120	1200	50	51	150	664	<5	600	50	80	274	7000	>10	<5
Customer amount in Huddinge *	1054	120	75	69	45	33	18	5	4	2	1	n.a.	n.a.	n.a.
Own quality declaration	-	X	X	X	-	X	X	-	-	-	-	X	X	-
Customer satisfaction index 2011	78	67	82	93	91	72	83	n.a.	n.a.	n.a.	n.a.	98	n.a.	n.a.

** = Data as of April 2012.*

7 ANALYSES OF THE PRIVATE HOME CARE

7.1 Description of the Analyses

Firstly, the basis for all analyses in this study is that they relate either directly or indirectly to *assessing the preconditions for conducting private business* in the service systems of the case-municipalities. Secondly, the analyses will be split into two time periods, where the first period concentrates on the *current situation*, while the second period is associated with the *future*, i.e. the development in the next few (2-4) years. Thirdly, the analyses will be made *separately for each municipality*. Fourthly, for each municipality the analyses are split into *three separate parts*, or so-called sub-analyses. The first part analyzes the service offering and revenue generation in the service systems for home care. More precisely, it aims to clarify the possibilities for accumulating customers, services and revenues among the service companies. The second part assesses operations and costs in the same service systems. It aims to clarify the implications – in terms of resources, activities and costs – for the service companies. The third part evaluates quality within the service systems. This assessment strives to disclose what implications the externally determined quality aspects have on the operations, costs and revenues of the service companies.

Summary of the sub-analyses on the *current situation (A)* of the preconditions for conducting private business in the service systems, per municipality:

- Analysis A1: Service offering and revenue generation
- Analysis A2: Operations and costs
- Analysis A3: Implications of quality

Summary of the sub-analyses on the *future situation (B)* of the preconditions for conducting private business in the service systems, per municipality:

- Analysis B1: Service offering and revenue generation (in the future)
- Analysis B2: Operations and costs (in the future)
- Analysis B3: Implications of quality (in the future)

All three sub-analyses utilize the Business Model Canvas and the components therein. Analysis A1 examines the components Value Propositions, Customer Segments, Customer Relationships, Channels and Revenue Streams for service producers. Analysis A2 in turn investigates the components Key Resources, Key Activities, Key Partners, Cost Structure and also Value Propositions for service producers. And lastly, analysis A3 encompasses all nine components of the Business Model Canvas.

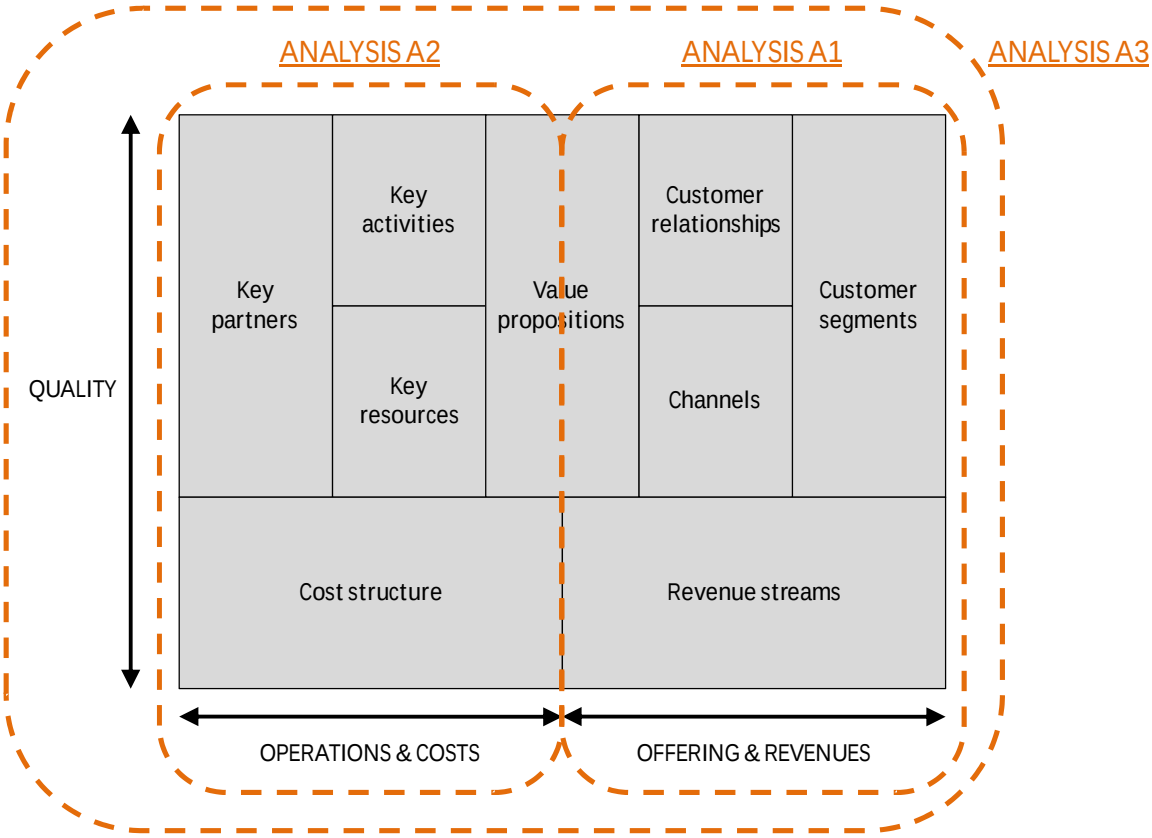

Figure 35: Illustration of the contents of Analysis A1-A3

The analyses of the current situation, i.e. analyses A1-A3, are carried out as personal and thereby subjective assessments by the author of the study. Assessments are made for each sub-analysis, and all issues being addressed are given own scoring points. The scoring points reflect the perspective of service producers. They take the values -3, -2, 1, 0, 1, 2, and 3, where -3 is the most negative outcome and 3 is the most positive outcome. The separate scoring points are then grouped together within their own sub-analyses. The groups of scoring points indicate the *current* positivity or negativity (equal to favorability or unfavorability) for

service producers regarding i) service offering and revenue generation (analysis A1), ii) operations and costs (analysis A2), and iii) implications of quality (analysis A3).

The analyses of the future situation, i.e. analyses B1-B3, cover the same areas as A1-A3, and also they are based on subjective assessments. The difference to analyses A1-A3 is that B1-B3 have been assessed by representatives of the participating municipalities. The questions and answers relate to future development (i.e. future changes) in the service system for home care and in the operating environment in general. The municipal representatives have provided answers to 18 multiple choice questions, which constitute the data for analyses B1-B3. The answers to the multiple choice questions have been given as scoring points, and these are converted to reflect the corresponding implications for service producers. And also here the separate scoring points and the converted implications are in all three sub-analyses grouped together. In these analyses the groups of scoring points and the converted implications express the *improvement or worsening of the situation in the next few years* for service producers – in terms of i) service offering and revenue generation (analysis A1), ii) operations and costs (analysis A2), and iii) implications of quality (analysis A3).

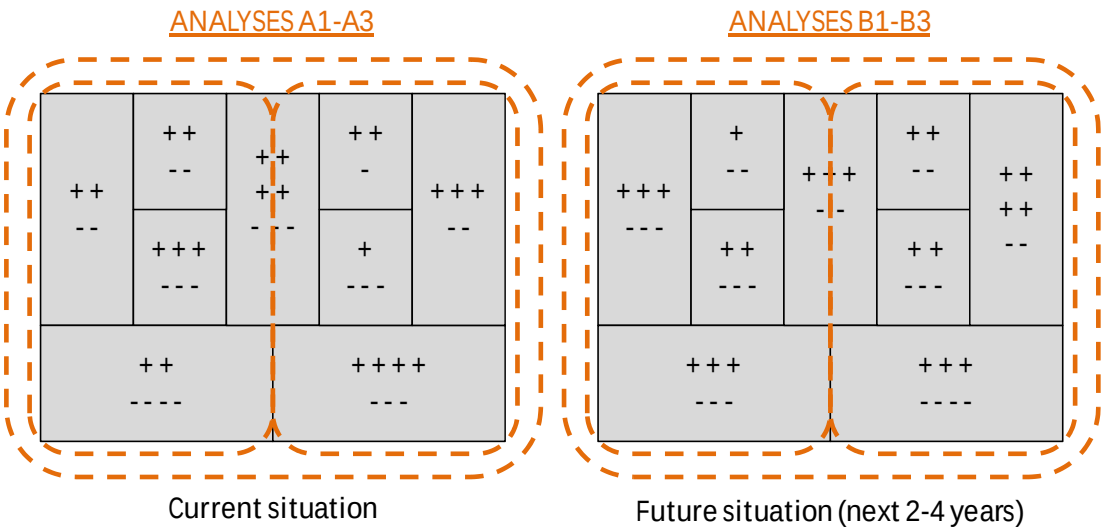

Figure 36: Illustration of the assessments and outcomes in analyses A1-A3 and B1-B3

The analyses B1-B3 concerning the future situation are processed rather briefly for a couple of reasons. A first reason is the simplicity of the underlying data – it consists of multiple choice answers provided by municipal representatives. A second reason is that the multiple

choice answers lack complementary data such as written or verbal specifications. In-depth assessments of the simple and qualitative data containing subjective elements would be hazardous and even unwarranted. Therefore the own conclusions are kept brief and mainly on a general level.

It is worth mentioning that the analyses of the study (A1-A3 and B1-B3) incorporate both business issues and issues related to the (business) environment, but they are not separated from each other. This is somewhat different from the underlying theoretical frameworks, where the Business Model Canvas and the Business Model Environment are held alongside but still apart. The main assumption here is that private companies are interested in all issues that *do* affect business operations, whereas they are less interested in whether these issues relate to the companies themselves, to the industry or to the environment. Furthermore, the service systems themselves create the majority of the operating environments for the service producers, which makes a separation of business and environment seem somewhat artificial. The service systems and their special features incorporate national legislation, decisions and recommendations by authorities, ministries and the municipalities themselves, as well as other relevant matters in the society and the economy.

7.2 Analysis of Lahti

7.2.1 A1: Service Offering and Revenue Generation

Value Proposition

The value proposition of the service system does in this analysis mean the service offering. The service offering for service producers in the service system for home care in Lahti contains five dimensions, which are i) *service type*, ii) *service range*, iii) *possibilities for choosing and combining a desired service offering*, iv) *service times* and v) *service area*. Service producers can choose between two types of home care service; either temporary home care or then temporary home care and regular home care. The services offered are the same in both types, but the lengths of the service contracts are different. The first type involves only short-term service contracts, while the second type also includes long-term contracts. The ability to choose between these two service types obviously has some positive value for

service producers. The service range is extensive, with five sub-services within home nursing and seven sub-services within home help services. There is large variety in the content and difficulty of the individual sub-services, e.g. doing laundry, assisting in showering and taking blood samples are all very different tasks. What is harmful is that service producers lack options to choose and combine among separate services. All service producers are committed to provide both home nursing and home help services with their respective sub-services. The service times, on the contrary, allow for great flexibility. Service producers can choose among six or seven different time slots in a weekly service time schedule, with three alternatives for the days of the week, and two to three alternatives for the times of the day. And there are two separate service time schedules, one for home nursing and one for home help services. The service area is another service offering factor containing no options – service producers need to cover the whole municipal area of Lahti.

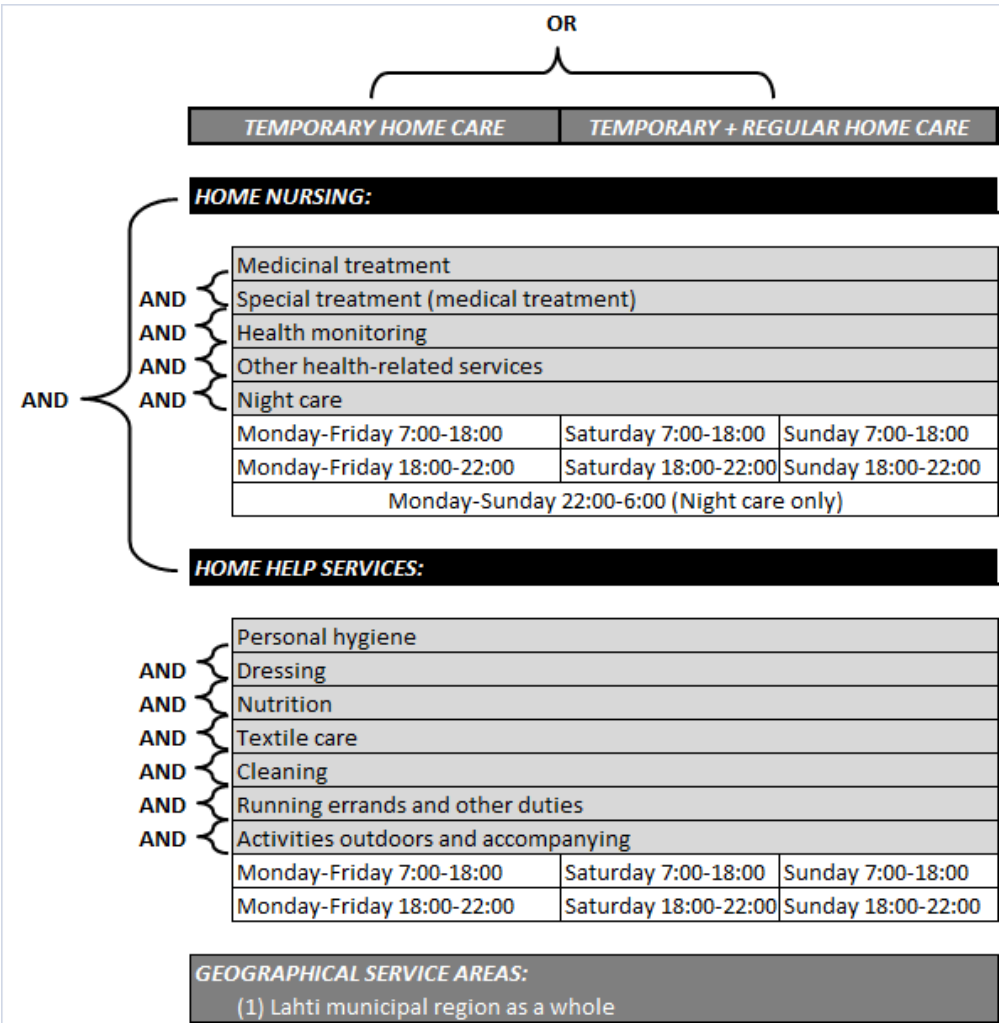

Figure 37: Overview of the service offering in Lahti (Lahti 2010 a, p. 1-3; Lahti 2010 d, p. 1-5; Lahti 2010 e, p. 1-3)

“Q*uality”, “performance”*, “*customization”* and “*convenience/usability”* are characteristics listed by the Business Model Canvas that describe the service offering of the service system in Lahti.

Service producers are allowed to offer additional services to their end customers. This makes it possible to provide more of existing services and to provide completely different services. The business opportunities related to these private market services will not be analyzed more detailed, as the scope of the study is limited to the service systems.

In 2011 end customers in Lahti with regular home care received on average 25 home visits per person per month, while those with temporary home care received on average a total of 2 visits (Lahti 2012 a, p. 25). Assuming that these average amounts of service hours per end customer are valid for both municipal and private producers, then the service volumes are partly positive and partly negative. The service volume is reasonable for producers of regular home care but unsatisfactory for producers of temporary home care. Temporary home care is primarily allocated to private producers. Nevertheless, it is encouraging that the role of temporary home care is diminishing, while that of regular home care is expanding.

The service system for home care involves a fair amount of all home-related services that City of Lahti arranges for its inhabitants. Home care is in practice offered also within two other service systems, within support for personal assistance and within support for informal care. This is why same producers operate in the three service systems. City of Lahti produces and offers the safety alarm/duty services, the meal service and the shopping service, and this reduces business opportunities for producers of home care. Personal assistance and accompanying services are arranged through private persons hired by end customers themselves, so these services are unavailable for home care companies.

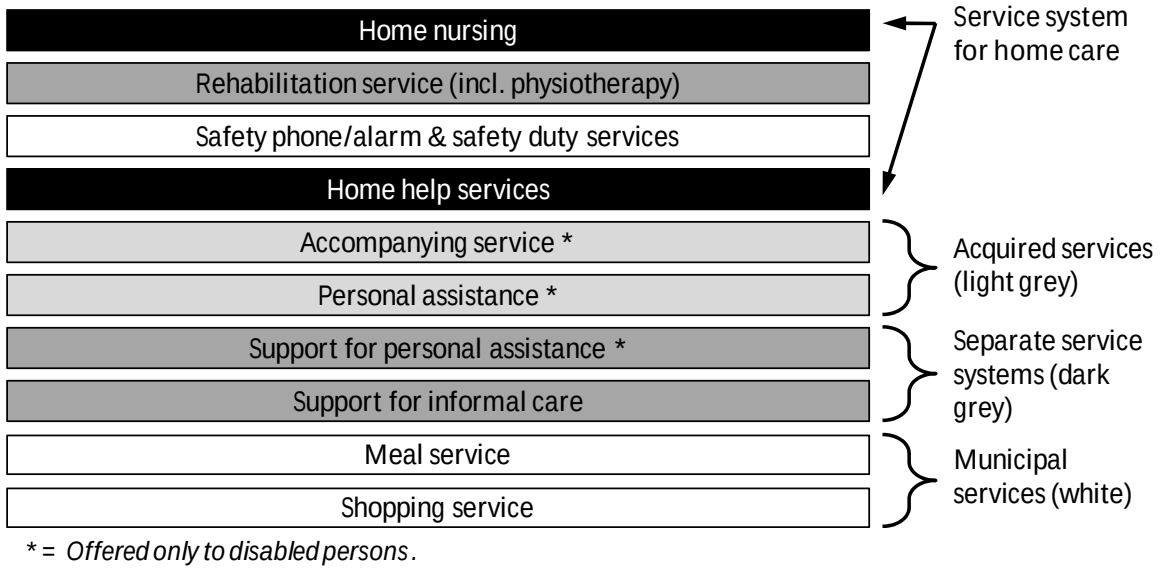

Figure 38: Range of home-related services in Lahti (Lahti 2011, web-pages)

Customer Segments

The amount of individuals who receive home care is to a large extent determined by City of Lahti. Municipal finances but also the situation of other wellbeing services affects the granting of home care. For instance collective efforts by the several NGOs may shift the municipal interest towards other services than home care. And as with all service voucher systems it is the coordinator, in this case City of Lahti, who has full authority to determine the amount and type of individuals who receive service vouchers. The size of the privatized market for home care is therefore dependent on municipal and political decisions, which may change from time to time. Private producers need to accept this ongoing uncertainty and take possible service system -based changes in end customer amounts as they come.

Over 1,400 end customers for statutory home care in Lahti is indeed a potential market for service producers. In 2011 the (service voucher) customer amount for temporary home care was 61, while the amount of service voucher customers for regular home care was 128. These are still modest amounts in relation to the whole market. However, in regular home care service vouchers were taken into use in autumn 2010, and the end customer amounts have been growing constantly since then.

The service system for home care has four different customer types. Elderly persons, disabled persons, families with children and “other persons” are part of the service system. Additionally there are two service types, temporary home care and regular home care. Private producers serve in total six customer segments; elderly persons with either temporary or regular home care, disabled persons with either temporary or regular home care, and families with children and other persons with temporary home care. Over 90% of all persons receiving regular home care in Lahti are elderly persons aged at 65 years or older, and this percentage is likely even higher in the service system. Elderly persons and disabled persons are provided with home nursing and home help services. Families with children are provided with home help services, while other persons are those primarily provided with home nursing. To summarize the customer segment situation for private producers, it appears that their regular end customers consist mainly of elderly persons, while their temporary end customers consist of a mixture of different kinds of people.

As already mentioned, City of Lahti directs almost all temporary home care to private producers by giving the end customers service vouchers. But within regular home care City of Lahti serves in parallel the same customer segments as private producers, i.e. elderly persons and disabled persons. Additionally the City serves families with children entirely itself. It also serves a special customer segment entirely itself. This segment consists of special groups such as mentally ill persons and war invalids, who receive regular home care but only few (1-2) visits per week. From perspective of private producers the lack of regular home care to families with children is unfortunate, whereas the lack of low-hour regular home care to special groups is beneficial.

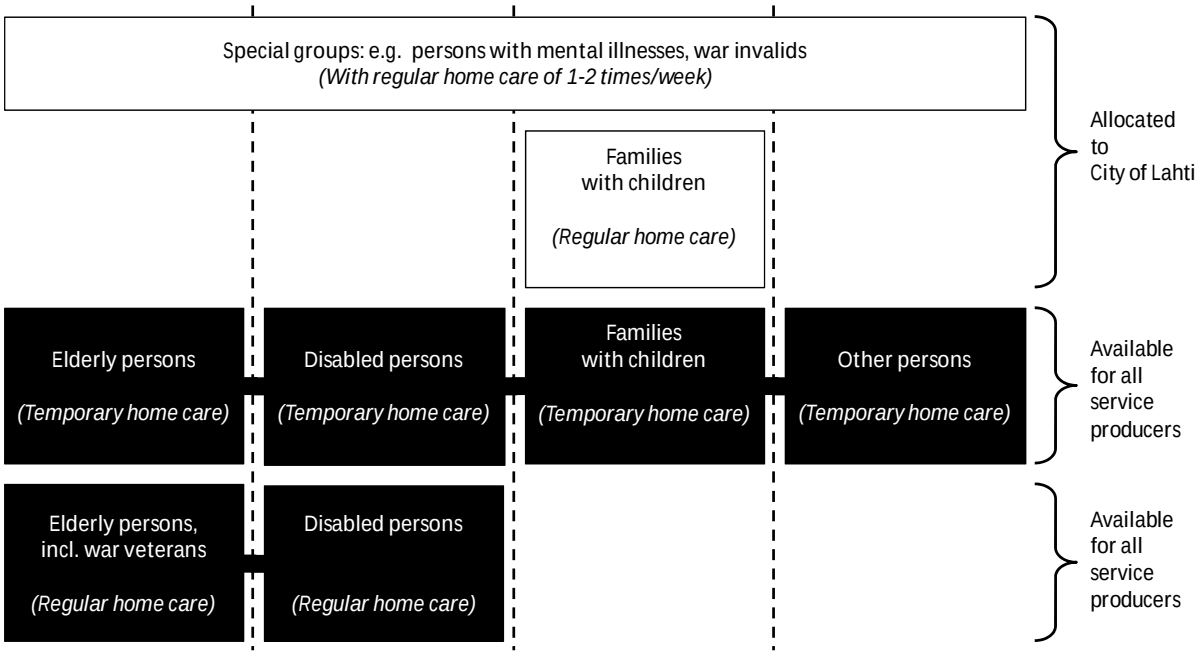

Figure 39: Customer segments within home care in Lahti

Although private producers serve a total of six different customer segments, the possibilities to target and choose among these is limited. Targeting is possible mainly between service types, i.e. between temporary home care and regular home care. Temporary home care is a bundle consisting of elderly persons, disabled persons, families with children and other persons. Only regular home care enables private producers to concentrate on 1-2 customer types, primarily elderly persons and secondarily disabled persons. Targeting of customer segments is challenging also since service producers have to approve and serve any and all service voucher customers within the boundaries of their own service system profile. Marketing activities are of course one way for conducting targeting, but pricing of services offered can be more effective. Setting the price level high, medium or low allows private producers to attract different kinds of end customers. On the other hand, pricing itself is perhaps not the best tool for approaching specific types of certain customer segments, so targeting still remains somewhat problematic.

If applying the Business Model Canvas on the customer segments of the service system in Lahti, it would determine them as "*segmented*", given that the service system identifies separate market segments with fairly similar needs and problems.

Private producers are allowed to attract and acquire end customers on the private market (non-statutory market) for home care. For instance the internet-based service portal PalveluSantra for the Lahti region includes also private services, so it constitutes an available and easy marketing channel for private producers interested in gaining additional customers. Nevertheless, this study and its analyses focus on markets for statutory home care.

Customer Relationships

Service producers shall accept all persons with service vouchers for home care as end customers. Service producers are also committed to nominate a care responsible person for every end customer. These are the main duties and obligations of the service producers. End customers, on the contrary, have the power not only to choose their service providers, but also to terminate the service relationship and to switch to other service producers. Service producers need to comply with this setup, except for situations where end customers violate their duties in the service relationship. It can be said that the customer relationships are not that strong from service producers' point of view, but they still incur a fair amount of obligations.

According to the Business Model Canvas, the customer relationships in the service system would be regarded as *"dedicated personal assistance"* – the deepest and most intense form.

City of Lahti is clearly the largest producer in the municipality, while the share held by private producers is clearly a minority of the total market for statutory home care. The amount of other service producers is 15, which is a large amount in relation to the size of the privatized market. Also, among the several service producers there are five NGOs and one large private healthcare group (Mainio Vire). These issues together suggest that the competition for service voucher customers is tough. Furthermore, the NGOs and Mainio Vire offer a variety of other wellbeing services in the Lahti region, so they are well-established and well-known by local end customers.

Channels

The channels of the service system contain two dimensions for service producers. They have two options for the service delivery channels; i) to utilize their *own channels* by providing

services itself, or to ii) utilize *partner channels* by outsourcing some services to one or many service partners within the service system. The second alternative means a combination of the own channel and the partner channel in delivering services.

For service producers the communication channel is a combination of the partner channel and the own channel. The internet-portal PalveluSantra and service offices of City of Lahti form the partner channel, and these provide key information on the service producers in a uniform way. The own communication channel is very different, as it enables service producers to carry out marketing in various forms and magnitudes.

Revenue Streams

A main feature of all service voucher systems, including that for home care in Lahti, is that it enables service producers to set the prices for their services. In Lahti the prices can be set separately for i) service categories (home help services, home nursing, night nursing), for ii) days of the week (Monday-Friday, Saturday, Sunday), and for iii) times of the day (daytime, evening, night). This makes price differentiation possible as a means to approach certain types of end customers or to focus on certain services. The fixed value of 24 EUR/hour for the service voucher for temporary home care decreases the risk of price competition, as service producers will unlikely price their services below that level. However, the value range of 7-24 EUR/hour for the service vouchers for regular home care might encourage some service producers to compete with prices. In practice the service producers have had higher prices than this. In 2011 there was only one service producer whose lowest service price (for home help services, on Monday-Friday, at daytime) went below 24 EUR/hour (PalveluSantra 2011, web-pages).

Service producers charge an hourly rate (EUR/hour) for all services they provide. This is a good solution, as it excludes risks associated with fixed charges for services where the tasks may exceed the times estimated and compensated for.

Service producers can charge only for i) providing granted services, and for ii) direct service time. Transportation times/costs can be charged only for those end customers who live more than 10 km outside the city center. Service producers are not able to charge for indirect

service time e.g. related to home nursing, which involves the most amount of additional work of all home-related services. These charging principles are nonetheless fair and acceptable for service providers, as they can e.g. set higher prices for home nursing as to compensate for the related indirect service time. The possibility to the adjust service prices is restricted to one time per year. This can be seen as a neutral or slightly negative matter for service producers, as a fixing the prices for 12 months onwards is a relatively long period of time.

The Business Model Canvas methodology would assess that the revenue streams for service producers in the service system arise from *"usage fees"* with *"list prices"* -based pricing.

Table 23: Service offering and revenue generation for service producers in the service system in Lahti

Analysis A1): Service Offering and Revenue Generation in Lahti			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Value Propositions (Service Offering)		0.7	Slightly positive
	The amount of different home care services (service range) offered by private producers	2	Positive
	The amount of home care provided, measured in service hours per person, by private producers	0	Neutral
	The relative (market) share of home care, compared to substitutive wellbeing services offered	0	Neutral
Customer Segments		-0.5	Slightly negative
	Private producers' access to individuals entitled to statutory home care	-1	Slightly negative
	The amount and type of customer segments (elderly persons, disabled persons etc.) served by private producers	0	Neutral
	Private producers' possibilities to target or focus on certain customer segments or service segments	-2	Negative
	The amount of elderly persons receiving home care by private producers	1	Slightly positive
	The amount of disabled persons receiving home care by private producers	-1	Slightly negative
	The amount of other persons (other than elderly and disabled) receiving home care by private producers	0	Neutral

Customer Relationships		-1.3	Slightly negative
	The market position (market share) of private producers, (+) limited or (-) significant	-1	Slightly negative
	The amount of private producers in the service system, (+) small or (-) large	-2	Negative
	The level of customer concentration in the service system, (+) diversified or (-) concentrated	-1	Slightly negative
Channels		1.0	Slightly positive
	Distribution channels and communication channels for private producers	1	Slightly positive
Revenue Streams		1.0	Slightly positive
	Private producers' possibilities to impact the price levels of services offered	2	Positive
	Compensation to private producers in relation to the associated costs	0	Neutral

7.2.2 A2: Operations and Costs

Key Resources

The most relevant input factor for service producers is human resources, i.e. the personnel. Service producers shall have enough employees with adequate competence what comes to education and work experience. As home nursing is a compulsory service in the service system, all service producers need to have nurses (assistant nurses or above) in their personnel. The service system also places a special emphasis on employees' knowhow in geriatrics – health and wellbeing of elderly persons. A significant part of the all requirements concerning human resources of service producers are set by legislation and by national authorities. This means that these requirements apply i) in all municipalities in the country, and ii) equally for municipal and private producers.

Apart from vehicles and basic medical equipment, service producers' need for physical resources is moderate. City of Lahti upholds the customer information IT-system Pegasos and offers it to the service producers free of charge. Also the internet-based service portal PalveluSantra is owned and operated by an external party (a service producer co-operative), but service providers must participate in associated marketing and training costs by paying a yearly fee. No instructions or requirements are set on the facilities, so service producers can arrange these as they prefer.

Key Activities

The key activities of service producers are greatly affected by the service offering. The ability to choose between only temporary home care and both temporary home care and regular home care is positive, in the sense that it enables service producers to limit their operations if they wish so. The obligation to offer the full scale of home nursing and home help services (12 sub-services in total) is perhaps the most critical requirement for service providers – they shall continuously be prepared to provide a broad range of services. This calls for a careful recruitment and co-ordination of personnel with end customers. Suitable human resources, meaning employees with either broad or focused competences, are a precondition for successful management of the broad service range. The service times are the most flexible dimension of the service offering, given that service producers can choose between six and seven time slots, separately for home nursing and for home help services. These options can, if wanted, even be used to diminish the impact of the broad service range. Service producers are e.g. able to minimize their service times for either home nursing or home help services, while maximizing their service times for the other.

The service area, Lahti municipality with 135 km^2 in one part, should not be a problem for service producers as it can be regarded as small. The population density of 753 persons/km^2 with 11 home care end customers/km^2 is on a good level, which keeps average transportation distances and transportation costs between end customers low.

The six customer segments served by service producers have distinct service needs, which impacts key activities. Elderly persons and disabled persons are typically provided with both home help services and home nursing, while families with children receive home help services, and other persons receive proportionally more of home nursing. The removal of special customers (war invalids, mentally ill patients etc.) with regular but low service needs is definitely beneficial for service producers, since these persons incur low service volumes (revenues) but serving them is demanding (costs).

Activities related to the customer relationships require time and efforts. Duties of responsible care persons, maintaining a statutory patient register, reporting to the customer information

system Pegasos and management of physical “home care folders” for each end customer are the main activities.

The lack of capacity limits is unfortunate, but service producers are able to restrict their key activities and key resources by e.g. i) offering only temporary home care, ii) limiting their service times, iii) pricing their services above average levels, or by iv) entering into partnerships.

A few technological solutions, such as automated or digitalized solutions, are applied within the service system and utilized by service producers. The web-portal PalveluSantra is one of the main solutions in the front-office (customer interface) of the service process. But the portal is still mainly an information channel since it lacks interactive features such as sales, booking and communication functions. In 2011 there was yet no electronic or digital solution for opening doors of end customers, but City of Lahti was in the process of initiating pilot projects on these issues. The service system also involves technological solutions in the back-office (support functions) of the service process. The customer information system Pegasos is the main solution here. The service voucher system itself is largely manual as the service vouchers are paper-based, i.e. physical instead of digital. No joint software application is available for patient registers, so service producers need to arrange this by themselves. The technological level of the service system overall can be categorized as medium or low.

The lack of task-based compensation for any of the offered services reduces the operational risks for the service producers. Service producers are encouraged to put time and efforts in serving end customers, but at the same time they are motivated to provide the services in a time equal to or less than granted service times.

An inconvenience of service voucher systems is that service producers usually have to charge both the municipality and the end customers. This is the case also with the service system in Lahti. The value range of 7-24 EUR/hour for the service voucher for regular home care leads to charging end customers in all cases where the service producer has set the price higher than the face value of the service voucher. But the fixed value of 24 EUR/hour for the service voucher for temporary home care might motivate some service producers to accept this price

level, solely to avoid additional work related to charging end customers. As already mentioned, the price levels of the services have in practice been above 24 EUR/hour, meaning that all service producers charge both the municipality and the end customers.

The service system in Lahti utilizes paper vouchers, which requires other administration as well. A used voucher is signed by both the end customer and the service producer, after which it is sent to City of Lahti for verification against records in Pegasos. A large part of this additional administration by service producers is manual work.

And if service producers offer any additional (non-statutory) services, these need to be charged directly and wholly from the end customers. The positive thing is that additional services need clearly less documentation, reporting and administration than services within the service system.

Service producers must arrange relevant training to the personnel. Service producers that offer home nursing need written medication plans for their operations. Written service reports with end customer signatures shall be included when invoicing City of Lahti. Other documentation of information and reporting of own activities have to be carried out on a recurring basis. These are all duties and tasks that require time and costs but do not generate revenues.

The Business Model Canvas methodology would determine the key activities of service producers in the service system to be "*production*".

Key Partnerships

Service producers are obliged to enter into co-operation to cover possible shortages in the ability to offer home nursing or medical services as a part of that. The service partners, to whom activities are outsourced, must be qualified operators in the service system and they have to offer home nursing. This is a valuable option for service producers, assuming that the broad service offering of the service system is the most potential cause of operative challenges. E.g. the size of the geographical service area should not be a problem requiring partnerships between service producers. Nevertheless, partnerships also involve co-ordination

of operations, which means additional work and costs. The partnerships also involve operational risks e.g. if the co-ordination of service chains does not function seamlessly.

Service producers need to co-operate with other parties as well, and these include both healthcare and social services producers. A special emphasis is placed on co-operation with some designated laboratory. Also co-operation with family and close friends shall be conducted and agreed upon in written form.

Cost Structure

The costs and investments that service producers in the service system face have been addressed indirectly in the sub-sections “Key Activities”, “Key Resources” and “Key Partnerships”. The focus here is primarily on what the cost structure and cost components for service producers are.

The Business Model Canvas analogue would rate the cost structure of the service system in Lahti as both *“cost-driven”* and *“value-driven”*. The maximum compensation obtained from City of Lahti is determined by the values of the service vouchers, and service vouchers may also lead to uniform market prices for the services offered to end customers. Service producers are therefore at least partly cost-driven, they are interested in keeping their costs low in order to reach or improve profitability. However, tight cost control including cost cutting is complicated by all the requisites and duties set by the service system. A value-driven cost structure applies to those service producers who conduct price differentiation by setting their service prices above the average. Those producers have higher cost levels as they need to offer above-average quality.

When assessing the implicit cost components of the service producers, it appears that fixed costs would dominate over variable costs. Personnel costs, investments in various IT-systems and software and acquisition or leasing of vehicles are the main sources of fixed cost. Fuel costs form a significant part of variable costs, together with possible partnerships costs.

Table 24: Operations and costs for service producers in the service system in Lahti

Analysis A2): Operations and Costs in Lahti			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Key Resources		0.0	Neutral
	The level of requirements for human resources (employees) of private producers	-1	Slightly negative
	Required investments in physical, intellectual and financial resources by private producers	1	Slightly positive
Key Activities		-1.1	Slightly negative
	The impact of service offering (service type, service range, combination possibilities, service times, geographical area) on the operations of private producers	-1	Slightly negative
	The impact of served customer segments (segment range, combination possibilities, profitability) on the operations of private producers	-2	Negative
	The impact of customer relationships (service producer obligations and end customer possibilities) on the operations of private producers	-2	Negative
	Private producers' possibilities to set capacity limits for their operations	0	Neutral
	The amount of technology solutions (automated services, digitalized services etc.) in the service system that is applied in customer work	-1	Slightly negative
	The amount of technology solutions (automated functions, digitalized functions etc.) in the service system that is applied in support services	-1	Slightly negative
	Activities related to charging and invoicing of end customers by private producers	-1	Slightly negative
	The amount of operative activities that private producers are not compensated for	-1	Slightly negative
Key Partnerships		-0.5	Slightly negative
	Private producers' obligations to co-operate with external parties	-2	Negative
	Private producers' possibilities to appoint service partners (to outsource)	1	Slightly positive
Cost Structure		0.0	Neutral
	Private producers' possibilities to impact their operative costs	0	Neutral

7.2.3 A3: Implications of Quality

The structure of the following quality analysis is aligning the Business Model Canvas in many respects. Quality is divided into three parts, the first of which concerns services, the second concerns operations while the third concerns communication related thereto. The categorization is in line with analyses A1-A2 and B1-B2.

Service Quality

Several quality matters associated with Value Proposition in the Canvas – in practice the service offering – can be identified. The customization of the services to match the specific needs of end customers is emphasized, as is the rehabilitative approach to the service provision. The handling of customers' keys and the procedures for management of customers' money needs to be agreed upon separately with the end customers. Also, the functioning of end customers' security systems, assistive devices and fire alarms shall be secured. Moreover, end customers shall be guided and assisted in the application of other available wellbeing services and of public allowances. The basis for new customer relationships is that service producers shall have a readiness to start serving a new end customer one day after signing the service contract.

Operational Quality

The operational quality matters are associated with Key Resources and in particular with Key Activities in the Canvas. Service producers must have systematic methods both for monitoring service quality and for correcting shortcomings in quality. End customer feedback and customer complaints shall be collected, stored and forwarded to City of Lahti. Sufficient, proper and careful management of customer data and patient data is of utmost importance. Documentation and reporting of operations, employees and end customers shall be submitted to City of Lahti regularly, as a part of the continuous quality work.

The quality-related requirements and duties result in additional work and costs for service producers. Even if a part of the additional costs for service producers depend on the scale of the operations, most of them seem to materialize as fixed costs irrespective of the operative situation. This drawback is in relative terms more significant for smaller service producers than for larger ones.

Quality and Communication

Service voucher systems, such as that for home care in Lahti, enable service producers to compete with both quality and prices. The service system itself sets minimum requirements with respect to service quality and operational quality. Service producers can naturally decide to deliver quality above the levels set by the requirements. The fact that service producers can set their service prices should facilitate the adjustment of quality levels to corresponding levels, especially in case of high-price and high-quality -combinations.

No quality indices or outcomes of customer satisfaction surveys on the service producers in the service system in Lahti are (publicly) available. This raises questions about what the position of quality within the service system and among service producers in reality is. The lack of objective data reflecting the quality of the service producers and/or their services makes it difficult for end customers to make comparisons between service producers. This in turn may lower the motivation of existing service producers to put more efforts than necessary into quality matters.

Table 25: Implications of quality for service producers in the service system in Lahti

Analysis A3): Implications of Quality in Lahti			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Quality and Costs		-1.0	Slightly negative
	The direct impact of service quality requirements on private producers' costs	-1	Slightly negative
	The direct impact of operational quality requirements on private producers' costs	-1	Slightly negative
Quality and Revenues		1.0	Slightly positive
	The potential impact of quality on private producers' customer amounts	1	Slightly positive
	The potential impact of quality on private producers' service prices	1	Slightly positive

Quality and Communication		-2.0	Negative
	Availability of public information on measured quality among private producers	-2	Negative
	Observed relation between measured quality and customer relationships among private producers	-	-

7.2.4 B1: Service Offering and Revenue Generation in the Future

The following table displays the answers provided by City of Lahti representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 26: Service offering and revenue generation for service producers in the service system in Lahti – in the future

Analysis B1): Service Offering and Revenue Generation in Lahti in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Value Propositions (Service Offering)			Improves
	Will the amount of different home services (=service range) offered by private service producers increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the granting of personal care, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the granting of home help, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same

	Will the granting of other existing home services (other than personal care and home help, for instance home nursing), in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the share (market share) of home care increase/decrease in proportion to offered substitutive wellbeing services in the future, when compared to the current situation?	Increases	Improves
Customer Segments			Improves slightly
	Will the amount of different customer segments (elderly persons, disabled persons, families with children, rehabilitators, demobilized hospital patients etc.) increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the amount of elderly persons receiving home care increase/decrease in the future, when compared to the current situation?	Increases significantly	Improves significantly
	Will the amount of disabled persons receiving home care increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
	Will the amount of other persons (other than elderly and disabled persons) currently receiving home care increase/decrease in the future, when compared to the current situation?	Decreases slightly	Worsens slightly
Customer Relationships			Worsens slightly
	Within home care, will the position of the municipal service producer (investments in physical/intellectual/human resources, in processes, in knowhow, in brands) increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
	Within the service system for home care, do you believe that that the amount of service producers will increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
	Within home care, do you believe that the concentration of the market (the customers) in relation to available service producers will increase/decrease in the future, when compared to the current situation?	Decreases slightly	Improves slightly *
Channels			
	-	-	-
Revenue Streams *(Calculated as the average of all points listed in this table)*			Improves slightly
	Within home care, will the increases in the compensation levels to service producers in the future be higher/lower than the increases in the actual production costs, when compared to the current situation?	Higher	Improves

Based on the answers provided by the representatives of City of Lahti, the future development appears to be positive what concerns the service offering in the service system for home care. The service range is expected to widen, as is the amount of service hours per person for all service categories except for home help services. This is supported by a strengthening of the relative position (increasing market share) of home care in comparison to substitutive wellbeing services arranged by City of Lahti.

Also the amount of customer segments, in terms of different types of end customers, is expected to increase. It still seems that elderly persons is the segment where the customer amounts will grow most in quantity, while e.g. the amount of disabled persons will increase only slightly. Altogether the customer amounts seem to develop quite favorably for service producers.

Although customer amounts is expected to increase somewhat, the competition for customerships can be expected to intensify. City of Lahti aims to invest in and thus strengthen the position of its own service production in future. In addition, the amount of service producers is expected to grow from current levels.

A promising signal is that the compensation levels to service producers are likely to increase more than the actual production costs rise. However, the assessment does not consider the current compensation levels as to whether they are high or low.

7.2.5 B2: Operations and Costs in the Future

The following table displays the answers provided by City of Lahti representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 27: Operations and costs for service producers in the service system in Lahti – in the future

Analysis B2): Operations and Costs in Lahti in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Key Resources			Improves slightly
	Within home care, will the local supply of employees with suitable education and work experience increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
Key Activities			Improves significantly
	In the direct customer work within home care, will the use of technology solutions (automated services, digitalized services etc.) increase/decrease in the future, when compared to the current situation?	Increases significantly	Improves significantly
	In the support functions within home care, will the use of technology solutions (automated functions, digitalized functions etc.) increase/decrease in the future, when compared to the current situation?	Increases significantly	Improves significantly
Key Partnerships			
	-	-	-
Cost Structure *(Calculated as the average of all points listed in this table)*			Improves
	-	-	-

The operational outlook for service producers in the service system in Lahti includes positive elements. The local availability of suitable workforce is expected to improve slightly, but more importantly, the utilization of technological solutions will expand significantly. This is very favorable for service producers, as it will likely eliminate a notable part of the current (manual) work and thereby improve overall productivity. It is also encouraging that the technology increases will occur in both customer service processes and support processes.

7.2.6 B3: Implications of Quality in the Future

The following table displays the answers provided by City of Lahti representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/issue in the table.

Table 28: Implications of quality for service producers in the service system in Lahti – in the future

Analysis B3): Implications of Quality in Lahti in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Quality and Costs			Worsens significantly
	Within home care, will the requirements set for the services offered increase/decrease in the future, when compared to the current situation?	Increases significantly	Worsens significantly *
	Within home care, will the requirements set for the service producers increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
Quality and Revenues			
	-	-	-
Quality and Communication			
	-	-	-

It appears as if City of Lahti intends to tighten the requirements within the service system considerably from current levels. This concerns both the services themselves as well as the

service producers. The upward shift in quality requirements is of course beneficial for the end customers and to some extent also for all service private, in case the shift will improve their offering and appeal compared to the municipal producer. Nevertheless, the direct effects of lifting quality levels within the service system are incremental costs for service producers. The magnitudes of the incremental costs are difficult to assess, as they are partly dependent on internal processes and thus specific for each service producer. For service producers with efficient service processes and/or business processes, the upward shifts in quality requirements may lead to only marginal cost increases.

7.2.7 Summary of Analyses

<table>
<tr><td rowspan="2">Key Partnerships:

Slightly negative</td><td>Key Activities:

Slightly negative</td><td rowspan="2">Value Propositions (Service Offering):

Slightly positive</td><td>Customer Relationships:

Slightly negative</td><td rowspan="2">Customer Segments:

Slightly negative</td></tr>
<tr><td>Improves significantly</td><td>Worsens slightly</td></tr>
<tr><td rowspan="2">-</td><td>Key Resources:

Neutral</td><td rowspan="2">Improves</td><td>Channels:

Slightly positive</td><td rowspan="2">Improves slightly</td></tr>
<tr><td>Improves slightly</td><td>-</td></tr>
<tr><td colspan="3">Cost Structure:

Neutral</td><td colspan="2">Revenue Streams:

Slightly positive</td></tr>
<tr><td colspan="3">Improves</td><td colspan="2">Improves slightly</td></tr>
</table>

Light grey cells indicate current situation | *Grey cells indicate the future situation (development)*

Figure 40: Summary of possibilities for conducting business in the service system in Lahti (analyses A1-A2 and B1-B2)

The analyses that evaluate the current and future possibilities for conducting business in the service system for home care in Lahti (A1-A2 and B1-B2) identify a couple of key issues. The most evident disadvantages for service producers are currently the difficulty to target or focus on specific customer or service segments, the competitive landscape, and challenges related to managing the customer relationships and also to managing the network of cooperation partners. On the other hand, the service offering is currently quite favorable due to e.g. the

wide service range, which covers a large share of all available wellbeing services. The service offering matters are even expected to improve in the coming years, and so are also the average amounts of service hours per end customer. It is also positive that the situation with operational activities, which currently involve a fair amount of manual and non-productive duties, is going to improve due to a clear increase in technological solutions within the service system. Revenue issues are advantageous due to nearly unrestricted pricing of services combined with hourly-based compensation for all services provided. Expected changes in the services system, including increases in compensation levels (i.e. in service voucher values), will improve revenue streams of service producers. Also their cost structure is likely to improve due to the aforementioned changes in the service system.

Quality and Costs:	Quality and Revenues:
Slightly negative	Slightly positive
Worsens significantly	-
Quality and Communication:	
Negative	
-	

Light grey cells indicate current situation	*Grey cells indicate the future situation (development)*

Figure 41: Summary of quality implications for businesses in the service system in Lahti (analyses A3 and B3)

The analyses that evaluate the implications of quality on business operations in the service system for home care in Lahti (A3 and B3) point out some drawbacks. The quality requirements create additional costs mainly because the service system itself offers only few tools and little support for the quality work, but also because the quality work emphasizes ongoing processes more than development of quality processes. The tightening requirements for both service quality and producer quality imply that quality-related costs will rise. The service system enables service producers to shift quality into service prices, which is of course useful. On the other hand, the lack of public information on recorded quality among service producers is a clear handicap for all service producers performing better than the average. The outcome of analyses A3 and B3 suggests that service producers may prefer to choose cost

control over service quality as a means to attract and serve customers – i.e. to choose cost strategies over quality strategies for their businesses.

7.3 Analysis of Hyvinkää

7.3.1 A1: Service Offering and Revenue Generation

Value Proposition

There are five aspects to the service offering of service producers in the service system for home care in Hyvinkää. These are i) *service type*, ii) *service range*, iii) *possibilities for choosing and combining a desired service offering*, iv) *service times* and v) *service area*. Service producers are bound to offer two service types together – temporary home care and light regular home care – in addition to which they can opt for support for informal care in the form of home care. This implies that the operations of service producers are characterized by both short-term contracts (temporary home care) and long-term contracts (light regular home care, support for informal care), with no possibilities for choosing only either type. Service producers face a broad service range, given that there are six sub-services within home help services and equally many within home nursing. There is consequently a large variety of different sub-services. Service producers have reasonably good possibilities to choose and combine among the services, as home nursing and night care are both optional. Offering end customers e.g. solely home help services is possible. Also the service times involve some leeway, with preparedness to serve end customers either 11, 15 or 24 hours every day (Monday-Sunday). The service area is an inflexible element in the service offering, as service producers need to cover the entire municipal area of Hyvinkää.

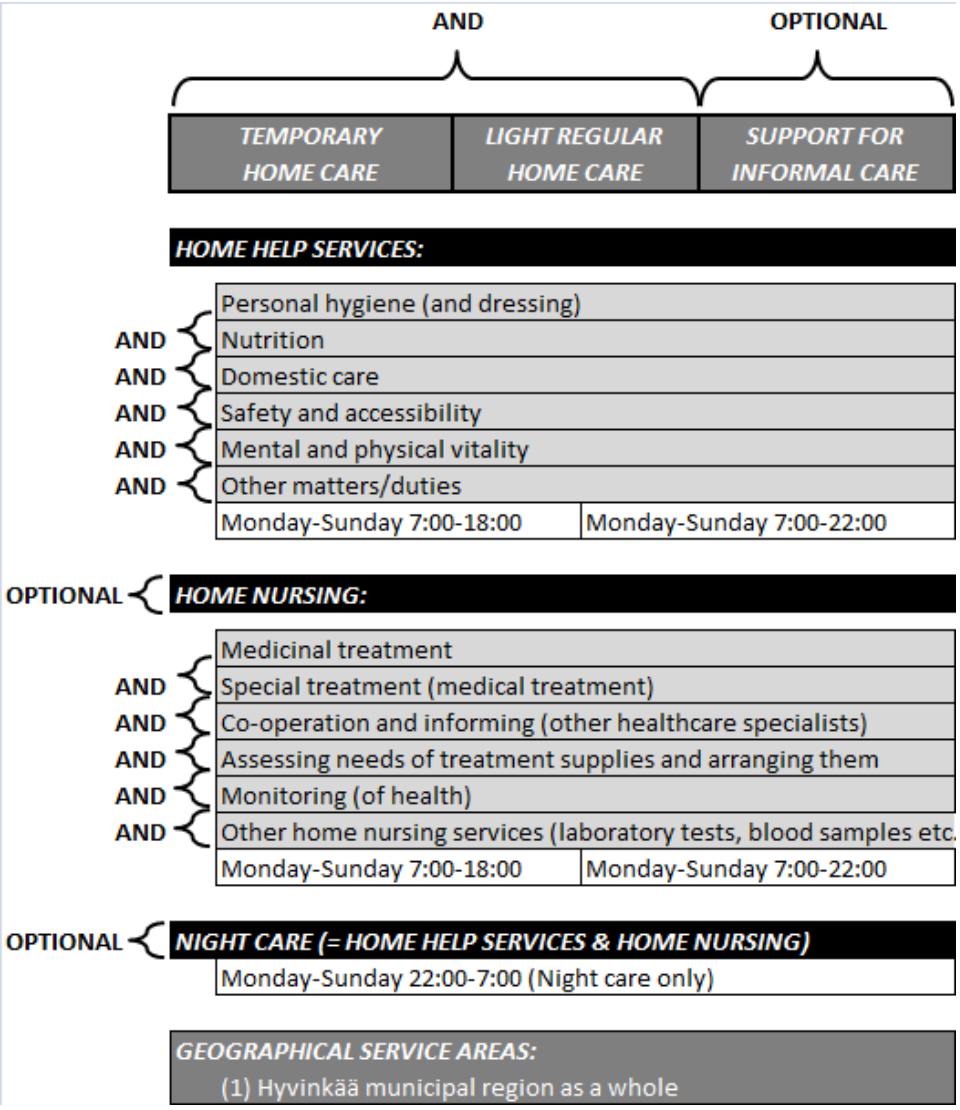

Figure 42: Overview of the service offering in Hyvinkää (Hyvinkää 2011 a, p. 1-8; Hyvinkää 2011 b, p. 1-6; Hyvinkää 2011 c, p 1-5)

"*Quality*", "*performance*", "*customization*" and "*convenience/usability*" are characteristics listed by the Business Model Canvas that describe the service offering of the service system in Hyvinkää.

All service producers are able to offer and supply additional and voluntary services to their end customers. This enables expansions of both service volumes and of services offered.

In 2011 (January-October) the private producers provided on average 3 hours of home care services per month per person. This service hour amount, which was the same for both temporary home care and for light regular home care, is very low and consequently

unsatisfactory for the private producers. The cause of the problem is in the definition of light regular home care itself – it encompasses only those persons who receive less than 8.00 hours of home care per month. Still, a comforting thing is that within support for informal care (in the form of home care), the private producers provided on average 17 hours of services per month per person. This implies that private producers of home care services can achieve significantly higher service volumes by also entering into the service system for support for informal care.

The amount of home-related services arranged by City of Hyvinkää is quite large, but the service system for home care covers only a part of that. The situation improves somewhat when including the service system for support for informal care. But it should be noticed that City of Hyvinkää produces a couple of more demanding services, i.e. intensified home care and home rehabilitation, entirely itself. Especially the absence of intensified home care cuts off business opportunities from private service producers. Another handicap is the handful of potential home-related services that are currently being acquired directly from one or a few nominated service producers. Home care for war invalids, the meal service and cleaning services for poor persons are typical home care services that are currently outside the service systems.

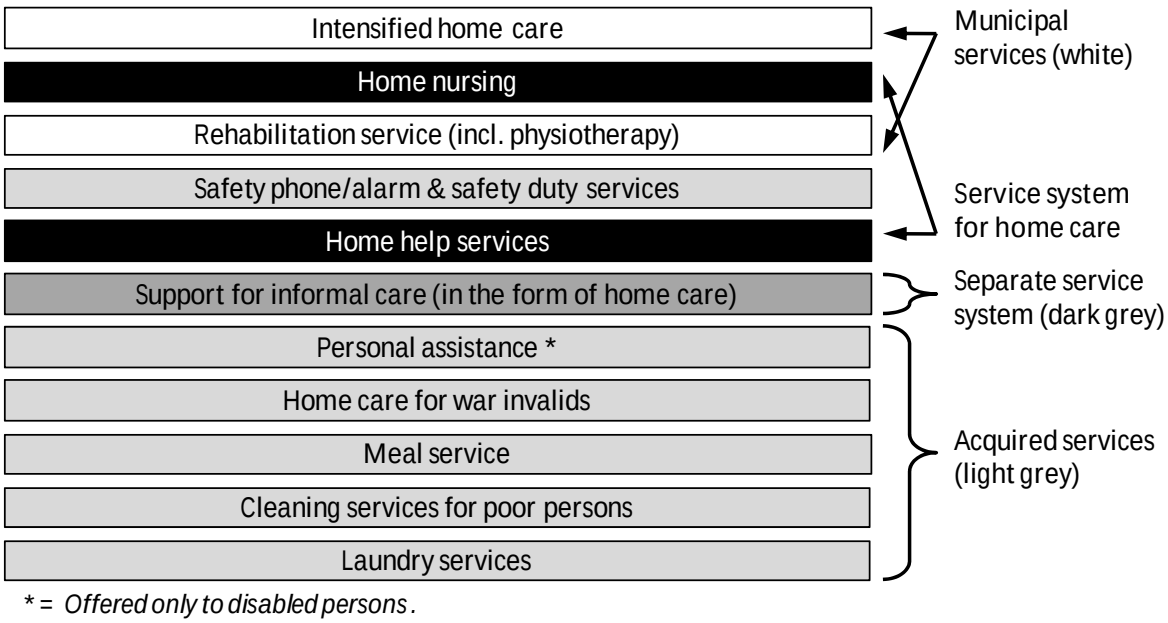

Figure 43: Range of home-related services in Hyvinkää (Hyvinkää 2011, web-pages)

Customer Segments

Given the legislation and praxis for service voucher systems, City of Hyvinkää can at its own discretion decide on which persons are granted service vouchers. And as these decisions may vary over time, it becomes evident that the position of private producers with respect to end customers and their amounts is constantly quite vague.

The size of the market for statutory home care in Hyvinkää is decent, considering that it comprised over 1,000 end customers in 2011. On the other hand, the amount of service voucher customers – in total approximately 40, or only 20 when excluding support for informal care – are definitely very low numbers. This applies especially for light regular home care, for which the service voucher customers amounted to less than 10.

The service system for home care involves 3 separate customer types; elderly persons, disabled persons and "other persons". Other persons are primarily those who are granted short-term home care in connection with demobilizing persons from hospital or other institutional treatment. Then there are 2 service types, temporary home care and light regular home care, and service producers offer these two in parallel. Additionally the home care itself can be split into home help services and home nursing. A total of 10 different customer segments can thus be identified in the service system. It should be remembered that the 3 customer types have been bundled together, as have the 2 service categories, resulting in 2 separate blocks for the service producers with 5 customer segments each. The large amount of customer segments may distort the reality that elderly persons are the dominating customer type. E.g. some 90% of the persons receiving municipal regular home care are 65 years or older, and the situation with temporary home care is assumingly similar. The customer segments that have been concentrated to City of Lahti are the following; all persons who receive intensified home care (3 customer segments), as well as war invalids and families with children who receive home care. These five customer segments are lost business for the service producers, especially those segments involving regular services and/or above-average service hours.

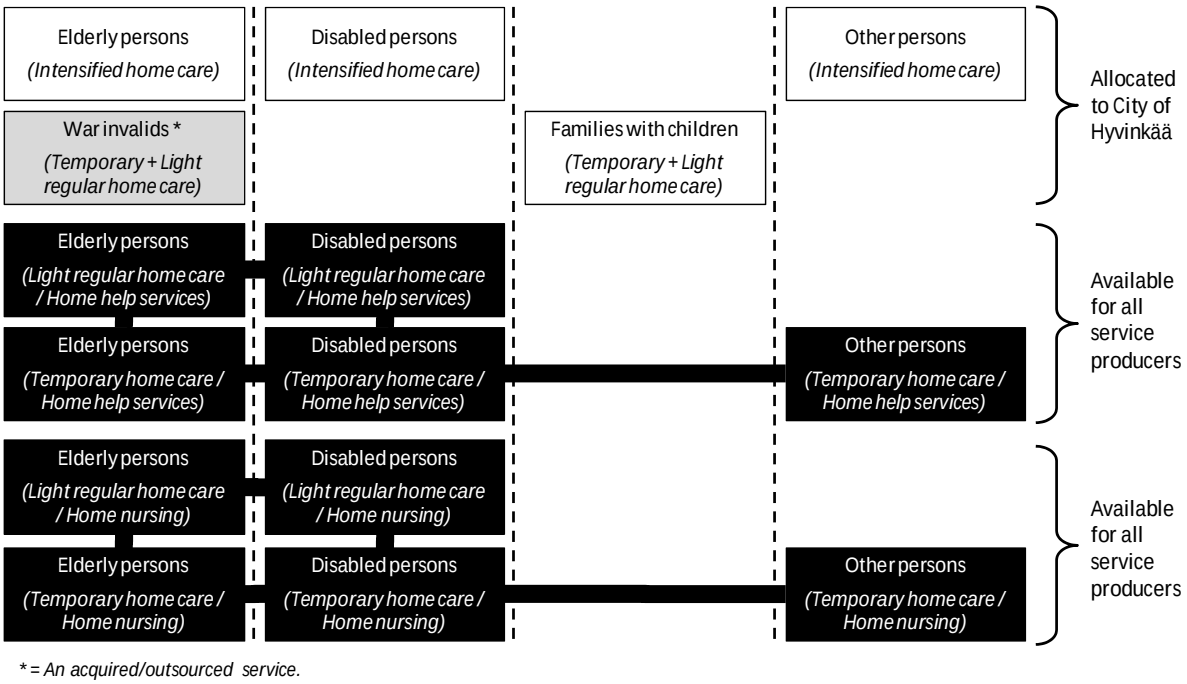

Figure 44: Customer segments within home care in Hyvinkää

As already mentioned, even if there are 10 customer segments the service producers can in practice only choose between two bundles – offering help services to 5 customer segments or offering home nursing to 5 customer segments, or both. So service producers have only limited possibilities to target and choose among the different customer segments. Service producers shall serve all end customers within the chosen customer segment bundles. Marketing and especially pricing remain secondary tools, by which service producers can try to approach and focus on different kinds of customer segments.

If applying the Business Model Canvas on the customer segments of the service system in Hyvinkää, it would determine them as "*segmented*", given that the service system identifies separate market segments with fairly similar needs and problems.

Private producers are allowed to attract and acquire end customers also on the private market (non-statutory market) for home care. This creates additional business opportunities.

<u>Customer Relationships</u>

Service producers are obliged to accept all persons with service vouchers for home care as end customers. Service producers shall also nominate a care responsible person for every end

customer. The end customers in turn have the authority to choose their service producers, terminate the service relationships and to switch to other service producers. The customer relationships between the service producers and the end customers are thus asymmetric, and relatively weak from perspective of the service producers.

According to the Business Model Canvas, the customer relationships in the service system would be regarded as *"dedicated personal assistance"*, which is the deepest and most intense form.

City of Hyvinkää is clearly the dominant producer of statutory home care in the municipality, while private producers account for only a small share. But it is nonetheless comforting that there are only four private producers of home care (and additionally one producer of support for informal care in the form of home care). Furthermore, all service producers are either small or mid-sized with 1-30 employees, which indicates that the competitive situation in the service system is manageable rather than fierce.

Channels

Service producers have two options for the service delivery channels; they either i) utilize their own channels by providing services themselves, or then they ii) utilize partner channels by outsourcing some services to one or many service partners within the service system.

For service producers the communication channel is a combination of the partner channel and the own channel. The web-pages and service offices of City of Hyvinkää form the partner channel, although the web-pages contain only a few key issues for each producer, such as service price, service types and addresses to their web-pages.

Revenue Streams

The service system in Hyvinkää allows service producers to price the services they offer. The service producers can set the prices separately for temporary home care and for light regular home care (also support for informal care in the form of home care is priced separately). The prices are valid for all days of the week and for all times of the day. This uniform pricing prevents producers from applying higher prices for evenings, nights or weekends. The pricing

of services permits some price differentiation as a way to approach certain types of end customers or to focus on certain services.

The fixed value of EUR 24 per hour for the service voucher for temporary home care decreases the risk of price competition, as service producers lack incentives to go below that level. However, the value range of EUR 0-24 per hour for the service vouchers for light regular home care might encourage service producers to set the price level below 24 EUR/hour. These risks did in practice not materialize in 2011, as the service producers had set their price levels within the range of EUR 24-30 per hour (Hyvinkää 2011, web-pages).

Service producers charge an hourly rate (EUR/hour) for all services they provide, which eliminates the risks associated with service tasks lasting longer than expected and compensated for.

Service producers can charge only for i) providing granted services, and for ii) direct service time. Neither transportation time/costs nor indirect service time can be charged for. These principles are sound on the whole, but they involve risks regarding end customers living in peripheral districts or far from service producers' premises. Higher pricing for the services can compensate for the indirect service time connected with e.g. home nursing. The possibility to adjust service prices upwards due to changes in the cost structure is valuable, especially as the transition period is only two months. This enables service producers to raise their service prices up to six times per year, if necessary. A drawback of the service voucher system in Hyvinkää is that service producers bear all losses from unpaid invoices by end customers.

The Business Model Canvas methodology would assess that the revenue streams for service producers in the service system arise from *"usage fees"* combined with *"list prices"* -based pricing.

Table 29: Service offering and revenue generation for service producers in the service system in Hyvinkää

Analysis A1): Service Offering and Revenue Generation in Hyvinkää			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Value Propositions (Service Offering)		-0.3	Neutral
	The amount of different home care services (service range) offered by private producers	2	Positive
	The amount of home care provided, measured in service hours per person, by private producers	-2	Negative
	The relative (market) share of home care, compared to substitutive wellbeing services offered	-1	Slightly negative
Customer Segments		-1.5	Negative
	Private producers' access to individuals entitled to statutory home care	-1	Slightly negative
	The amount and type of customer segments (elderly persons, disabled persons etc.) served by private producers	-1	Slightly negative
	Private producers' possibilities to target or focus on certain customer segments or service segments	-1	Slightly negative
	The amount of elderly persons receiving home care by private producers	-2	Negative
	The amount of disabled persons receiving home care by private producers	-2	Negative
	The amount of other persons (other than elderly and disabled) receiving home care by private producers	-2	Negative
Customer Relationships		-1.3	Slightly negative
	The market position (market share) of private producers, (+) limited or (-) significant	-3	Very negative
	The amount of private producers in the service system, (+) small or (-) large	0	Neutral
	The level of customer concentration in the service system, (+) diversified or (-) concentrated	-1	Slightly negative
Channels		1.0	Slightly positive
	Distribution channels and communication channels for private producers	1	Slightly positive
Revenue Streams		0.0	Neutral
	Private producers' possibilities to impact the price levels of services offered	1	Slightly positive
	Compensation to private producers in relation to the associated costs	-1	Slightly negative

7.3.2 A2: Operations and Costs

Key Resources

Human resources is the most critical component in the service production. This applies especially to those service producers that choose to offer home nursing. The service employees need to have a legitimized status of public health nurse, nurse, practical nurse or assistant nurse. Additionally they need to prove their skills or alternatively have permits granted by a doctor. Service producers are on certain conditions able to have students as temporary workforce. Nonetheless, most of all requirements concerning human resources of service producers are set by legislation and by national authorities, meaning that they are not only specific for Hyvinkää or for private producers.

Service producers need to make some smaller investments in physical resources, e.g. in case of creating their customer databases in electronic forms. No instructions or requirements are set on the facilities, so service producers can arrange these as they prefer.

Key Activities

The service offering has direct impacts on the key activities of the service producers. The fact that home nursing and night nursing are optional services provides flexibility to service producers for designing their operations. Service producers can adjust their operations including the management of human resources for a narrow service range (6 sub-services) or a broad service range (12 sub-services). The service times involve some flexibility, as service producers can choose a preparedness to serve end customers either 11, 15, 20 or 24 hours/day.

The service area for service producers is the entire municipal region of Hyvinkää. The geographical area of 323 km^2 can be seen as small or mid-sized, but the population density of 141 persons/km^2 with 2 home care end customers/km^2 is low. The population density is clearly higher in the city center, but it should be remembered that some 68% of the inhabitants in Hyvinkää live in sparsely populated areas. The conclusion is that service producers have on average quite long transportation distances between end customers, and this raises costs. On the other hand, for each end customer there is a roughly 1/3 chance that the person lives in the densely populated city center.

The service system concerns a total of ten customer segments in two separate bundles, one focusing on home help services and the other on home nursing. Both bundles include both elderly persons, disabled persons and other persons. Also – and more importantly – both bundles include both temporary home care and light regular home care. This means that service producers do in any case serve a fragmented group of end customers, which may complicate their operations and provision of services. Serving end customers of temporary home care differs from serving those of light regular home care, as the service contracts are shorter and the relative costs for customer relationships are higher. The lack of all customer segments for intensified home care is naturally unfortunate, given the higher service volumes and the easier coordination of services for these persons.

Managing the customer relationships consumes time and generates costs. The most relevant components for this are the work of the responsible care persons and the upholding of the own customer database, including the own patient register in case of home nursing customers. However, for service producers offering only home help services the managing of customer relationships is easier and less costly.

Even if service producers are not able to set capacity limits, they can restrict their operations and resources by i) offering only home help services, ii) choosing minimum service times, iii) pricing their services above average levels, or by iv) entering into partnerships.

One of the most obvious disadvantages with the service system in Hyvinkää is that it provides almost no technological solutions to service producers. This seems to be the situation both in service functions and support functions. Service producers themselves need to e.g. create compulsory customer databases (with patient registers in case of home nursing), and also ascertain sufficient data security, as specified by City of Hyvinkää. The service voucher system itself is largely manual as the service vouchers are paper-based, i.e. physical instead of digital. Also the transmission of customer- and patient data between service producers and City of Hyvinkää is paper-based and consequently manual, as no integrated CRM- or ERP-solution exists between the two parties. The technological level of the service system is overall low.

The hourly-based compensation for all services offered is beneficial for service producers, as it removes risks that would be associated with task-based compensation. It also directs the incentives towards providing proper service to end customers.

The service system in Hyvinkää drives service producers to charge both City of Hyvinkää and the end customers. The values of the service vouchers – EUR 0-24 per hour for light regular home care and EUR 24 per hour for temporary home care – leads to a charging of end customers in most cases, given that 3 of 4 producers had set their price levels above EUR 24 per hour in October 2011.

The invoicing procedures and the service vouchers call for administration and work related thereto. The invoices shall be paper-based, which means that the invoicing of City of Hyvinkää is manual. Also the service vouchers are paper-based, and they need to be manually filled, signed and attached to the invoices. Additional services that service producers may offer have to be invoiced separately and directly from the end customers.

Service producers are obliged to arrange sufficient updating education to the employees. Written medication plans for the operations need to exist for service producers offering home nursing. Miscellaneous documentation and reporting has to be carried out regularly. These activities are associated with costs but not with revenues.

The Business Model Canvas methodology would determine the key activities of service producers in the service system to be "*production*".

Key Partnerships

Service partnerships constitute a useful option for service producers that want to shift parts of their service operations to external parties. A positive thing is that the service producers can be outside the service system, but they still need to meet the same requirements that qualified service producers do. This is also logical, due to the limited amount of service producers in the service system. Service producers can hire partners for e.g. providing certain services or customers, or for serving certain geographical areas. However, the fact that home nursing and

night nursing are optional for the service producers will obviously reduce the need for service partners for these service categories.

Other compulsory cooperation parties for service producers are family members, relatives or close persons to the end customers. These are natural and relatively uncomplicated co-operation parties for the service producers. Service producers shall also cooperate with district doctors, but this is likely to concern mainly home nursing and end customers therein.

Cost Structure

The costs and investments that service producers in the service system face have been addressed indirectly in the previous sub-sections “Key Activities”, “Key Resources” and “Key Partnerships”. The focus here is primarily on what the cost structure and cost components for service producers are.

The cost structure of the service system in Hyvinkää is both *“cost-driven”* and *“value-driven”*, as defined by the Business Model Canvas. Service producers need to be cost-driven, given that there are maximum values for the service vouchers and thereby maximum levels for the compensation received from City of Hyvinkää. But cutting down on costs is being challenged by the requisites and duties imposed by the service system itself. This stimulates at least some service producers to strive for a value-driven cost structure, i.e. for higher prices and higher quality and thereby higher costs.

Cost components of the service producers are primarily fixed and secondarily variable. Main fixed cost items are personnel costs, investments in various IT-systems and software and acquisition or leasing of vehicles. Main variable costs in turn are fuel costs and costs from potential outsourcings, i.e. from services partnerships.

Table 30: Operations and costs for service producers in the service system in Hyvinkää

Analysis A2): Operations and Costs in Hyvinkää			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Key Resources		0.0	Neutral
	The level of requirements for human resources (employees) of private producers	0	Neutral
	Required investments in physical, intellectual and financial resources by private producers	0	Neutral
Key Activities		-1.5	Negative
	The impact of service offering (service type, service range, combination possibilities, service times, geographical area) on the operations of private producers	-2	Negative
	The impact of served customer segments (segment range, combination possibilities, profitability) on the operations of private producers	-3	Very negative
	The impact of customer relationships (service producer obligations and end customer possibilities) on the operations of private producers	-1	Slightly negative
	Private producers' possibilities to set capacity limits for their operations	0	Neutral
	The amount of technology solutions (automated services, digitalized services etc.) in the service system that is applied in customer work	-2	Negative
	The amount of technology solutions (automated functions, digitalized functions etc.) in the service system that is applied in support services	-2	Negative
	Activities related to charging and invoicing of end customers by private producers	-1	Slightly negative
	The amount of operative activities that private producers are not compensated for	-1	Slightly negative
Key Partnerships		0.5	Slightly positive
	Private producers' obligations to co-operate with external parties	-1	Slightly negative
	Private producers' possibilities to appoint service partners (to outsource)	2	Positive
Cost Structure		0.0	Neutral
	Private producers' possibilities to impact their operative costs	0	Neutral

7.3.3 A3: Implications of Quality

The structure of the following quality analysis is aligning the Business Model Canvas in many respects. Quality is divided into three parts, the first of which concerns services, the second concerns operations while the third concerns communication related thereto. The categorization is in line with analyses A1-A2 and B1-B2.

Service Quality

The service system contains a number of quality issues related to the service offering (Value Proposition in the Canvas). Customization of the services and a rehabilitative approach are key principles of the service provision. Service producers shall secure a safe demobilization of end customers returning from hospital care. End customers shall also be guided and assisted in the application of public allowances they are entitled to. Service producers shall have procedures for the handling of end customers' keys and for the management of their finances, and these need to be agreed upon. A quality aspect related to the customer relationships is that service producers shall have be prepared to start serving new end customers at the latest two days after signing the service contract.

Operational Quality

Issues related to operational quality are mainly connected to Key Activities. One of the few quality issues related to Key Resources is the requirement that service producers shall secure sufficient personnel also for exceptional situations, such as for unexpected sick leaves.

Quality of the operations is brought out as its own topic. Service producers shall define quality requirements and quality goals for their operations, as well as adapt some quality assessment system for their services. They shall also have some customer feedback system and collect feedback on an ongoing basis. Quality tracking data and customer feedback data with complementary information shall be forwarded to City of Hyvinkää. Service producers shall carry out yearly customer surveys and allow monitoring and audits performed by City of Hyvinkää. Moreover, service producers shall follow regulations, advices, programs, guidelines, steering documents and recommendations on quality as specified by ministries, authorities and City of Hyvinkää.

Other areas of operational quality are e.g. proper administration of the own customer database with the possible own patient register, including the data security related thereto. Another area is personnel quality, which involves e.g. confidentiality issues, validity of permits and licenses and controlling for criminal records. The quality work also commits service producers to documentation and regular reporting of own operations and end customers to City of Hyvinkää.

Operational quality leads to incremental activities and costs for service producers. In particular the initial costs for establishing required systems and procedures for quality are fixed-type of costs. Also the upholding of operational quality is mostly associated with fixed costs, yet partly also with variable costs. Operational quality in the service system in Hyvinkää thereby causes larger burdens to new and small producers than it does to established and large ones.

However, it should be emphasized that both service quality and operational quality are largely dependent on the chosen service offering. Service producers offering only home help services face a smaller amount of requirements and duties than those offering also home nursing and night care.

Quality and Communication

Service producers in Hyvinkää can emphasize both quality and prices when competing for end customers, as this is a key feature of service voucher systems. Minimum requirements for service quality and operational quality are set by the service system, and service producers are able to exceed these quality levels. Service producers are thus able to align service price levels with quality levels, in particular in cases of offering high-quality for high-prices.

There are no publicly available surveys or data on customer satisfaction for service producers in the service system. This has a negative effect on the position and the relevance of quality within the service system in practice. The absence of recorded quality for the service producers complicates the decision-making of end customers, which in turn may lower service producers' incentives to invest in quality and to improve it.

Table 31: Implications of quality for service producers in the service system in Hyvinkää

Analysis A3): Implications of Quality in Hyvinkää		
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)	Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Quality and Costs	-0.5	Slightly negative
The direct impact of service quality requirements on private producers' costs	-1	Slightly negative
The direct impact of operational quality requirements on private producers' costs	0	Neutral
Quality and Revenues	1.0	Slightly positive
The potential impact of quality on private producers' customer amounts	1	Slightly positive
The potential impact of quality on private producers' service prices	1	Slightly positive
Quality and Communication	-2.0	Negative
Availability of public information on measured quality among private producers	-2	Negative
Observed relation between measured quality and customer relationships among private producers	-	-

7.3.4 B1: Service Offering and Revenue Generation in the Future

The following table displays the answers provided by City of Hyvinkää representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 32: Service offering and revenue generation for service producers in the service system in Hyvinkää – in the future

Analysis B1): Service Offering and Revenue Generation in Hyvinkää in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Value Propositions (Service Offering)			Improves slightly
	Will the amount of different home services (=service range) offered by private service producers increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the granting of personal care, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the granting of home help, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Decreases slightly	Worsens slightly
	Will the granting of other existing home services (other than personal care and home help, for instance home nursing), in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the share (market share) of home care increase/decrease in proportion to offered substitutive wellbeing services in the future, when compared to the current situation?	Decreases slightly	Worsens slightly
Customer Segments			Improves
	Will the amount of different customer segments (elderly persons, disabled persons, families with children, rehabilitators, demobilized hospital patients etc.) increase/decrease in the future, when compared to the current situation?	Increases	Improves
	Will the amount of elderly persons receiving home care increase/decrease in the future, when compared to the current situation?	Increases significantly	Improves significantly

	Will the amount of disabled persons receiving home care increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same
	Will the amount of other persons (other than elderly and disabled persons) currently receiving home care increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
Customer Relationships			Worsens
	Within home care, will the position of the municipal service producer (investments in physical/intellectual/human resources, in processes, in knowhow, in brands) increase/decrease in the future, when compared to the current situation?	Increases slightly	Worsens slightly *
	Within the service system for home care, do you believe that that the amount of service producers will increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
	Within home care, do you believe that the concentration of the market (the customers) in relation to available service producers will increase/decrease in the future, when compared to the current situation?	(no answer)	-
Channels			
	-		
Revenue Streams *(Calculated as the average of all points listed in this table)*			Improves slightly
	Within home care, will the increases in the compensation levels to service producers in the future be higher/lower than the increases in the actual production costs, when compared to the current situation?	Stays the same	Stays the same

The answers submitted by City of Hyvinkää representatives generate a reasonably promising outlook for the service offering in the service system for home care. The service range and the amount of service hours per person within both personal care and other home services are all expected to expand in the future. On the other hand, the amount of service hours per person within home help services will apparently decline slightly. Overall it seems that the position of home care in relation to other substitutive services arranged by City of Hyvinkää is going to deteriorate somewhat, and this would naturally be unfavorable for service producers.

The situation with customer segments looks promising from service producers' viewpoint. The amount of customer segments served will increase. Furthermore, the most important

customer segment – elderly persons – is expected to grow significantly in terms of end customer amounts. Also other persons than elderly and disabled will increase to some extent going forward.

The development for service producers with respect to customer relationships seems to be overshadowed by a couple of issues. Firstly, the general position of the municipal service producer is forecasted to strengthen. And secondly, the amount of service producers in the service system is forecasted to increase.

7.3.5 B2: Operations and Costs in the Future

The following table displays the answers provided by City of Hyvinkää representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 33: Operations and costs for service producers in the service system in Hyvinkää – in the future

Analysis B2): Operations and Costs in Hyvinkää in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Key Resources			Worsens slightly
	Within home care, will the local supply of employees with suitable education and work experience increase/decrease in the future, when compared to the current situation?	Decreases slightly	Worsens slightly
Key Activities			Improves slightly
	In the direct customer work within home care, will the use of technology solutions (automated services, digitalized services etc.) increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
	In the support functions within home care, will the use of technology solutions (automated functions, digitalized functions etc.) increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
Key Partnerships			
	-	-	-
Cost Structure *(Calculated as the average of all points listed in this table)*			Stays the same
	-	-	-

The operational development of service producers seems to involve some negative and some positive themes. Negative is that the availability of suitable employees is expected to decrease in the future. But then again, the utilization of technology solutions is expected to enhance slightly both in the service provision (customer work) and in the support functions. This is encouraging for service producers, in particular if it eliminates some of the current and possibly manual work, and subsequently improves productivity.

7.3.6 B3: Implications of Quality in the Future

The following table displays the answers provided by City of Hyvinkää representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/issue in the table.

Table 34: Implications of quality for service producers in the service system in Hyvinkää – in the future

Analysis B3): Implications of Quality in Hyvinkää in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Quality and Costs			Worsens
	Within home care, will the requirements set for the services offered increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
	Within home care, will the requirements set for the service producers increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
Quality and Revenues			
	-	-	-
Quality and Communication			
	-	-	-

The assessments made by City of Hyvinkää are clear concerning the requirements within the service system – they will become stricter for the services offered and also for the service producers. Even if a rise in minimum levels of quality may benefit service producers in the longer term, the direct impacts in the short-term are likely primarily negative. It leads to new quality-related investments and duties and thereby to additional costs for the service producers. Nonetheless, quality enhancements can also be achieved through process improvements, which are usually not so expensive. The direct implications of stricter requirements in the future are all in all difficult to specify, as they do most likely vary across service producers.

7.3.7 Summary of Analyses

Key Partnerships:	Key Activities:	Value Propositions (Service Offering):	Customer Relationships:	Customer Segments:
Slightly positive	Negative	Neutral	Slightly negative	Negative
	Improves slightly		Worsens	
-	Key Resources:	Improves slightly	Channels:	Improves
	Neutral		Slightly positive	
	Worsens slightly		-	

Cost Structure:	Revenue Streams:
Neutral	Neutral
Stays the same	Improves slightly

Light grey cells indicate current situation | *Grey cells indicate the future situation (development)*

Figure 45: Summary of possibilities for conducting business in the service system in Hyvinkää (analyses A1-A2 and B1-B2)

The results of the analyses on the current and future possibilities for conducting business in the service system for home care in Hyvinkää (A1-A2 and B1-B2) are mixed, which has a neutralizing effect on the wholeness. Both the current (A1-A2) and the future (B1-B2) analyses involve advantages and disadvantages that partly offset each other.

Among the current advantages the most important ones are the wide service range and the good possibilities to outsource activities to external service partners. Current disadvantages in turn include e.g. the low amounts of service hours per person, the low amounts of end customers, the dominating position share of the municipal producer, the operational challenges related to both services offered and customer segments served, as well as the low level of technology in the service system.

The most promising issues regarding the future development are a broadening of the service offering, a rise in service hours per person, an addition in customer segments, and especially a clear increase in the amount of elderly persons served. The group of most unfavorable future changes involves an increase in the number of service producers, and to a lesser extent also a strengthening position of the municipal producer, as well as a weakening position of home care in relation to substitutive wellbeing services.

Quality and Costs:	Quality and Revenues:
Slightly negative	Slightly positive
Worsens	-
Quality and Communication:	
Negative	
-	

Light grey cells indicate current situation	*Grey cells indicate the future situation (development)*

Figure 46: Summary of quality implications for businesses in the service system in Hyvinkää (analyses A3 and B3)

The analyses on quality implications on business operations of the service producers in Hyvinkää (A3 and B3) are largely unfavorable. The quality requirements on services and service producers are burdened by home nursing, but then again service producers can choose to exclude this service category from their offering. Service producers can in theory gain from quality through higher prices or end customer inflows, but existing and potential end customers have in practice nearly no access to objective quality data on the producers. Also expected tightening of quality requirements in the future predicts incremental obligations and

costs for service producers. Still, service producers should be at least in principle able to adjust their service prices accordingly. Analyses A3 and B3 indirectly display that both quality strategies (quality focus) and cost strategies (cost focus) stand out as viable alternatives for service producers in the service system.

7.4 Analysis of Uppsala

7.4.1 A1: Service Offering and Revenue Generation

Value Proposition

Service offering is here used as a synonym to the value proposition of the service system for home care in Uppsala. The service offering for service producers in the service system can be viewed from at least four different perspectives; *i) the service range, ii) the possibilities for choosing and combining a desired service offering, iii) the service times,* and *iv) the service area.* The service range is wide, as it stretches from simple domestic services (containing four sub-services) onwards to personal services (containing seven sub-services) and on to more challenging services with healthcare and medical emphasis. However, services such as support for informal care and home nursing at night (between 22:00-7:00) are not available for service producers, as these have been retained by V&B. The possibilities for choosing and combining a desired service offering are good, because only a few services have been bundled together. The service bundle consisting of personal care, safety alarm service, home nursing and rehabilitation is logical though, but service producers can choose not to offer this package. Also, the four domestic services can be chosen separately and combined by service producers. The service times offer service producers with sufficient service volume but also with slight flexibility. All services shall be offered 15 hours/day (7:00-22:00), and a service producer may choose to prolong the service hours for personal care service to 24 hours/day. The service area for the service system is the least flexible component related to the service offering. The service area covers the entire region of Uppsala municipality in one single piece.

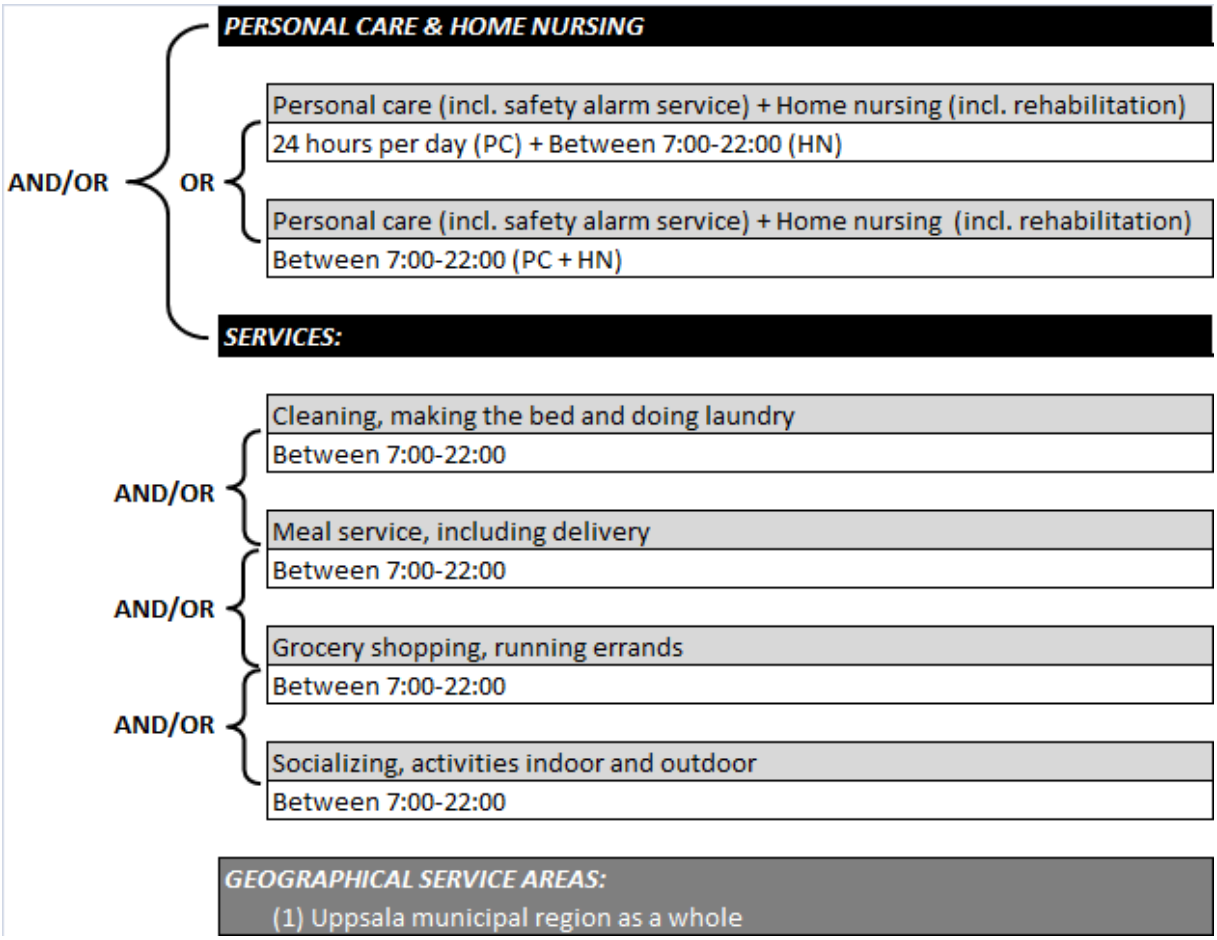

Figure 47: Overview of the service offering in Uppsala (Uppsala 20110 a, p. 3-12)

The Business Model Canvas methodology would identify a number of key features for the value proposition in the Uppsala service system, such as *"quality"*, *"performance"*, *"customization"*, and *"convenience/usability"*.

Apart from the service offering of the service system, additional services offered to end customers on a voluntary basis constitute a valuable option for all service producers. The possibilities for additional services are obviously vast, but more thorough analyses of this private market segment would go outside the scope and analysis of this study.

In 2011 private producers in Uppsala delivered on average 25 hours of home care services per end customer per month (in October) – a service volume that can be regarded as medium or even high (Socialstyrelsen 2012, web-pages).

When reviewing wellbeing services arranged by City of Uppsala, it seems apparent that the service offering of the service system for home care covers a notable share of all home-related services. Nonetheless, more advanced healthcare services at home, support for informal care and a few niche services are produced municipally or with support from NGOs. On the other hand, the separate service systems for personal assistance and for accompanying services are fully available for home care producers interested in expanding into new services.

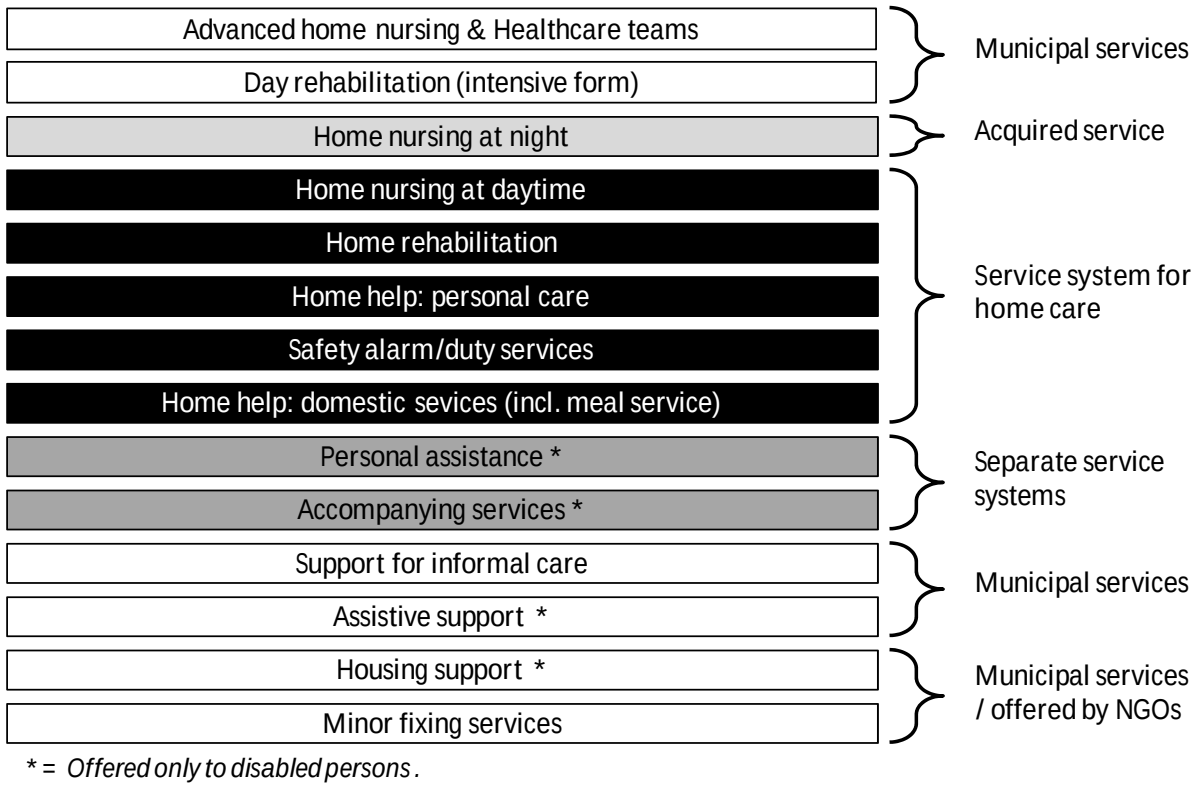

Figure 48: Range of home-related services in Uppsala (Uppsala 2011, web-pages)

Customer Segments

City of Uppsala has substantial influence over which and how many persons in Uppsala are granted home care. Also the availability and costs of substitutive wellbeing services – provided either outside the home or in the form of accommodation services – affect to what extent home care is granted. As appeared earlier in the study, there is a fairly wide range of wellbeing services and a large variety of alternative service solutions in Uppsala. Nevertheless, the relevant point is that the market size, measured as home care customer amounts, is determined externally, and service producers have to take this as given. A positive aspect is that the service system, which is based on the system of choice, prevents social

service officers at City of Uppsala from favoring some specific producers (e.g. the municipal producer) by directing end customers there.

The large population in Uppsala and the consequent large customer base with circa 2,750 registered end customers receiving statutory home helps services makes a good starting point for any service producer in the service system for home care. The situation is actually even better, as the end customers of home nursing are not included in that number. Although the market size in terms of end customer amounts has varied over recent years, the decent growth in 2011 among both municipal (4%) and private producers (8%) is a reassuring signal. Moreover, the fact that 43% of all end customers are served by private producers reveals that choosing other than the municipal producer is widely accepted by inhabitants in Uppsala. It is still worth remembering that a significant part of the private producers' current end customers originate from before the system of choice was introduced in late 2008 – when end customers were allocated to private producers based on geographical location.

The end customers in Uppsala can be split into three distinct customer types; elderly persons aged 65 years and more, disabled persons younger than 65 years and adults. Elderly persons is the primary a customer type, given that 90% of all end customers receiving home care (excluding home nursing) belong to this group, while the remaining 10% are disabled persons. The amount of adults receiving home nursing in Uppsala is not known in/for this study. This customer type is somewhat heterogeneous, as it withholds all persons aged 17 years and more who receive home nursing for a period of more than 14 days. Elderly persons and disabled persons can be further divided into two parts – those receiving personal care and home nursing, and those receiving domestic services. And domestic services can in turn be split into four parts in line with its sub-services cleaning services, meal service, shopping service and socializing services. The division of customer types and service types results in a total of 11 different customer segments. Anyhow, the customer segments listed here represents only one alternative among several for segmenting the end customers.

A couple of additional customer segments can be identified. These are the end customers with special characteristics – non-choice customers, night customers within home nursing, as well as customers with only safety/alarm services, assistive devices or housing adaption

assessment – as determined by City of Uppsala. Persons belonging to these minor customer segments are directed to and allocated between Attendo Care, Aleris Äldreomsorg, Förenade Care and Uppsala Vård & Bildning (V&B), and they are therefore unavailable for all other service producers. This has a slightly negative impact on the revenue potential among other/new service producers. Also customers of advanced home nursing and healthcare teams are out of reach for service producers.

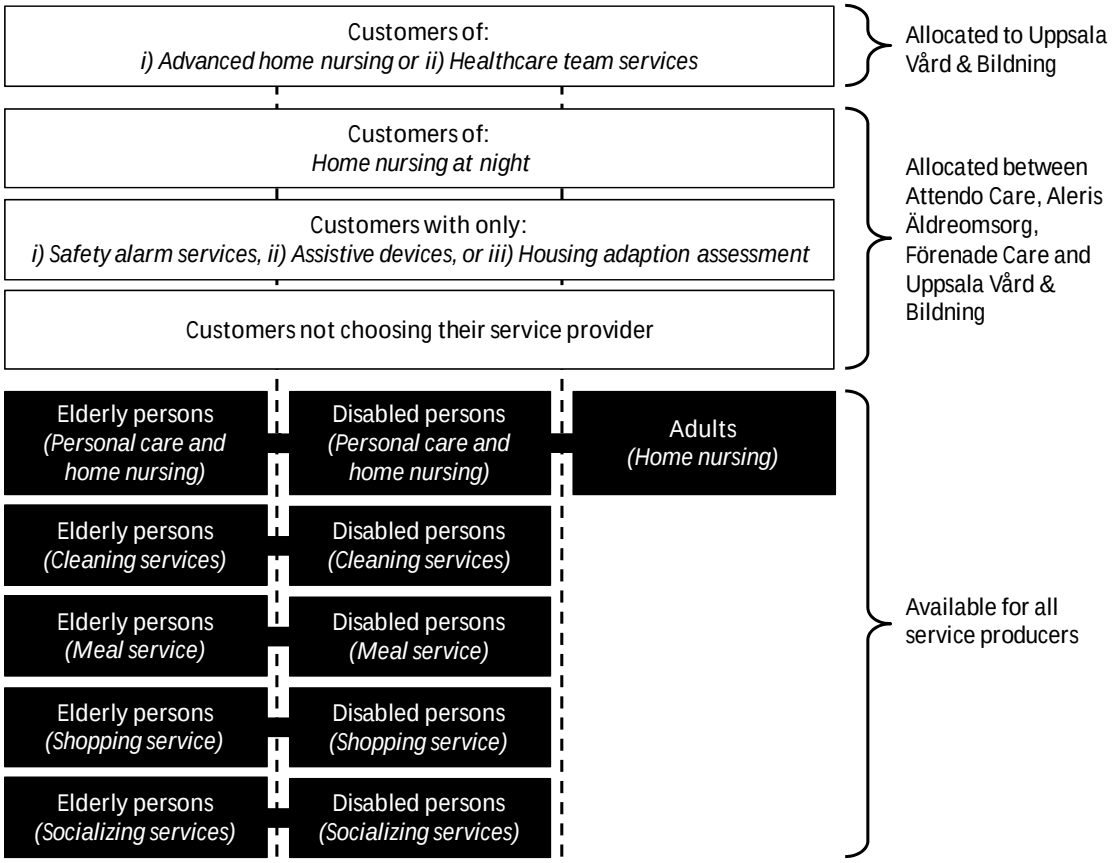

Figure 49: Customer segments within home care in Uppsala

Customer segmentation and targeting in the service system is possible only to some extent. The main restriction comes from the fact that service producers are bound to serve all customer types, i.e. elderly persons, disabled persons and adults (within home nursing). On the other hand, the service system has been designed to allow service producers to choose their services among personal care including home nursing and four separate sub-services related to domestic services. Service producers can thus concentrate on certain services, but not on certain customer types. Apart from choosing among five different service packages,

market communication and corporate branding remain the primary means for service producers to affect their customer base.

The Business Model Canvas methodology would classify the customer segment -situation in the Uppsala service system as *"segmented"* – the system distinguishes between market segments with slightly different needs and problems.

The fact that qualified service producers can freely attract and choose customers outside the system of choice is of course a positive, and it creates additional business opportunities. However, this entirely private market is outside the scope and analysis of this study.

Customer Relationships

The obligation to accept and serve all end customers who choose a specific service producer is the cornerstone for all customer relationships in the service system. Customer relationships are thus set to be strong, with the decision making power regarding continuation, strengthening or termination of customer relationships being placed on the end customers. Only violation of the service contract or neglecting the customer duties by an end customer allows a service producer to terminate a customer relationship. The individual customer relationships are strengthened by a service producer's obligation to appoint a designated contact person and/or a designated care-responsible nurse for each of its customers.

Another feature linked to customer relationships is that end customers are allowed to split their services between several service producers. Thereby a wide service range does not automatically bring a competitive advantage to service producers, which is beneficial for (smaller) service producers with limited service offerings. But the splitting of services by end customers not only increases the average amounts of end customers among service producers in the system, it also decreases the average amounts of service hours per end customer. This may have different effects on the behavior of single service producers – some may choose to offer several services with uniform quality, whereas others may choose to limit to only a few services with high quality.

The Business Model Canvas would rate the customer relationships in the service system as *"dedicated personal assistance"*, which is the deepest and most intimate of all types.

The municipal home care producer V&B has a strong position in the local market with respect to both resources and end customers. The additional 15 service producers in the service system – a large amount – imply that the competition is intense. The competitive situation is further accentuated by the fact that the non-municipal end customers are highly concentrated to the four largest service producers Aleris Äldreomsorg, Attendo Care, Carema Care and Förenade Care.

Channels

The assessment of the channels in the service system is quite straightforward. A service producer can choose between two service delivery channels; either i) it utilizes its *own channel* by providing services itself, or then ii) it utilizes a *partner channel* by outsourcing some services to one or several service partners within the service system. The latter alternative leads to a mix of the own channel and the partner channel in the service delivery.

The communication channel is a mix of the partner channel and the own channel. The partner channel consists of the web-site and customer service offices upheld by City of Uppsala, but these provide limited possibilities for additional exposure for an individual service producer. The own communication channel works the opposite way, as a service provider is able to conduct marketing activities at their discretion as long as they follow good marketing practice.

Revenue Streams

A key characteristic of the service system, like all systems of choice, is that it prevents service producers from setting the compensation levels for the services they offer. All compensation levels for services offered are determined by City of Uppsala, and they are equal for all service producers. This is a drawback for service producers, as it undermines efforts to serve certain market segments such as high-end customers or high-volume customers. But again, it also hinders price wars from arising on the market, i.e. it prevents compensation levels from declining due to increasing competition.

The main compensation principles in the service system – compensation for granted services and granted service hours only, and compensation for direct service time – is logical and encourages service producers to operate efficiently. However, service producers that offer home nursing are also compensated for such indirect service time that relates to duties performed by legitimized personnel (nurses, occupational therapists and physiotherapists). Indirect service time emerges from certain duties, e.g. from end customer calls, contacts with close persons and with other care/service providers, giving instructions, care planning and from end customer documentation. The indirect services form a major but indispensable part of all home nursing activities.

Hourly-based compensation (SEK/hour) for services with a personal focus and task-based compensation for a few domestic services through predetermined service times is sound, although the latter one involves downside risks for service producers. This is because doing laundry, shopping and running errands are not fully identical for all customers in Uppsala, and service times can be prolonged due to challenges caused by others than the service producers themselves. But then again, these services enable producers to carry out tasks for several end customers simultaneously (pooling of tasks), so the task-based compensation may in good situations even lead to overcompensation.

Having separate hourly compensation levels for different services (care and nursing services vs. domestic services), for different times of the day (daytime vs. nighttime) and for different geographical areas (town area vs. sparsely populated area) is fair from the perspective of service producers.

The fact that the compensation levels to service producers are fixed for one calendar year at a time has a stabilizing effect on revenues. But again, it also involves risks in case certain cost items deviate from the original estimations underlying the compensation levels. Service producers will thereby not be compensated for unexpected and/or exceptionally high rises in e.g. fuel costs. According to the Business Model Canvas terminology, the revenue streams for service producers in the service system arise from *"usage fees"* and *"list prices"* for the separate services.

Table 35: Service offering and revenue generation for service producers in the service system in Uppsala

Analysis A1): Service Offering and Revenue Generation in Uppsala			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Value Propositions (Service Offering)		1.7	Positive
	The amount of different home care services (service range) offered by private producers	2	Positive
	The amount of home care provided, measured in service hours per person, by private producers	2	Positive
	The relative (market) share of home care, compared to substitutive wellbeing services offered	1	Slightly positive
Customer Segments		1.5	Positive
	Private producers' access to individuals entitled to statutory home care	2	Positive
	The amount and type of customer segments (elderly persons, disabled persons etc.) served by private producers	2	Positive
	Private producers' possibilities to target or focus on certain customer segments or service segments	0	Neutral
	The amount of elderly persons receiving home care by private producers	3	Very positive
	The amount of disabled persons receiving home care by private producers	1	Slightly positive
	The amount of other persons (other than elderly and disabled) receiving home care by private producers	1	Slightly positive
Customer Relationships		-0.3	Neutral
	The market position (market share) of private producers, (+) limited or (-) significant	2	Positive
	The amount of private producers in the service system, (+) small or (-) large	-1	Slightly negative
	The level of customer concentration in the service system, (+) diversified or (-) concentrated	-2	Negative
Channels		1.0	Slightly positive
	Distribution channels and communication channels for private producers	1	Slightly positive
Revenue Streams		-0.5	Slightly negative
	Private producers' possibilities to impact the price levels of services offered	-2	Negative
	Compensation to private producers in relation to the associated costs	1	Slightly positive

7.4.2 A2: Operations and Costs

Key Resources

Human resources are naturally the most important production factor for service producers in the service system for home care in Uppsala. Service producers shall continuously secure the sufficient availability of employees in terms of amounts, educations and skills. A notable part of the requirements for human resources is determined by legislation and by national authorities, so they apply i) across the country and ii) for all producers in the sector, both municipal and private. However, a distinct feature of this specific service system is that employees providing personal care and home nursing shall have the ability to serve both elderly persons and disabled persons.

The extensive set of IT-systems, which are owned and operated by City of Uppsala but offered to service producers free of charge, is very valuable for producers as it minimizes their needs for related investments and costs. “Prator” (co-ordination of end customers moving between healthcare and social services units within Uppsala), “Time Registration & Personnel Lock” and especially the new “Siebel” (joint ERP-system and service portal between Uppsala City, service producers and end customers) are the most essential IT-systems in use. The utilized IT-systems also decrease the amount of manual work and improve the quality of various data, and thereby facilitate the business operations for service producers.

The commitment to choose environmental cars when investing in new vehicles should not be a major issue for the service producers. It may actually even be beneficial in the long run due to lower fuel expenses. Still, vehicles constitute the most significant investments for service producers.

It is also positive that service producers can arrange and uphold their facilities according to their own needs and preferences without constraining regulation.

Key Activities

The service offering has a direct impact on the key activities among service producers. The good possibilities to choose the services offered make it easier for service producers to plan

and carry out their own operations. Domestic services, personal services and healthcare services are all three produced and delivered in somewhat different ways. The service times imply a readiness to serve either 15 hours/day or 24 hours/day every day throughout the year, and also this calls for continuous scheduling of work shifts and co-ordination of personnel.

A wide undivided service area (Uppsala municipality as a whole, 2,136 km^2), combined with a low population density (90 persons/km^2 with 2 home care end customers/km^2), is perhaps the most important factor related to the service offering. Service producers in Uppsala will on average record high rates of non-chargeable service hours due to long transportation distances between end customers. This operational disadvantage, which prolongs service times and creates additional costs, is to some extent covered by higher compensation levels for services delivered in the sparsely populated areas of Uppsala.

Also the differences between the three customer types affect key activities. Even if elderly persons and disabled persons are both offered the same home care services, these are provided and delivered slightly differently for both segments. This is because the characteristics and the individual service needs are to certain extent different between these two customer types. The commitment to serve both elderly persons and disabled persons needs to be considered in recruitment and development of human resources.

There is a clear rationale for why the of end customers with special characteristics (non-choice customers, night customers within home nursing, customers with only niche services) are not allocated to all service providers. This is because these marginal customer segments are the most challenging ones – for most service producers they would generate more efforts (costs) than value (revenues). This additional segmentation is thus beneficial for ordinary and new service producers in the service system.

Upholding the strong customer relationships, with individual service plans and designated contact persons and/or care-responsible nurses for every end customer, demands both time and efforts by the employees of service companies. And those customers, who decide to split their services between several service producers, simultaneously multiply and spread their customer relationship costs over each separate producer. On the other hand, the various

technology solutions offered by City of Uppsala may facilitate the management of customer relationships.

The capacity limit is a helpful mechanism for service producers to prevent their business operations from expanding larger than available resources. Capacity limits help service producers to control their service offering and customer segments (service hour volumes), and correspondingly also their key activities and key resources.

The use of technological solutions (e.g. automated or digitalized solutions) by service producers in the system appears clearly in support functions, with the joint IT-systems being in a key position. Technological solutions are also used in the service delivery work, i.e. in the customer interface, but to a somewhat lesser extent. E.g. the “Time Registration & Personnel Lock” system also includes a mobile application for opening end customers’ doors. An internet-based end customer portal has been in development, and this will be taken into use gradually starting in 2012 (Uppsala 2011 d, p. 40). Technological solutions that facilitate work processes and improve efficiency for service producers are consequently utilized in many different functions of the service system.

The task-based compensation for certain services, such as meal service, doing laundry, shopping and running errands, will incur additional efforts and costs for service producers. These additional efforts and costs are associated primarily with those end customers who live in the sparsely populated areas of Uppsala, but also with “demanding” end customers who require above-average service times.

A positive thing with the service system is that service producers do not need to charge or invoice their end customers, which saves efforts for more productive activities. But still, service producers offering any additional (non-statutory) services have to charge these directly and entirely from the end customers.

Instructing and training of personnel is compulsory for all service producers. Also extensive documentation of information and regular reporting of own operations have to be made. All these activities consume time and incur direct costs, but they do not yield revenues as such.

The Business Model Canvas analogy would categorize the key activities for service producers in the service system as "*production*".

Key Partnerships

The possibility to appoint service partners that meet the qualification criteria creates many opportunities. This enables service producers to e.g. outsource certain services such as home nursing, or to allocate end customers living in certain geographical areas to some other service producer(s). Apart from the opportunities, the partnerships also involve requirements for seamless co-ordination with the service partners. Well-functioning partnerships imply solid service chains with limited efforts and costs.

Service producers are bound to co-operate with several different parties. The list of co-operation partners includes healthcare and social service personnel at City of Uppsala, other service producers and organizations, the non-profit sector, family members and close persons of end customers. The service producers offering home nursing obviously need the most extensive partner networks involving the healthcare sector.

Cost Structure

The costs and investments that service producers in the service system face have been addressed indirectly in the sub-sections "Key Activities", "Key Resources" and "Key Partnerships". The focus here is primarily on what the cost structure and cost components for the service producers are.

The cost structure of service producers would from a Business Model Canvas perspective be categorized as "*cost-driven*". This is because the price levels for the services, more precisely the compensation levels towards the service producers, are fixed and determined by City of Uppsala. Keeping costs at low levels or even minimum levels is thus necessary for service producers who aim to generate profits and/or increase them. The drawback of the cost-driven cost-structure is that the service system sets several requisites and duties on the service producers, and this complicates attempts to reduce costs.

The cost components of the service producers are represented by both fixed and variable costs. Wages and salaries as well as leasing or acquisitions of vehicles incur the largest fixed costs. The fixed costs are to some extent lowered by the extensive set of IT-systems owned and provided by City of Uppsala. Variable costs include fuel costs and outsourcing costs coming from potential service partnerships. The long list of requisites and duties in turn incur a fair amount of smaller variable cost items.

Table 36: Operations and costs for service producers in the service system in Uppsala

Analysis A2): Operations and Costs in Uppsala			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Key Resources		1.0	Slightly positive
	The level of requirements for human resources (employees) of private producers	0	Neutral
	Required investments in physical, intellectual and financial resources by private producers	2	Positive
Key Activities		0.3	Neutral
	The impact of service offering (service type, service range, combination possibilities, service times, geo-graphical area) on the operations of private producers	-2	Negative
	The impact of served customer segments (segment range, combination possibilities, profitability) on the operations of private producers	-1	Slightly negative
	The impact of customer relationships (service producer obligations and end customer possibilities) on the operations of private producers	-1	Slightly negative
	Private producers' possibilities to set capacity limits for their operations	2	Positive
	The amount of technology solutions (automated services, digitalized services etc.) in the service system that is applied in customer work	1	Slightly positive
	The amount of technology solutions (automated functions, digitalized functions etc.) in the service system that is applied in support services	2	Positive
	Activities related to charging and invoicing of end customers by private producers	0	Neutral
	The amount of operative activities that private producers are not compensated for	1	Slightly positive

Key Partnerships		0.0	Neutral
	Private producers' obligations to co-operate with external parties	-2	Negative
	Private producers' possibilities to appoint service partners (to outsource)	2	Positive
Cost Structure		-1.0	Slightly negative
	Private producers' possibilities to impact their operative costs	-1	Slightly negative

7.4.3 A3: Implications of Quality

The quality analysis is adapting themes from the Business Model Canvas. Quality is divided into three parts, the first of which concerns services, the second concerns operations while the third concerns communication related thereto. The procedure is largely the same as in analyses A1-A2 and B1-B2.

Service Quality

There are a number of quality issues that relate to Value Propositions in the Canvas. Co-operation and coordination with other parties involved in the service provision is critical, especially in home nursing and personal care. And some services, such as the meal service, have their own quality instructions, and service producers need to follow them. Service producers also need to have routines for safe handling of end customers' keys.

Operational Quality

Most quality requirements are connected with Key Activities and Key Resources in the Canvas. Direct quality work includes both corrective and preventive measures to secure sufficient quality. Quality development is compulsory for service producers, as is periodical reporting for experienced shortcomings in quality. A large part of all documentation and reporting activities by service producers are linked to quality. Accounting of environmental impacts of service producers' own driving activities is an example of this. Other operational quality -related duties involve readiness for crisis and accidents, which includes e.g. action planning, statistical recording and systematic fire prevention work. Service producers also need to have installed own support systems that secure quality.

Most of the requisites and duties related to operational quality incur additional activities rather than additional resources, i.e. additional costs rather than additional investments. Still, it appears that a significant share of the costs from additional activities is by type rather fixed. The costs of the additional activities are proportionally greater for smaller producers than for larger producers.

Quality and Communication

A key characteristic of all systems of choice is that service producers cannot compete with prices (prices and compensation levels are fixed), instead they compete with quality. Although minimum requirements relating to quality are determined, service producers are allowed to exceed these requirements with respect to both service quality and operational quality. This applies to the service system for home care in Uppsala as well.

The annual customer survey for home care producers in Uppsala from November 2011 showed only small variations in the customer satisfaction index between service producers. The index varied only between 68 and 73 (on a 0-100 scale) and it showed no clear correlation with the amounts of employees – a figure that also indicates the amounts of end customers. This assessment is clearly a simplification, and it does unfortunately not reveal the yearly movements of end customers. Nonetheless, it does not provide evidence that service producers with a higher quality performance would gain more customers than those with a lower quality performance.

Table 37: Implications of quality for service producers in the service system in Uppsala

Analysis A3): Implications of Quality in Uppsala			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Quality and Costs		-0.5	Slightly negative
	The direct impact of service quality requirements on private producers' costs	-1	Slightly negative
	The direct impact of operational quality requirements on private producers' costs	0	Neutral
Quality and Revenues		2.0	Positive
	The potential impact of quality on private producers' customer amounts	2	Positive
	The potential impact of quality on private producers' service prices	-	-
Quality and Communication		0.5	Slightly positive
	Availability of public information on measured quality among private producers	1	Slightly positive
	Observed relation between measured quality and customer relationships among private producers	0	Neutral

7.4.4 B1: Service Offering and Revenue Generation in the Future

The following table displays the answers provided by City of Uppsala representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 38: Service offering and revenue generation for service producers in the service system in Uppsala – in the future

Analysis B1): Service Offering and Revenue Generation in Uppsala in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Value Propositions (Service Offering)			Stays the same
	Will the amount of different home services (=service range) offered by private service producers increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same
	Will the granting of personal care, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Decreases slightly - Stays the same	Worsens slightly - Stays the same
	Will the granting of home help, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Decreases slightly - Stays the same	Worsens slightly - Stays the same
	Will the granting of other existing home services (other than personal care and home help, for instance home nursing), in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Stays the same - Improves slightly
	Will the share (market share) of home care increase/decrease in proportion to offered substitutive wellbeing services in the future, when compared to the current situation?	Increases slightly - Increases	Improves slightly - Improves
Customer Segments			Improves slightly
	Will the amount of different customer segments (elderly persons, disabled persons, families with children, rehabilitators, demobilized hospital patients etc.) increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Stays the same - Improves slightly
	Will the amount of elderly persons receiving home care increase/decrease in the future, when compared to the current situation?	Increases - Increases significantly	Improves - Improves significantly

	Will the amount of disabled persons receiving home care increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Stays the same - Improves slightly
	Will the amount of other persons (other than elderly and disabled persons) currently receiving home care increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Stays the same - Improves slightly
Customer Relationships			Stays the same
	Within home care, will the position of the municipal service producer (investments in physical/intellectual/human resources, in processes, in knowhow, in brands) increase/decrease in the future, when compared to the current situation?	Decreases slightly - Stays the same	Stays the same - Improves slightly *
	Within the service system for home care, do you believe that that the amount of service producers will increase/decrease in the future, when compared to the current situation?	Increases slightly - Increases	Worsens - Worsens slightly *
	Within home care, do you believe that the concentration of the market (the customers) in relation to available service producers will increase/decrease in the future, when compared to the current situation?	Decreases - Decreases slightly	Improves slightly - Improves *
Channels			
	-	-	-
Revenue Streams *(Calculated as the average of all points listed in this table)*			Stays the same
	Within home care, will the increases in the compensation levels to service producers in the future be higher/lower than the increases in the actual production costs, when compared to the current situation?	Stays the same	Stays the same

The answers submitted by City of Uppsala representatives regarding the future development of the service offering in the service system for home care predict only marginal changes. Service hours of both personal care and home help services may decrease slightly, whereas other home care (e.g. home nursing) may increase slightly. Still, the position of home care in relation to comparable wellbeing services controlled by Uppsala is expected to improve.

The customer situation appears to develop favorably in the future for service producers. A clear growth in the customer amount of elderly persons is expected. Also the amounts of other customers and the amount of customer segments served may show minor enhancements.

The forces impacting customer relationships of service producers seem to remain largely unchanged. Competition will likely intensify due to rising numbers of service producers, but customer concentration will simultaneously decrease, which neutralizes the total impact in particular for new service producers.

The compensation levels to service producers are forecasted to develop (grow) in line with the production costs. Neither an escalation of nor a correction for possible over- or underpayment is thus visible for the coming years.

7.4.5 B2: Operations and Costs in the Future

The following table displays the answers provided by City of Uppsala representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 39: Operations and costs for service producers in the service system in Uppsala – in the future

Analysis B2): Operations and Costs in Uppsala in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Key Resources			Stays the same - Improves slightly
	Within home care, will the local supply of employees with suitable education and work experience increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Stays the same - Improves slightly
Key Activities			Improves slightly - Improves
	In the direct customer work within home care, will the use of technology solutions (automated services, digitalized services etc.) increase/decrease in the future, when compared to the current situation?	Increases slightly - Increases	Improves slightly - Improves
	In the support functions within home care, will the use of technology solutions (automated functions, digitalized functions etc.) increase/decrease in the future, when compared to the current situation?	Increases slightly - Increases	Improves slightly - Improves
Key Partnerships			
	-	-	-
Cost Structure *(Calculated as the average of all points listed in this table)*			Improves slightly
	-	-	-

The outlook for operational issues for service producers in the service system in Uppsala is altogether encouraging. Availability of employees will remain stable or rise a bit, and the utilization of technology both in customer service processes and in support function processes will grow at least modestly. Jointly the aforementioned matters are set to improve work processes and thereby to increase productivity. This lowers the cost level for service producers, meaning that it improves the cost structure.

7.4.6 B3: Implications of Quality in the Future

The following table displays the answers provided by City of Uppsala representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/issue in the table.

Table 40: Implications of quality for service producers in the service system in Uppsala – in the future

Analysis B3): Implications of Quality in Uppsala in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Quality and Costs			Worsens slightly - Stays the same
	Within home care, will the requirements set for the services offered increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Worsens slightly - Stays the same *
	Within home care, will the requirements set for the service producers increase/decrease in the future, when compared to the current situation?	Stays the same - Increases slightly	Worsens slightly - Stays the same *
Quality and Revenues			
	-	-	-
Quality and Communication			
	-	-	-

The requirements within the service system in Uppsala will remain on current levels or possibly become a bit stricter. The development appears to be the same both for the services offered and for the service producers themselves. Any upward shifts in quality requirements may result in cost increases for service producers, but these would supposedly be limited in size and to some extent also company-specific. And also, possible cost increases in the beginning might in fact be offset by reduced costs of failure at later stages.

7.4.7 Summary of Analyses

Key Partnerships:	Key Activities:	Value Propositions (Service Offering):	Customer Relationships:	Customer Segments:
Neutral	Neutral	Positive	Neutral	Positive
	Improves slightly - Improves		Stays the same	
-	Key Resources: Slightly positive	Stays the same	Channels: Slightly positive	Improves slightly
	Stays the same - Improves slightly		-	

Cost Structure:	Revenue Streams:
Slightly negative	Slightly negative
Improves slightly	Stays the same

Light grey cells indicate current situation | *Grey cells indicate the future situation (development)*

Figure 50: Summary of possibilities for conducting business in the service system in Uppsala (analyses A1-A2 and B1-B2)

The general outcome of the analyses on the current and future possibilities for conducting business in the service system in Uppsala (A1-A2 and B1-B2) is partly positive and partly neutral. The current situation with respect to services offered, customers served and resources required are the most favorable areas. The wide service range, the high amount of elderly person customers and also service hours, the low levels of investments, and the technological advancement in the service system are currently favorable for service producers. Unfavorable elements include the high customer concentration, operational challenges related to the service offering, and the managing of the broad cooperation network. Revenues and costs, in

turn, are somewhat harmed by the service system itself – primarily service producers' inability to price their services and adjust their costs accordingly.

The future development seems to remain quite stable on the whole, although it includes a few areas with improvement. Examples are the forecasted significant increase in the amount of elderly persons receiving home care, and the increase in technology solutions in the service system.

Quality and Costs:	Quality and Revenues:
Slightly negative	Positive
Worsens slightly - Stays the same	-
Quality and Communication:	
Slightly positive	
-	

Light grey cells indicate current situation	*Grey cells indicate the future situation (development)*

Figure 51: Summary of quality implications for businesses in the service system in Uppsala (analyses A3 and B3)

The implications of quality on business operations in the service system for home care in Uppsala (A3 and B3) are somewhat mixed. The service system itself makes quality the main competition factor for winning more end customers. But in practice there was no clear evidence of the existence of a positive relationship between observed customer satisfaction and customer amounts among service producers. In the future the requirements for both the services offered and the service producers themselves will become slightly stricter. Analyses A3 and B3 distinguish a difference between quality in theory and quality in practice. It may be that some service producers prefer to choose service costs over service quality as the area of focus – i.e. they choose cost strategies over quality strategies for their businesses.

7.5 Analysis of Huddinge

The analysis of Huddinge encompasses both service systems for home help services; that for elderly persons and that for disabled persons. The service system for elderly persons constitutes the core of the analysis, but the service system for disabled persons is separately dealt with and discussed in those areas where there are clear differences between the two of them.

7.5.1 A1: Service Offering and Revenue Generation

Value Proposition

There are clear differences in the service offering (value proposition) between the service system for elderly persons and that for disabled persons. In the service system for elderly persons the service offering contains at least four dimensions; i) *service range*, ii) *possibilities for choosing and combining a desired service offering,* iii) *service times* and iv) *service area.* The service range is definitely wide even though it lacks healthcare services such as home nursing. The service range encompasses three traditional sub-services of home care (personal care, domestic services and meal service) and four home-related services (housing support, accompanying services, support for informal care and safety alarm/duty services). The wide service range is beneficial for service producers, as it pools together many end customers with slightly varying service needs. But the possibilities to choose and combine a desired service offering are very poor, given that service producers are obliged to offer all of the aforementioned seven services. Service producers are thus not able to restrict their service offering to e.g. home help services only. Service producers can choose between two service times, either 15 hours/day (7:00-22:00) or then 24 hours/day, on every day in the week (Monday-Sunday). The service times offer some flexibility for service producers, but even the lower alternative covers the vast majority of all service needs that occur during one day. The service area is the most flexible element of the service offering in the service system. Service producers can choose and combine among five separate service districts in the municipal region of Huddinge, where the minimum is one district and the maximum is five districts (Huddinge as a whole). The smallest district in terms of population holds 10% of all inhabitants in Huddinge while the largest one holds 37%. Choosing among the five districts is thus one way to control the volumes of end customers and services offered.

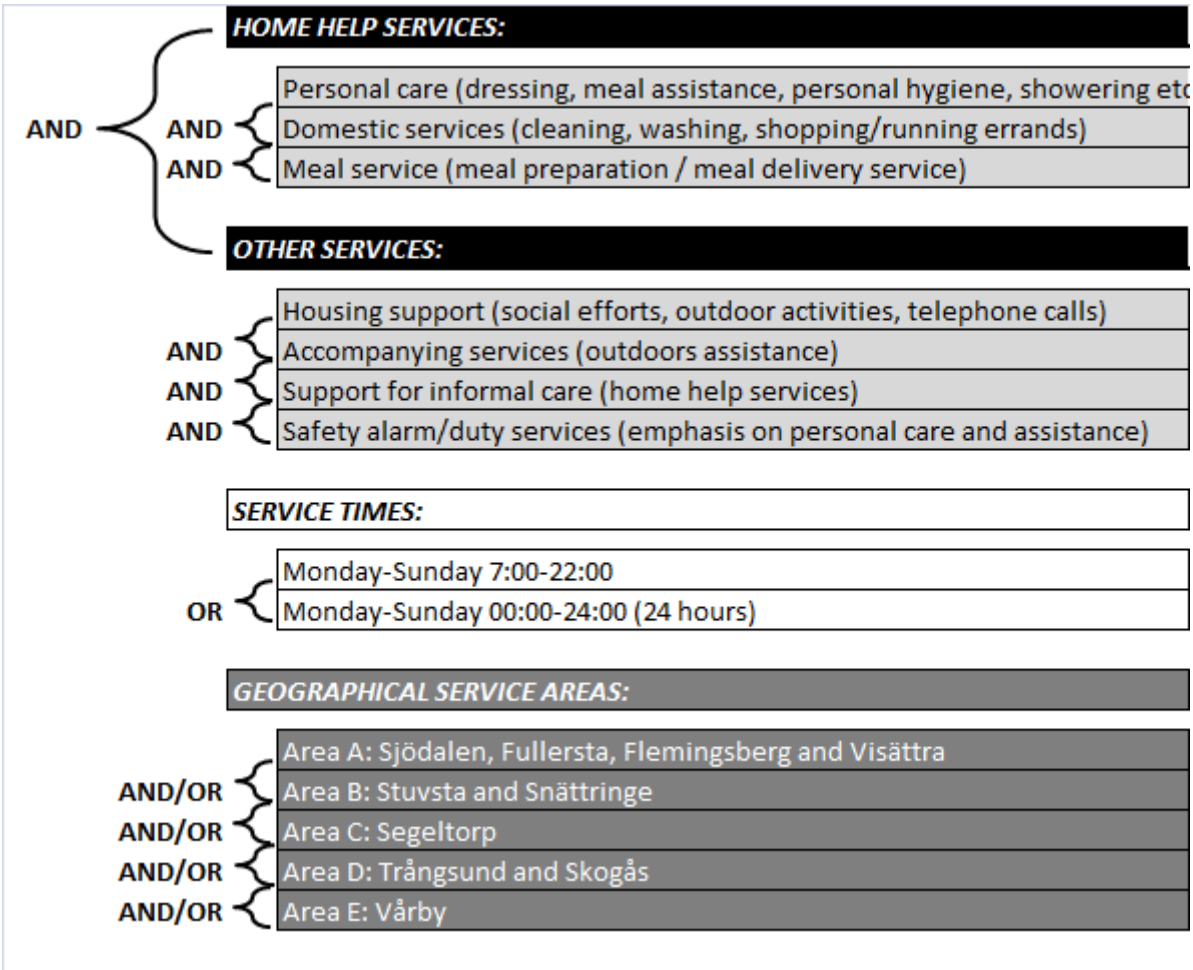

Figure 52: Overview of the service offering for elderly persons in Huddinge (Huddinge 2011 a, p. 6-12; Huddinge 2011 b, p. 7-33; Huddinge 2011 d, p. 8-24; Huddinge 2010 a, p. 4-18; Huddinge 2009 c, p. 8)

The service offering in the service system for disabled persons differs from the corresponding one for elderly persons in three dimensions out of four. The service range consists of the same three home help sub-services, whereas the home-related services are only partly the same. Safety alarm/duty services are not part of the offering, while personally formed support is. The possibilities to choose and combine a desired service offering are very good, as service producers are free to choose any of the available services. Service producers can thus choose any combination starting from one home help sub-service to all three of them, and possibly also include some or the other four home-related services. Service producers can choose among two service time slots, which are mornings and daytimes (7:00-19:00) totaling 12 hours/day, and evenings (19:00-22:00) totaling 3 hours/day, on every day in the week (Monday-Sunday). The service times offer flexibility, given that service producers can choose whether they offer services for 3, 12 or 15 hours/day. The service area on the other hand is the

least flexible element in the service system for disabled persons. Service producers are bound to operate in the entire municipal region of Huddinge, whereas limiting the operations to smaller service districts is not possible.

Figure 53: Overview of the service offering for disabled persons in Huddinge (Huddinge 2011 a, p. 6-12; Huddinge 2011 b, p. 7-33; Huddinge 2011 d, p. 8-24; Huddinge 2010 a, p. 4-18; Huddinge 2009 c, p. 8)

The Business Model Canvas methodology would identify a number of key features for the value proposition in the service systems in Huddinge, such as “quality”, “performance”, “customization”, and “convenience/usability”.

Also in Huddinge the service systems enable service producers to offer additional services to end customers, and this constitutes a useful and valuable option.

In October 2011 private producers in Huddinge delivered home care services totaling on average 47 hours per month per elderly person and 37 hours per month per disabled person. These services volumes can be regarded as very high for both groups. (Socialstyrelsen 2012, web-pages)

An inspection of the wellbeing services administrated by Huddinge Municipality reveals that the two service systems for home help services, which either involve or enable also other home-related services, together cover the majority of the available services. However, the home help services (personal care, domestic services and meal service) constitute only a part of all home-related services. The production of medical services, implying home nursing and

rehabilitation, is concentrated to Stockholm County Council. Some of the least demanding services, such as snowplowing services and minor fixing services are produced by Huddinge Municipality, while NGOs and private persons participate in the provision of the friend service and the contact person service. These services are offered to a limited amount of persons and in modest volumes. Only a couple of services are acquired externally, namely personal assistance and extensive cleaning of homes and windows.

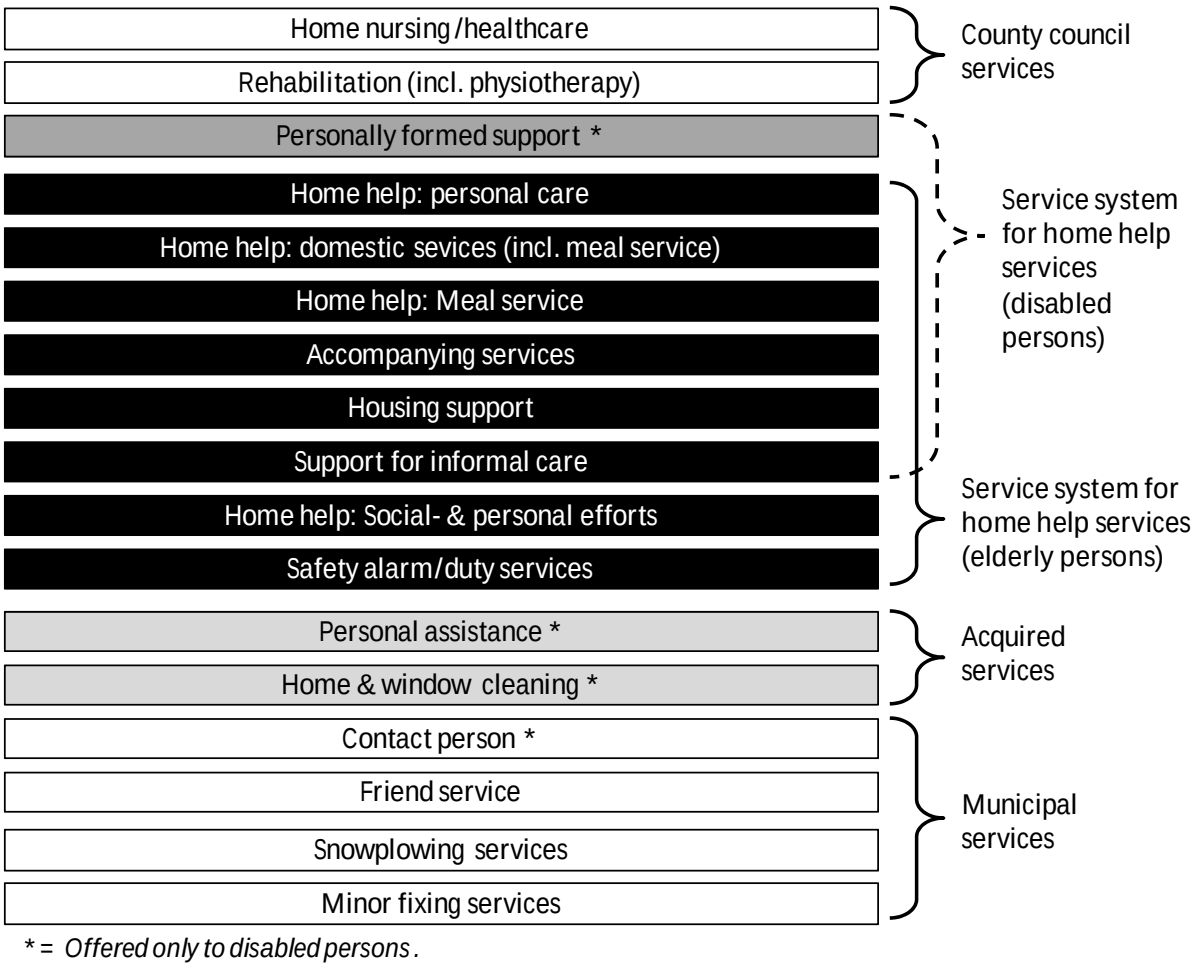

Figure 54: Range of home-related services in Huddinge (Huddinge 2012, web-pages)

Customer Segments

Guidelines and decisions made by Huddinge Municipality have a direct impact on the type and amount of persons that are granted home help services. The extensive variety of wellbeing services includes possible substitutes to home help services, also among services occurring outside the home and among housing services. The size of the market for home help

services is thus largely determined by external factors, and service producers have to comply with this. On the other hand, all producers of home help services in the service systems – both municipal and private – are equally positioned to gain incoming end customers. This is largely due to the implementation of systems of choice.

The solid population base of Huddinge together with its more than 1,500 registered end customers for statutory home help services makes Huddinge a potential market for any service producer. The total amount of end customers has grown consecutively for many years, and private producers' share of this market has during this time increased to 24% (2011). The end customer base of the private producers enlarged by 28% in 2011.

The end customers in Huddinge consist of two customer types; elderly persons (65 years or more) and disabled persons (less than 65 years). 85% of all persons receiving home help services are elderly persons, while disabled persons amount to 15%. Both elderly persons and disabled persons can be split into sub-segments based on the services received/offered. This yields sub-segments for personal care, domestic services, meal services and for the other home-related services offered to the elderly and the disabled. Elderly persons thus comprise a total of eight different customer segments, of which three relate directly to home help services. For disabled persons the customer segments amount to seven, with three connected to home help services. Nevertheless, the customer segmenting presented here is more of a subjective assessment than an objective fact. Regardless of the segmentation method, these customer segments represent those persons and services that are available for private producers.

In addition to the customer segments presented above, there are a couple of additional ones being allocated to either Huddinge Municipality or Stockholm County Council. The first of these customer segments comprises all persons who cannot or do not choose a service producer for themselves, i.e. the non-choice customers. Another customer segment is elderly persons receiving home nursing or home healthcare, as these services are completely outside the service system and appointed to Stockholm County Council. Furthermore, all home-related services offered to disabled persons during nights (22:00-7:00) have been concentrated

to Huddinge Municipality. The unavailability of end customers in these customer segments shrinks the potential customer base for private producers to some extent.

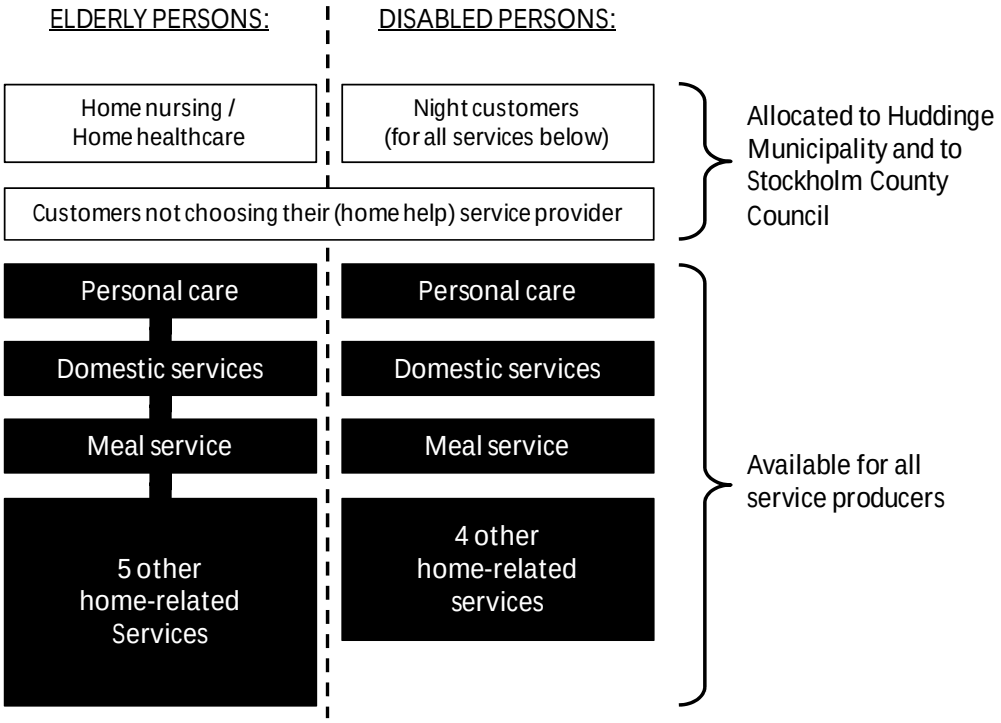

Figure 55: Customer segments within home-related services in Huddinge

Private producers have some possibilities to conduct customer segmentation and targeting in the service systems for home help services. The two separate service systems allow private producers to focus on either elderly persons or disabled persons, or on both. However, the service system for elderly persons with its service bundle of eight different services prevents producers from targeting only certain services for elderly persons. For disabled persons the situation is the opposite, as service producers are free to choose any of the seven home-related services made available. So service producers can target certain customer types (elderly persons and disabled persons), whereas they can target certain services only among disabled persons but not among elderly persons. Market communication, advertising and brand building are other available methods for service producers as to approach specific customer segments.

The Business Model Canvas methodology would classify the customer segment -situation in the Huddinge service system as “segmented” – the system distinguishes between market segments with slightly different needs and problems.

Also in Huddinge the service systems allow service producers to target, approach and approve end customers in the private market according to their own preferences. This is naturally a potential source of additional customers and incremental business.

Customer Relationships

The basis for all customer relationships is that service producers are bound to accept and serve any and all persons in the service system. End customers make the decisions on the continuation, development and termination of the customer relationships, except for situations where they violate the service contracts or neglect their duties. In order to secure the strength and quality of the customer relationships, the service providers are bound to nominate a designated contact person for every end customer. Also, service producers with reported shortcomings in the operations are prohibited from accepting new end customers until the open issues have been solved.

Elderly persons can only have one service producer for all their home help services, whereas disabled persons can split separate services between several producers. Similarly, service producers in the service system for elderly persons need to offer all available home-related services, whereas producers in the service system for disabled persons can choose their offering freely from the available services. This means that the competitive positions are identical for service producers in the service system for elderly persons, and similar for those in the service system for disabled persons. A narrow service offering in the service system for disabled persons does not directly limit service producers’ possibilities to gain customers. The splitting of services by disabled persons increases the average amounts of end customers among service producers in that service system, but it also decreases their average amounts of service hours per end customer.

The Business Model Canvas would rate the customer relationships in the service system as “dedicated personal assistance”, which is the deepest and most intimate of all types.

Huddinge Municipality possesses three quarters of all end customers in the service system, which implies it has a dominant position among all service producers. The remaining quarter of the end customers is divided between 13 private producers serving elderly persons, and 7 private producers serving disabled persons. The amount of producers is high, considering the market share of the privatized market. Several of the private producers are well-established companies, as 6 of them have over 100 employees and 3 of them have over 500 employees. Also the high concentration of end customers (71-92%) among the 3-5 most popular producers in the service systems makes the competitive landscape harsh especially for new producers.

Channels

In the service delivery channel the service producers are also able to use a partner channel. The service partners need to meet the same requirements as the qualified service producers themselves do.

The communication channel is a combination of the partner channel and the own channel. The partner channel is formed by the web-pages and the customer service offices of Huddinge Municipality. The web-pages provide consistent and mainly objective information on the service producers, but these are able to provide own descriptions of their service profiles (additional service features, own competences) and of quality issues and quality declarations that they might have. The own communication channel refers to service producers' own marketing activities in different forms and scales.

In April 2012 Huddinge Municipality launched a web-based tool to the inhabitants for gathering, sorting and comparing basic information on the producers of home-related services in the service systems (Huddinge 2012, web-pages).

Revenue Streams

As with all systems of choice, all service producers in the service systems in Huddinge are equally compensated for the services they produce. Pricing of own services is thus excluded for service producers, as are the possibilities to target customer segments with certain price preferences. A positive aspect is that the compensation mechanism of the service system brings some stability to the revenues among service producers.

Service producers are compensated based on the following rules; compensation only for i) those services being granted, ii) the amount of service hours being granted, and iii) for direct service time. These compensation principles are overall fair for service producers.

Another favorable issue is that hourly-based compensation (SEK/hour) applies for all home help services and for all other home-related services except for the meal service, which is task-based (SEK/delivery). A uniform price applies for all home-related services, even though there are some variations in the contents and requirements of the separate services. Higher compensation levels for evenings, weekends and nights is positive, yet largely expected. Compensation levels are not adjusted for different service districts, but this should not be a problem given the fairly homogenous population density across Huddinge.

Compensation levels to service producers are fixed for one calendar year at a time, and this increases stability and predictability of revenues. The downside with this relates to potential fluctuations in cost levels during the calendar year, especially surprising and/or significant cost increases.

According to the Business Model Canvas terminology, the revenue streams for service producers in the service system arise from "*usage fees*" and "*list prices*" for the separate services.

Table 41: Service offering and revenue generation for service producers in the service system in Huddinge

Analysis A1): Service Offering and Revenue Generation in Huddinge			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Value Propositions (Service Offering)		1.7	Positive
	The amount of different home care services (service range) offered by private producers	2	Positive
	The amount of home care provided, measured in service hours per person, by private producers	3	Very positive
	The relative (market) share of home care, compared to substitutive wellbeing services offered	0	Neutral
Customer Segments		0.8	Slightly positive
	Private producers' access to individuals entitled to statutory home care	2	Positive
	The amount and type of customer segments (elderly persons, disabled persons etc.) served by private producers	1	Slightly positive
	Private producers' possibilities to target or focus on certain customer segments or service segments	1	Slightly positive
	The amount of elderly persons receiving home care by private producers	2	Positive
	The amount of disabled persons receiving home care by private producers	1	Slightly positive
	The amount of other persons (other than elderly and disabled) receiving home care by private producers	-2	Negative
Customer Relationships		-1.0	Slightly negative
	The market position (market share) of private producers, (+) limited or (-) significant	1	Slightly positive
	The amount of private producers in the service system, (+) small or (-) large	-2	Negative
	The level of customer concentration in the service system, (+) diversified or (-) concentrated	-2	Negative
Channels		1.0	Slightly positive
	Distribution channels and communication channels for private producers	1	Slightly positive
Revenue Streams		-0.5	Slightly negative
	Private producers' possibilities to impact the price levels of services offered	-2	Negative
	Compensation to private producers in relation to the associated costs	1	Slightly positive

7.5.2 A2: Operations and Costs

Key Resources

Service producers need to have continuously adequate amounts of employees with appropriate qualifications. Legislation and national authorities determine a significant part of the requirements concerning human resources. The lack of home nursing from the service offering apparently facilitates the finding and recruiting of suitable employees.

Service producers shall choose environmental cars when acquiring new vehicles. Investing in environmental cars instead of regular cars has a limited impact on operations. It may even be more beneficial for service producers with high utilization of vehicles.

Previously Huddinge Municipality offered almost no IT-systems or IT-infrastructure for service producers in the service systems, but the situation has recently improved following the introduction of a new integrated ERP-system. Service producers still need to invest in their own IT-systems and software. The web-pages of Huddinge Municipality, which display various kind of information on service producers, are financed and managed entirely by the municipality.

The qualification requires three different service references from service producers in the application process. This means that service producers need certain intellectual resources in the form of accumulated know-how in provision of wellbeing services, which may exclude some companies from the service system.

A credit rating of “A” or higher (with “AAA” being the highest) is compulsory for service producers, or alternatively some form of warranty or other contribution. This implies sufficient financial stability or financial resources among the service producers.

Key Activities

The impact of the service offering on key activities is assessed separately for the two service systems (elderly persons versus disabled persons). The service system for elderly persons encompasses a wide service range but limited possibilities to concentrate on certain services only, whereby service producers carry out a large variety of different tasks. But even if the

service range with seven different services is wide, the separate services are nonetheless quite similar and closely related to each other. Also, the lack of healthcare services lowers the level of advancement and demand levels for producing and managing the service offering. The service times, 15 hours/day or 24 hours/day every day throughout the year, may lead to almost continuous serving of end customers. Staffing is thus crucial for service producers. The possibility to limit the operations to certain districts only is beneficial, and service producers can use that to adjust and control their own activities.

The service system for disabled persons allows service producers to limit their service range and thereby also the scope of their activities. Concentrating entirely on e.g. home help services is in fact possible only in this service system. The service times – 3, 12 or 15 hours/day excluding night shifts – offer more flexibility than the service system for elderly persons. But the lack of service districts limits service producers' possibilities to restrict the scale and geographical coverage of their operations. Still, the modest size of Huddinge (141 km^2 in total) together with the fairly high population density (689 inhabitants/km^2) should not be a problem for service producers.

The maintenance of the customer relationships, such as co-ordination of service plans and activities of designated contact persons, consumes time and efforts from service producers. On the other hand, the absence of home nursing in the service offering should reduce the burden of the activities related to the customer relationships. Such end customers in the service system for disabled persons, who decide to split their services between several service producers, lead to an increase and spreading of customer relationship costs over a larger number of producers.

The capacity limits can be useful mechanisms for those service producers that want to restrict the scale of their operations. The transition periods for altering capacity limits, 90 days for reductions and 30 days for increases, are perhaps somewhat lengthy for service producers, especially for the reductions.

A drawback of the service systems is that they provide only few technological solutions for service providers. This seems to be the case especially in the service delivery processes but

also in the support function processes. The migration of the fax-based communication to electronic communication through the new integrated ERP-system has improved the cooperation between Huddinge Municipality and the service producers. Invoicing procedures are still largely paper-based and thus manual.

The service system relieves service producers from charging and invoicing of end customers, which is beneficial. Any additional services provided outside the service plans still need to be charged directly from end customers.

Service producers need to arrange training to the personnel on a continuous basis. Other cost-generating activities are e.g. regular reporting of own activities to Huddinge Municipality. Specifications of services provided, possible deviations from service plans, and collection of end customer signatures for non-attended service times are procedures that service producers carry out and report for on a monthly basis.

The Business Model Canvas analogy would categorize the key activities for service producers in the service system as “production”.

Key Partnerships

Service producers can hire service partners to manage the provision of services to their customers, which is undoubtedly a valuable option. The service partners themselves do not need to be qualified producers in the service system, but they need to meet the same qualification requirements that approved service producers do. This combined with the closeness of Stockholm widens the range of potential service partners. Hiring a service partner for certain services can thus be a solution for e.g. a service producer wishing to concentrate on merely a few services within the service system for elderly persons.

There are number of parties that service producers are committed to co-operate with, such as the primary healthcare organization, Huddinge Municipality, family members and close friends, and with other relevant persons and organizations. However, the lack of home nursing in the service offering is likely to lower service producers’ need to co-operate with other healthcare organizations.

Cost Structure

The costs and investments that service producers in the service systems face have been addressed indirectly in the earlier sub-sections “Key Activities”, “Key Resources” and “Key Partnerships”. The focus here is primarily on what the cost structure and cost components for service producers are.

Due to the fixed and pre-determined compensation levels in the service systems in Huddinge, the service producers have a “cost-driven” cost structure. But again, the requirements and obligations imposed on the service producers limit their possibilities to cut down on costs.

For service producers the main fixed costs are wages and salaries, leasing or acquisition of vehicles and IT-related costs. Primary sources of variable costs are fuel costs and possible service partnership costs.

Table 42: Operations and costs for service producers in the service system in Huddinge

Analysis A2): Operations and Costs in Huddinge			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Key Resources		0.5	Slightly positive
	The level of requirements for human resources (employees) of private producers	1	Slightly positive
	Required investments in physical, intellectual and financial resources by private producers	0	Neutral
Key Activities		0.0	Neutral
	The impact of service offering (service type, service range, combination possibilities, service times, geographical area) on the operations of private producers	0	Neutral
	The impact of served customer segments (segment range, combination possibilities, profitability) on the operations of private producers	1	Slightly positive
	The impact of customer relationships (service producer obligations and end customer possibilities) on the operations of private producers	0	Neutral

	Private producers' possibilities to set capacity limits for their operations	2	Positive
	The amount of technology solutions (automated services, digitalized services etc.) in the service system that is applied in customer work	-2	Negative
	The amount of technology solutions (automated functions, digitalized functions etc.) in the service system that is applied in support services	-1	Slightly negative
	Activities related to charging and invoicing of end customers by private producers	0	Neutral
	The amount of operative activities that private producers are not compensated for	0	Neutral
Key Partnerships		1.0	Slightly positive
	Private producers' obligations to co-operate with external parties	-1	Slightly negative
	Private producers' possibilities to appoint service partners (to outsource)	3	Very positive
Cost Structure		-1.0	Slightly negative
	Private producers' possibilities to impact their operative costs	-1	Slightly negative

7.5.3 A3: Implications of Quality

The quality analysis is adapting themes from the Business Model Canvas. Quality is divided into three parts, the first of which concerns services, the second concerns operations while the third concerns communication related thereto. The procedure is largely the same as in analyses A1-A2 and B1-B2.

<u>Service Quality</u>

Many quality issues in the service systems relate to the service offering (Value Propositions in the Canvas). Service producers shall allow end customers to participate in the planning and the provision of their services. The contents, preparation and delivery of meals have their own guidelines and recommendations as formed by Huddinge Municipality. Cleaning activities and other domestic services have to meet certain standards, and service producers also need to have routines for upholding basal hygiene.

The customer relationships are subject to some requirements. Service producers are bound to allocate predetermined time slots to each end customer for phone calls. They shall also inform their end customers of changes in the operations or in the manning of the regular service

personnel. A preparedness to start serving new end customers one day after signing a service contract is required by service producers.

Quality failures in the service offering can lead to notable surcharges for service producers. For instance each delayed customer visit on connection with the safety alarm service (i.e. arrival later than 30 minutes from the alarm center call) leads to a SEK 2000 fine.

Operational Quality

The operations of the service producers shall follow the definition of *good quality*, as specified in legislation. A management system for quality is compulsory for all service producers, and the quality of the operations shall be assured and developed on a continuous basis. The management system for quality deals with a number of areas, such as with quality of the services, availability of the operations, management, personnel, co-operation, documentation, defects in the operations, feedback, complaints, monitoring and with evaluation.

As a part of the management system for quality, the service producers shall assure that there are routines for how defects in the operations are treated. They shall also assure that there are appropriate routines for handling with feedback and complaints coming from external parties. Moreover, personnel of service producers shall report abuses and shortcomings in the care or treatment of end customers, and immediately take corrective measures.

Securing operational quality also demands various and recurring reporting activities by service producers, and mainly to Huddinge Municipality. The municipality conducts producer audits, customer surveys, crisis planning and crisis exercises, and service producers shall co-operate in these procedures when they occur.

The vast majority of the operational quality aspects in the service systems relate to Key Activities in the Canvas. The initial costs resulting from operational quality can be seen as required investments, given that service producers need to establish management systems for quality for their operations. Once established, the quality costs appear to be mainly fixed, but

to some extent also dependent on end customer amounts. All in all the operational quality seems to cause the largest burdens to new and/or small service producers.

The absence of home nursing in the service offering should downsize the requirements, activities and costs related to operational quality. Service producers therefore have less frequent needs for co-ordination and co-operation with external healthcare organizations, and more limited needs for documentation and reporting of patient data.

Quality and Communication

Given that the service systems in Huddinge are based on systems of choice, they prevent service producers from setting the prices or compensation levels for their services. This should make quality a primary competition factor for service producers, with the minimum levels for quality being determined by the service systems.

The web-pages of Huddinge Municipality highlight a couple of quality aspects for each service producer. The two voluntary sections for quality – one for additional quality features and the other for own quality declarations – enable service producers to present their position within quality. A clear majority of the service producers have utilized these possibilities, which suggests that quality would be a competition factor also in practice. Also the web-based tool, which recently was initiated by Huddinge Municipality for comparing qualified producers of home help services, is intended to highlight quality features of the producers.

The latest customer survey for home help producers in Huddinge (November 2011) revealed large variations in the customer satisfaction index between service producers. The outcomes ranged from 67 to 98 (on a 0-100 scale), but a correlation with end customer amounts could not be observed. In fact, the largest private service producer in terms of end customer amounts (HSB Omsorg) reported the lowest outcome for the customer satisfaction index. However, the customer survey reflects the actual situation only partly, given that 6 out of 14 service producers were excluded as a result of insufficient (<10) end customer amounts. Nonetheless, the customer survey does not provide direct evidence for that high quality among service producers would lead to high amounts of end customers.

Table 43: Implications of quality for service producers in the service system in Huddinge

Analysis A3): Implications of Quality in Huddinge			
The scoring points and the analysis in this table reflect the current situation for service producers The scoring points are outcomes of subjective assessments Average scoring points are given to each separate sub-area (Canvas component)		Scoring points (outcomes): From -3 to +3	Converted outcomes: +3 = Very positive +2 = Positive +1 = Slightly positive 0 = Neutral -1 = Slightly negative -2 = Negative -3 = Very negative
Quality and Costs		-0.5	Slightly negative
	The direct impact of service quality requirements on private producers' costs	-2	Negative
	The direct impact of operational quality requirements on private producers' costs	1	Slightly positive
Quality and Revenues		2.0	Positive
	The potential impact of quality on private producers' customer amounts	2	Positive
	The potential impact of quality on private producers' service prices	-	-
Quality and Communication		1.0	Slightly positive
	Availability of public information on measured quality among private producers	2	Positive
	Observed relation between measured quality and customer relationships among private producers	0	Neutral

7.5.4 B1: Service Offering and Revenue Generation in the Future

The following table displays the answers provided by City of Huddinge representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 44: Service offering and revenue generation for service producers in the service system in Huddinge – in the future

Analysis B1): Service Offering and Revenue Generation in Huddinge in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Value Propositions (Service Offering)			Improves slightly
	Will the amount of different home services (=service range) offered by private service producers increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
	Will the granting of personal care, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
	Will the granting of home help, in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Decreases slightly	Worsens slightly
	Will the granting of other existing home services (other than personal care and home help, for instance home nursing), in terms of service hours per person, increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same
	Will the share (market share) of home care increase/decrease in proportion to offered substitutive wellbeing services in the future, when compared to the current situation?	Increases	Improves
Customer Segments			Improves slightly
	Will the amount of different customer segments (elderly persons, disabled persons, families with children, rehabilitators, demobilized hospital patients etc.) increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
	Will the amount of elderly persons receiving home care increase/decrease in the future, when compared to the current situation?	Increases	Improves

	Will the amount of disabled persons receiving home care increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same
	Will the amount of other persons (other than elderly and disabled persons) currently receiving home care increase/decrease in the future, when compared to the current situation?	Increases slightly	Improves slightly
Customer Relationships			Worsens slightly
	Within home care, will the position of the municipal service producer (investments in physical/intellectual/human resources, in processes, in knowhow, in brands) increase/decrease in the future, when compared to the current situation?	Decreases	Improves *
	Within the service system for home care, do you believe that that the amount of service producers will increase/decrease in the future, when compared to the current situation?	Increases significantly	Worsens significantly *
	Within home care, do you believe that the concentration of the market (the customers) in relation to available service producers will increase/decrease in the future, when compared to the current situation?	Increases slightly	Worsens slightly *
Channels			
	-	-	-
Revenue Streams *(Calculated as the average of all points listed in this table)*			Stays the same
	Within home care, will the increases in the compensation levels to service producers in the future be higher/lower than the increases in the actual production costs, when compared to the current situation?	Slightly lower	Worsens slightly

Based on the answers provided by representatives of Huddinge Municipality, the future development of the service offering in the service systems for home help services appears to be modestly optimistic. The amount of service hours will increase slightly for personal care, whereas they will decrease slightly for domestic services. The position of home care (home help services) is expected to improve in comparison to other available wellbeing services.

The situation with customers reflects mainly positive matters. The amount of different customer segments receiving home care will increase slightly, as will the amount of elderly person end customers. Also the amounts of other than elderly persons and disabled persons receiving home care are expected to grow slightly in the future.

The most evident changes seem to occur for customer relationships. The market position of the municipal service producer will diminish. On the other hand, this will probably be more than offset by a significant increase in the amount of service producers in the service systems.

7.5.5 B2: Operations and Costs in the Future

The following table displays the answers provided by City of Huddinge representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/component of the Business Model Canvas.

Table 45: Operations and costs for service producers in the service system in Huddinge – in the future

Analysis B2): Operations and Costs in Huddinge in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Key Resources			Stays the same
	Within home care, will the local supply of employees with suitable education and work experience increase/decrease in the future, when compared to the current situation?	Stays the same	Stays the same
Key Activities			Improves
	In the direct customer work within home care, will the use of technology solutions (automated services, digitalized services etc.) increase/decrease in the future, when compared to the current situation?	Increases	Improves

	In the support functions within home care, will the use of technology solutions (automated functions, digitalized functions etc.) increase/decrease in the future, when compared to the current situation?	Increases	Improves
Key Partnerships			
	-	-	-
Cost Structure *(Calculated as the average of all points listed in this table)*			Improves slightly
	-	-	-

The operational prospects for producers in the service systems for home help services in Huddinge are promising. Huddinge Municipality will increase the use of technology solutions in all areas, i.e. in the direct customer work as well as in the support functions. This predicts improved operational efficiency among service producers and consequently also reductions in the costs.

7.5.6 B3: Implications of Quality in the Future

The following table displays the answers provided by City of Huddinge representatives on the future development in the service system and in the operating environment. The numerical answers provided by the municipal representatives have been expressed in equivalent written forms. The written equivalents have then been converted to outcomes that assumingly reflect the perspective of service producers. Average outcomes have then been calculated for each theme/issue in the table.

Table 46: Implications of quality for service producers in the service system in Huddinge – in the future

Analysis B3): Implications of Quality in Huddinge in the Future			
The answers (scoring points) in the table are subjective assessments provided by municipal representatives of the future development The converted answers (scoring points) in the table reflect the future development for service producers Averages of the converted answers (scoring points) are given to each separate sub-area (Canvas component)		Answers: +3 = Increases significantly +2 = Increases +1 = Increases slightly 0 = Stays the same -1 = Decreases slightly -2 = Decreases -3 = Decreases significantly	Converted outcomes: +3 = Improves significantly +2 = Improves +1 = Improves slightly 0 = Stays the same -1 = Worsens slightly -2 =Worsens -3 = Worsens significantly * = Opposite conversion applied
Quality and Costs			Worsens
	Within home care, will the requirements set for the services offered increase/decrease in the future, when compared to the current situation?	Increases	Worsens *
	Within home care, will the requirements set for the service producers increase/decrease in the future, when compared to the current situation?	Increases slightly	Worsens slightly *
Quality and Revenues			
	-	-	-
Quality and Communication			
	-	-	-

It seems that service producers will face a higher amount or alternatively more severe requirements in the future. This trend applies to both the services offered and to the producers themselves, although more distinctly to the services. The negative impacts of this for service producers are difficult to assess reliably.

7.5.7 Summary of Analyses

<table>
<tr><td rowspan="2">Key Partnerships:

Slightly positive</td><td>Key Activities:

Neutral</td><td rowspan="2">Value Propositions (Service Offering):

Positive</td><td>Customer Relationships:

Slightly negative</td><td rowspan="2">Customer Segments:

Slightly positive</td></tr>
<tr><td>Improves</td><td>Worsens slightly</td></tr>
<tr><td rowspan="2">-</td><td>Key Resources:

Slightly positive</td><td rowspan="2">Improves slightly</td><td>Channels:

Slightly positive</td><td rowspan="2">Improves slightly</td></tr>
<tr><td>Stays the same</td><td>-</td></tr>
<tr><td colspan="3">Cost Structure:

Slightly negative</td><td colspan="2">Revenue Streams:

Slightly negative</td></tr>
<tr><td colspan="3">Improves slightly</td><td colspan="2">Stays the same</td></tr>
</table>

Light grey cells indicate current situation | *Grey cells indicate the future situation (development)*

Figure 56: Summary of possibilities for conducting business in the service system in Huddinge (analyses A1-A2 and B1-B2)

The aggregated view on the current situation regarding possibilities for conducting business in the service system in Huddinge (analyses A1-A2) is mostly favorable. The service offering itself, such as the wide service range and the high amounts of service hours are perhaps the best elements. Also some customer issues, e.g. amounts of elderly person customers and private producers' access to the customer base in Huddinge are positive for service producers. The most significant drawbacks for service producers relate to customer relationships – the intense competition and the concentrated customer base among the private producers. Also the modest level of technology within the service systems affects the activities of service producers. The future development (analyses B1-B2) looks mostly promising, as increases are expected in the amount of elderly person customers and in the utilization of technological solutions. The largest risks relate to a significant increase in the amount of service producers, i.e. to an escalation of the competitive situation.

Quality and Costs:	Quality and Revenues:
Slightly negative	Positive
Worsens	-
Quality and Communication:	
Slightly positive	
-	

Light grey cells indicate current situation	*Grey cells indicate the future situation (development)*

Figure 57: Summary of quality implications for businesses in the service system in Huddinge (analyses A3 and B3)

Quality-related issues (analyses A3 and B3) have mixed implications on the businesses of producers in the service systems in Huddinge. The strict quality requirements for the services offered incur risks and direct costs. On the other hand, the design of the service system itself should reward producers for quality with inflows of end customers. Also the (indirect) communication channels operated by Huddinge Municipality highlight quality issues among service producers. But the benefits of quality could not be proven in practice, as no obvious positive correlation between customer satisfaction and amounts of end customer amounts was found among the service producers. Forecasted increases in the quality requirements are likely to impose incremental costs to service producers in the future. The analyses suggest that all service producers do not necessarily compete with quality, some may prefer to emphasize cost control while keeping quality at or slightly above the required levels.

8 COMBINED RESULTS

This chapter combines the results of the analyses for the separate municipalities and presents them on an aggregated level for comparative purposes. More thorough assessments of the results and discussions are presented in the subsequent chapter (Conclusions).

8.1 A1-A3: Combined Results of the Current Situation

Table 47: Aggregated results of the analyses on the current situation (A1-A3) for service producers in all municipalities

A1-A3: Analyses of the Current Situation *	Max./Min.	Lahti	Hyvinkää	Uppsala	Huddinge
Value Propositions (Service Offering)	3/-3	1	0	2	2
Customer Segments	3/-3	-1	-2	2	1
Customer Relationships	3/-3	-1	-1	0	-1
Channels	3/-3	1	1	1	1
Revenue Streams	3/-3	1	0	-1	-1
A1: Services and Revenues	*15/-15*	*1*	*-2*	*3*	*2*
Key Resources	3/-3	0	0	1	1
Key Activities	3/-3	-1	-2	0	0
Key Partnerships	3/-3	-1	1	0	1
Cost Structure	3/-3	0	0	-1	-1
A2: Operations and Costs	*12/-12*	*-2*	*-1*	*0*	*1*
A1-A2: Services and Operations	*27/-27*	*-1*	*-3*	*4*	*3*
Quality and Costs	3/-3	-1	-1	-1	-1
Quality and Revenues	3/-3	1	1	2	2
Quality and Communication	3/-3	-2	-2	1	1
A3: Implications of Quality	*9/-9*	*-2*	*-2*	*2*	*3*
Services & Operations incl. Quality (Total)	36/-36	-3	-5	6	5

** = Each figure in the table represents a scoring point avarage (or sum), which is here presented as a rounded figure.*

The aggregated results of analyses A1-A3 on the current situation for service producers in all municipalities give the highest scoring points to Uppsala, which in turn is followed by Huddinge. Lahti ranks third with a clear difference to Huddinge, and Hyvinkää comes fourth with slightly lower points than Lahti.

The aggregated outcomes from analysis A1 indicate that the best situation with respect to service offering and revenues is currently – and in relative terms – in Uppsala. The benefits of the service offering itself and of the customer segments served are the key reasons for the upbeat situation in Uppsala. The situation in Huddinge is nearly as good, but there the lack of

home nursing dilutes the composition of customer segments. Also the competition landscape for private producers is more severe. Lahti in turn provides service producers a satisfactory service offering and good possibilities to price the services, whereas the customer segments served involve inflexible elements for service producers. The situation is in relative terms the weakest in Hyvinkää. The business potential for service producers is restricted, the customer segments served are partly unfavorable, and the amounts of end customers are very limited. On the whole it seems as if service producers operating in Sweden are in a better position to obtain services, end customers and revenue inflows, compared to those operating in Finland.

Analysis A2 and its combined results denote that the situation with operations and costs is in relative terms most advantageous in Huddinge and Uppsala, i.e. in Sweden. In Uppsala service producers benefit from the technological infrastructure provided by the municipality. This area is clearly weaker in Huddinge, but there the service producers have extensive opportunities for arranging their partnerships. In Hyvinkää the operational conditions are weakened by e.g. difficulties in managing the service offering, and by the pool of end customers. In this analysis Lahti ends up in the last position. This is largely due to its several operational burdens such as customer relationship management (within home nursing), together with the duties and limitations related to partnerships.

When pooling together the results for analysis A3 it appears that the municipality, where service producers are rewarded the most for quality, is Huddinge. This is partly because of the service system itself, where producers compete with quality instead of price, but also because of extensive quality information on the service producers. Uppsala is in a slightly weaker position, mostly due to somewhat lesser amounts of quality information. Lahti and Hyvinkää, and thereby the Finnish market, provide the least rewards for quality. The end customers have virtually no access to quality information on service producers, meaning that quality is in practice not communicated. Hyvinkää is perhaps in a marginally better position than Lahti, given that its service producers that choose to leave out home nursing have lower quality costs.

8.2 B1-B3: Combined Results of the Future Situation

Table 48: Aggregated results of the analyses on the future situation (B1-B3) for service producers in all municipalities

B1-B3: Analyses of the Future Situation *	Max./Min.	Lahti	Hyvinkää	Uppsala	Huddinge
Value Propositions (Service Offering)	3/-3	2	1	0	1
Customer Segments	3/-3	1	2	1	1
Customer Relationships	3/-3	-1	-2	0	-1
Channels	-	-	-	-	-
Revenue Streams	3/-3	1	1	0	0
B1: Services and Revenues	*12/-12*	*3*	*1*	*2*	*1*
Key Resources	3/-3	1	-1	1	0
Key Activities	3/-3	3	1	2	2
Key Partnerships	-	-	-	-	-
Cost Structure	3/-3	2	0	1	1
B2: Operations and Costs	*9/-9*	*6*	*0*	*3*	*3*
B1-B2: Services and Operations	*21/-21*	*9*	*2*	*5*	*5*
Quality and Costs	3/-3	-3	-2	-1	-2
Quality and Revenues	-	-	-	-	-
Quality and Communication	-	-	-	-	-
B3: Implications of Quality	*3/-3*	*-3*	*-2*	*-1*	*-2*
Services & Operations incl. Quality in the Future (Total)	24/-24	7	0	4	3

** = Each figure in the table represents a scoring point avarage (or sum), which is here presented as a rounded figure.*

The aggregated results of analyses B1-B3 on the future situation for service producers in all municipalities give the highest scoring points to Lahti. Lahti is followed by Uppsala and Huddinge, both of which have lower but quite similar points amongst themselves. Hyvinkää ranks fourth with the lowest combined points.

The conjoint analysis on the service offering and revenue generation in the future (B1) differs from that of the current situation (A1). Lahti ranks the highest largely due to an upbeat outlook for service offering matters, supported by expected improvements in compensation levels to service producers. Lahti is followed by Uppsala, which expects increases in end customer amounts across all end customer types. Huddinge and Hyvinkää have the least promising prospects for business and revenues. They both forecast improvements in the customer situation, but these are offset by challenges in customer relationships, such as increasing amounts of service producers. It appears that no obvious conclusions for analysis B1 can be made on differences in the development between Finland and Sweden.

The combined analysis on the operations and costs for service producers in the future (B2) is more encouraging than it is for the current situation (A2), although the comparability of these two is dubious. Lahti has the best prospects by far, and this is largely due to forecasted increases in the utilization of technology in the service system, supported by a slight improvement in the availability of labor. Lahti is followed by Uppsala and Huddinge, which also expect pick-ups in technology but with more modest magnitudes. Hyvinkää is clearly in the weakest position, with only slight increases in technology but with a mild deterioration in the availability of labor. No direct conclusions on differences in the development between Finland and Sweden can be made in analysis B2.

The aggregated outcomes from analysis B3 suggest that quality requirements will become stricter in both Finland and Sweden, somewhat more in Finland though. Lahti expects the most significant changes, whereas Uppsala forecast them to be only marginal. Both Lahti and Huddinge forecast higher increases in the requirements for the services offered, and lower increases for the service producers themselves.

8.3 Combined Results of the Study

Table 49: Aggregated results of all analyses (A1-A3 & B1-B3) for service producers in all municipalities

A1-A3 & B1-B3: Summary of All Analyses *	Max./Min.	Lahti	Hyvinkää	Uppsala	Huddinge
Services and Operations	27/-27	-1	-3	4	3
Implications of Quality	9/-9	-2	-2	2	3
A1-A3: Services and Operations incl. Quality	*36/-36*	*-3*	*-5*	*6*	*5*
Services and Operations in the Future	21/-21	9	2	5	5
Implications of Quality in the Future	3/-3	-3	-2	-1	-2
B1-B3: Services and Operations incl. Quality in the Future	*24/-24*	*7*	*0*	*4*	*3*
Combined Current and Future Results (Total)	60/-60	4	-5	10	8

** = Each figure in the table represents a scoring point avarage (or sum), which is here presented as a rounded figure.*

The summarized results from all analyses in the study (A1-A3 and B1-B3) display a couple of key issues. Firstly, the current premises for conducting business in the municipalities are in relative terms clearly better in Sweden than in Finland. Secondly, the inclusion of quality aspects into the assessment does not change the set-up – it actually amplifies the aforementioned results. The outcome points out Uppsala as the most feasible municipality and

Hyvinkää as the least feasible one for service producers in the current situation. Huddinge is positioned nearly as high as Uppsala, whereas Lahti lies clearly below Uppsala but still clearly above Hyvinkää. The results concerning the future development are partly different from the current situation. The preconditions for conducting business seem to be improving in all municipalities in the future, but increasing quality requirements erode a part of these benefits. The most promising future outlook is held by Lahti, followed by Uppsala and Huddinge. Hyvinkää in turn has the least favorable prospects of the four municipalities, and they are altogether more or less neutral.

The combination of the results from the current and future analyses is not very appropriate, given the underlying incompatibility between them. Nevertheless, a simple addition of all results shifts Lahti closer to Uppsala and Huddinge – largely due to its strong outlook. It is also fair to say that the situation in Hyvinkää is, from a service producer perspective, now and in the coming years the least favorable among the four municipalities investigated.

9 CONCLUSIONS

This chapter begins by assessing the various results and findings of the study. The results and findings are reviewed separately for all four municipalities, but also on an aggregated level. The results are also reflected on the main theoretical frameworks chosen for the study, as well as on alternative frameworks presented in the study. Then the utilization of the results is discussed, and the chapter ends with recommendations for future research.

9.1 Assessment of the Results

The following assessments compare the results of the analyses with the actual situations within the service systems and municipalities. The assessments are made separately for all four municipalities, after which they are summarized by joint findings and conclusions. The assessments aim to answer the research questions set for the study, in addition to which they relate to the theoretical frameworks.

9.1.1 Assessment of the Results for Lahti

Table 50: Connecting research questions with results for Lahti

Research Question	Current Situation	Future Development
What are the preconditions for conducting private business?	Neutral *(Total scoring points: -1 of -27)*	Improves *(Total scoring points: 9 of 21)*
What are the implications of quality-related issues?	Slightly negative *(Total scoring points: -2 of -9)*	Worsens significantly *(Total scoring points: -3 of -3)*

The aggregated results of the current situation for service producers in Lahti are quite neutral on the whole. Services and operations (analyses A1-A2) are a mixture of advantages and disadvantages, most of which were moderate in magnitude. The implications of quality (analysis A3) are mainly negative, which worsens the situation for service producers.

The aggregated results reflect the actual situation in the service system in Lahti only to some extent. The fact that 15 producers, most of which are private companies, operate in the service system for home care (in November 2011) is indeed a positive signal for a city with approximately 100,000 inhabitants. The fact that the large healthcare group Maino Vire is part of the service system gives an indication that the premises for conducting home care business are at least satisfactory. On the other hand, Mainio Vire also offers also other wellbeing services in Lahti such as service housing, so home care may in practice be more of a convenient support business. Furthermore, it appears that service producers have in practice utilized the flexibility of the service offering – there are many varieties in the service times but also in the service production (outsourcing). 6 out of 15, or 40% service producers have chosen to acquire the home nursing services from another producer. The results of current situation analyses (A1-A3) include the benefits and drawbacks of home nursing, and it may well be that the exclusion of home nursing from the service offering would improve the overall results. Costs of quality and poor communication of quality are drawbacks particularly associated with home nursing. Nearly all service producers offer informal care and different kinds of additional home services. Three of the service producers offer also support for personal assistance for disabled persons. These observations suggest that the service system for home care is not the only business or service area of the service producers, rather it is one among many.

The aggregated results of the future development for service producers (analyses B1-B3) in Lahti are promising, despite the forecasted notable rise of quality costs. The ultimate impact of the increasing quality requirements is difficult to assess, but a clear tightening is nonetheless expected in the coming years. The favorable outlook is of course difficult to verify in practice, but it is supported by the honorable amount of service producers currently in the service system. If the business outlook would in reality not be promising, then the service system most likely consisted of clearly less than 15 service producers.

It seems that the service system for home care in Lahti suits private producers of different kinds. Small companies are able to enter the system and operate on a limited scale. Alternative service times, partnerships, short transportation distances and good pricing possibilities are beneficial and also widely used. The service system is suitable for large

companies as well. The size of the total market, the growth of the privatized market (service voucher market), and the business possibilities among related wellbeing services are all fairly attractive for companies seeking for volume and growth. However, the level of competition is a prevailing challenge for all companies in the service system, and especially the actions of the four NGOs may weaken the business possibilities of the private companies.

9.1.2 Assessment of the Results for Hyvinkää

Table 51: Connecting research questions with results for Hyvinkää

Research Question	Current Situation	Future Development
What are the preconditions for conducting private business?	Slightly negative *(Total scoring points: -3 of -27)*	Stays the same *(Total scoring points: 2 of 21)*
What are the implications of quality-related issues?	Slightly negative *(Total scoring points: -2 of -9)*	Worsens *(Total scoring points: -2 of -3)*

The current situation for service producers in Hyvinkää is according to the aggregated results unambiguously weak. Services and operations (analyses A1-A2) are poor across all areas assessed, and especially what concerns the service offering and the customers served. The negative implications of quality (analysis A3) undermine the situation further.

The aggregated results for the service system in Hyvinkää correspond well to the real situation. A total of 4 producers operate in the service system for home care (as of November 2011), which can be seen as a modest amount in a city with roughly 45,000 inhabitants. All producers are small- or micro-firms, whereas mid-sized or large firms are lacking from the service system. The two large healthcare groups Esperi Care and Mainio Vire offer service housing in Hyvinkää and home care services in several cities in Finland – but not in the service system in Hyvinkää. 2 out of 4, or half of the service producers have chosen to offer only home help services but not home nursing. It seems as if the drawbacks of home nursing would outweigh the benefits for many producers, whereby these have chosen a lighter model for their home care business. Challenges related to quality may well be a key reason for these

decisions. All 4 service producers offer informal care and 3 of them offer additional home services and property management services in Hyvinkää. This supports the belief that the service system for home care is not their only business, it may in fact be a support business for the other operations.

The aggregated results on the future development for service producers (analyses B1-B3) in Hyvinkää forecast no major changes the current situation. The slight improvements in services and operations seem to be offset by stricter quality requirements in the future. The quality-related issues need to be considered, as their coming development may impact overall operations. The current low amount of service producers supports these views.

It is quite apparent that only small companies are potential operators in the service system for home care in Hyvinkää. Small companies can limit their service offering to home help services only, choose manageable service times (11 hours) and find service partners outside the service system. The small size of the privatized market (service voucher market), the restrictions on the services offered and the potentially long transportation distances seem to be the main reasons that drop the interest among larger companies.

9.1.3 Assessment of the Results for Uppsala

Table 52: Connecting research questions with results for Uppsala

Research Question	Current Situation	Future Development
What are the preconditions for conducting private business?	Slightly positive *(Total scoring points: 4 of 27)*	Improves slightly *(Total scoring points: 5 of 21)*
What are the implications of quality-related issues?	Slightly positive *(Total scoring points: 2 of 9)*	Worsens slightly *(Total scoring points: -1 of -3)*

The service system in Uppsala receives, in relation to the other case-municipalities, the best aggregated results from the analyses on the current situation (A1-A3). The services and the customers (part of A1) are the most advantageous areas for service producers, whereas the

impacts of the operations (A2) are rather neutral. The design of the service system rewards service producers for quality (A3), and this improves their position further.

It seems that the aggregated results are at least to some extent valid for the service system in Uppsala. There were 15 producers, most of which private and local companies, in the service system in October 2011. The amount is reasonably good for a city with roughly 200,000 inhabitants. It is reassuring that the 3 large and privately owned healthcare groups Förenade Care, Aleris Äldreomsorg and Attendo Care operate in the system. But again, these companies were already well-established and shifted into the service system when it was launched in late-2008. Additionally these three healthcare companies provide other wellbeing services in Uppsala such as service housing, so it is evident that they currently benefit from economies of scale and scope. Apart from a few other large and mid-sized companies such as Omsorgshuset i Stockholm, most of all service producers are nonetheless micro-firms with 10 employees or less. The possibility to choose between personal care and domestic services can be observed among the service producers. 8 of 15, or roughly half of all producers have chosen to offer only domestic services, while the remaining 7 offer also personal care and home nursing. Only the four aforementioned large healthcare companies offer personal care and home nursing on a continuous basis (24 hours per day). It seems as if the smaller companies have concluded that an operating model that excludes home nursing is the most beneficial solution from their perspectives. The operational burdens and the costs of quality related to home nursing are in relative terms presumably higher for smaller companies than for larger ones. Furthermore, smaller companies with less than 10 customers are excluded from the customer satisfaction surveys, which makes quality communication more difficult for them. This is set to lower their interest for home nursing even more. All service producers offer additional domestic services, and 3 of them offer also additional care-related services. 4 of the service producers offer also accompanying services for disabled persons through a separate service system. The private producers thus seem to have opted for parallel businesses or services to the home care.

The future situation for service producers in the service system (analyses B1-B3) in Uppsala looks quite favorable. The outlook is good for the value creation (i.e. for services and business) and also for the operations, and the implications of quality are forecasted to be only

modestly negative. Although this cannot be proven in reality, at least 15 service producers in the service system seem to share similar types of views.

The service system for home care in Uppsala should in principle interest both large and small companies. The large size of the market and the wide service offering should enable sufficient business volumes for large companies. Small companies may be willing to enter the service system with a limited service offering or with a partnership with another producer. Nevertheless, new service producers need to attract a critical mass of end customers as soon as possible, as to minimize the disadvantages of the long transportation distances in the wide service area. Also the high level of customer concentration (market concentration) among the largest service producers, combined with the competition between the several producers, form potential barriers of entry for new companies.

9.1.4 Assessment of the Results for Huddinge

Table 53: Connecting research questions with results for Huddinge

Research Question	Current Situation	Future Development
What are the preconditions for conducting private business?	Slightly positive *(Total scoring points: 3 of 27)*	Improves slightly *(Total scoring points: 5 of 21)*
What are the implications of quality-related issues?	Slightly positive *(Total scoring points: 3 of 9)*	Worsens *(Total scoring points: -2 of -3)*

The aggregated results for the current situation for service producers in the service systems in Huddinge are quite positive. The service offering is the strongest single area within value creation (analysis A1), whereas the operational areas (analysis A2) have more mild effects on overall business preconditions. Moreover, of all four municipalities in the study Huddinge is where service producers benefit the most from quality (analysis A3).

The de facto situation of the service systems in Huddinge is in line with the results, and it may even be that the results understate the reality. 13 service producers of home help services for

elderly persons – all of which are private companies – operating in a municipality with a population of 100,000 is a good amount. The pool of companies is heterogeneous as it consist of large companies (Attendo Care, HSB Omsorg, Omsorgshuset i Stockholm and OmsorgsCompagniet), mid-sized companies and of a couple of micro-firms. The heterogeneity of companies is a signal of the vitality of the service system. The proximity of Stockholm has surely also a positive effect on the amount and type of producers in Huddinge, although these type of factors were not taken into account in the study. The vast majority of the companies operate in all 5 service districts in Huddinge, and this reflects the attractiveness of the entire municipality. 5 out of 13, or 38% of the companies have chosen service times of 15 hours per day instead of 24 hours per day. 9 of the companies or 69% have entered into some form of partnership for their meal services. 7 of the companies or roughly half also offer home help services for disabled persons in the parallel service system. And additionally these provide other services for disabled persons in Huddinge, such as personally formed support, accompanying services and support for informal care. All companies offering home help services also offer additional services of various kinds. It appears that the lack of home nursing from the service system is not a major loss for the service producers, and the inclusion of other home-related and personal services may even be more beneficial for their businesses. The structure of the service system for home help services for elderly persons, together with the other service areas chosen by the service producers, suggest that offering multiple yet closely related home- and personal services is a viable businesses model.

The companies seem to emphasize communication of quality issues, as the vast majority has listed special competences and many (7 of 13) have also formed own quality declarations. Quality communication is nonetheless challenging for smaller companies with less than 10 customers, as these are excluded from the customer satisfaction surveys for statistical reasons. On the other hand, the lack of demanding home nursing services and the large representation of domestic and less critical type of services might to some extent lower end customers' interest for customer surveys and related kind of data. The lack of home nursing from the service systems also lowers the costs of quality for all service producers, and small companies are set to gain the most from this.

The combined results of the future development for service producers (analyses B1-B3) in Huddinge are mostly favorable. In particular the operational premises (B2) are expected to improve going forward. This will at least to some extent be weakened by the consequences of increasing quality requirements. The future development of quality-related issues is surely worth taking into account. Anyhow, 13 companies in the service systems appear willing to accept what future will bring.

Both large companies and small companies are potential candidates for the service systems for home help services in Huddinge. The size and the geographical location of the market, the broad service offering and the high amount of service hours per end customer are the main incentives for large companies. Small companies find possibilities to enter the service system(s) gradually, e.g. through offering selected services to disabled persons, through restricting their service times or their service areas, or through service partnerships. But the fairly high customer concentration and the competitive situation in the service systems can cause problems for both new entrants and existing companies.

9.1.5 Joint Assessment of the Results

The combined results and findings from the several analyses are miscellaneous and they reveal that all four municipal service systems are unique, from perspective of private companies. Not only are there clear differences between service systems in Finland and Sweden, but also between service systems in the same country. This shows that the municipalities have numerous possibilities to design or develop their service systems with such features that meet their own specific needs and correspond to prevailing situations. Although it was expected that municipalities create their service systems from their own premises, the significance of the differences is somewhat of a surprise. It is possible that an inclusion of additional municipal service systems for home care the study would not bring more coherence, but rather more diversity to the results. Comprehending this set-up is a good starting point for all private companies in or interested in municipal service systems for home care.

Although there is much diversity among the four municipal service systems, the combined results and findings still display some similarities and common patterns. It becomes evident that the *current* preconditions for conducting business are in many respects different in the Finnish municipalities as compared to the Swedish ones. More specifically, it seems that the preconditions for conducting home care business would currently be more favorable in the Swedish municipalities. The divergence of the results between the two countries is partly expected, given the differences in the underlying service systems (service voucher systems versus systems of choice) due to their distinct characteristics. Also legislation, recommendations, responsibilities, duties and general praxis are in many respects different between the two countries. The limited amount of case municipalities – two from both countries – prevents from drawing reliable and generally applicable conclusions on whether there are fundamental differences in the preconditions for conducting private business in municipal service systems between Finland and Sweden.

The combined results and findings of the current situation also show a positive correlation with the population of the municipality. The highest total scoring points were received by Uppsala (approx. 200,000), followed by Huddinge and Lahti (both approx. 100,000), and Hyvinkää (approx. 45,000) with the lowest total scoring points. Also the level of privatization, i.e. the percentage of home care customers being served by private companies and NGOs, correlates positively with the results. The order is here the same, going from highest to lowest; Uppsala, Huddinge, Lahti and Hyvinkää. An interesting finding is that the largest populations and highest levels of privatization are held by the two Swedish municipalities. It is in other words possible that a part of the differences in the results between the Finnish and the Swedish municipalities is less because of the characteristics of the two services systems, and more because of the differences in population and privatization. Drawing conclusions from these observations is perhaps not recommendable, given the apparent risks of mixing applied data (input) with generated results (output).

Based on the combined results of the study it becomes apparent that the elements of the service systems are not permanent – they are rather subject to changes due to ongoing development conducted by the municipalities. The most positive and most significant *future development* is forecasted for the Finnish case municipality Lahti. It is not extraordinary that

the development is most significant in a municipality where the privatization is in relative terms on a lower level. On the other hand, also the least positive and least significant future development is forecasted for a Finnish case municipality, Hyvinkää, where the level of privatization is the lowest among the four municipalities. More important is perhaps that the future development is forecasted to be favorable (i.e. the situation will improve) for virtually all case-municipalities, although there are variances in the magnitudes of these. Increasing amounts of home care customers and increasing utilization of technology solutions are common themes for all four case-municipalities in the future – for the benefit of private companies.

The study and its findings also detect that quality is a critical yet inseparable element of service systems, and thereby also for private service producers. The role of quality is much determined by the type of the service system, i.e. the service voucher system or the system of choice. The starting point is that quality is more highly rewarded for in Sweden than in Finland, given that quality is more visibly integrated into the design of the Swedish service system. Also legislation, recommendations, responsibilities, duties and general praxis contribute to determining the role and position of quality. Municipal decisions still remain an important factor for the end result, as municipalities can always raise quality requirements for their service systems above the minimum levels determined by external factors, such as legislation. These decisions have impacts on the direct quality costs for all service producers – both municipal and private.

Communication of quality is an area that affects how quality *can be* rewarded for. But whether this rewarding occurs in practice remains open, as it is unclear whether end customers prefer service producers with higher quality records (customer satisfaction indices) or not. The study shows that communication of quality is primarily determined by municipalities themselves and their own actions. As expected and for logical reasons, the Swedish case municipalities seem to be the more advanced in this area than the Finnish.

Moreover, continuous development of quality is a main feature of the service systems in the Swedish municipalities, whereas it lacks in the Finnish ones. This *proactive* approach on quality may benefit service producers in the longer term, as opposed to only *reactive*

approaches to quality. This can of course be replicated by private service producers voluntarily, in case they prefer to. But the study indicates that the current situations of quality are not permanent – all municipalities expect to raise their quality levels in the future. This is a clear signal to private companies that the importance of quality will increase going forward.

The study suggests that the size of the service producers correlate positively with the breadths of the service offerings and with the lengths of the service times. Large service producers are more likely to offer also home nursing in addition to home help services, and they are also more likely to operate with maximum service times. Another observation is that large companies would have comparative advantages to smaller companies in those municipal service systems, where the level of technology is low. Investing in software, hardware and devices is more challenging for small companies that cannot leverage on existing technology resources. All of these issues denote that economies of scale prevail in the municipal service systems and/or in the home care business overall.

The study also reveals that most private companies in the four municipal service systems for home care offer also other wellbeing services in parallel service systems. Furthermore, all companies operate also on the private market for home care. These observations suggest that the service systems for home care are not the only service areas or businesses of the private companies, rather they are one among many. This denotes that also economies of scope prevail in the businesses of home-related services and healthcare services.

This study did unfortunately not manage to analyze the geographical distribution of home care services within the borders of the separate municipalities. For service producers in geographically wide municipalities with sparsely populated areas (such as Uppsala and Hyvinkää), it would be important to comprehend how home care services are being granted from a geographical perspective. Municipal decisions to grant home care primarily to persons living in densely populated areas would clearly be beneficial for service producers, as opposed to granting procedures that do not consider the locations of the service users. Information on possible municipal guidelines and on other substitutive services (scheduled/pre-routed moving services, housing services etc.) for sparsely populated areas would be a useful addition to the study, as it would improve the quality of the analyses and

the results. These issues can of course be cleared separately, and be utilized in parallel with the contents of this study.

9.1.6 Comparing the Results with the Theoretical Frameworks

The theoretical framework set by the Business Model Generation (Business Model Canvas) has in this study proven to be a viable tool, by which private service producers can identify, incorporate and structure critical issues for operating a business in a given service system in a given environment. Also the integration of numerical assessments, or scoring points, into the Business Model Canvas, has proven to generate at least reasonably comparable results between service systems and municipalities. And even if the numerical outcomes as such are not very informative or precise, they can still be useful for private service producers considering between two or several service systems and municipalities.

As mentioned earlier in chapter Analyses of the Private Home Care, a feature of this study is that the separate analyses (A1-A3 and B1-B3) do not distinguish between issues related to the business and issues related to the environment – all issues are jointly allocated among the individual areas of the Business Model Canvas and quality. The conjoining of business issues and environmental issues has proved to be a feasible solution for the purpose of this study, even though Business Model Generation (Business Model Canvas) retains these as separate concepts/tools. It is of course possible that some private companies operating in the home care business might be interested in separating business issues from environmental issues, as the latter ones are those that they themselves cannot affect. Business development activities of private companies concern primarily business issues.

The roadmap for assessing and developing business models by M. W. Johnson, C. C. Christensen and H. Kagermann (2008) could have provided additional support to the study. Especially the profit formula (the revenue model, the cost structure, the margin model and the resource velocity) outlined by the framework is a highly important component that is not as clearly defined in the Business Model Generation (Business Model Canvas). The profitability in terms of the margin model is a key question for all home care service producers, something that was not fully analyzed in this study. In the Swedish service systems the private

companies need to measure the gaps between the fixed compensation levels (service prices) and the fairly inflexible cost levels. The private companies in the Finnish service systems in turn need to measure the gaps between their target prices (or the market prices) for the services and the fairly inflexible cost levels. Service systems not enabling sufficient profit margin ranges (Finland) or profit margins (Sweden) will attract only few private companies.

The results and findings of this study are largely in line with the conceptual framework presented by C. Zott and R. Amit (2010), where business models are regarded as activity systems. Service producers in municipal service systems for home care do not operate in isolation, as they need and choose to cooperate with other service producers to assure provision of adequate home care for their end customers. Additionally the service producers need to cooperate with the municipality and with other parties of the public sector, as to contribute to a proper functioning of end customers' aggregated care chains within healthcare and social services. The frameworks utilized in this study comprise links to external parties outside the service companies, but they do not measure the value being created and delivered in the entire activity systems related to the municipal service systems. The relevant question for each municipal service system would be: what share of the value of the entire activity system is allocated to the service producers, as compared to the share that is allocated to the other parties? The findings of this study also found proof of "complementarities" in the business models designs, given that all home care producers operate in parallel markets and/or service segments.

The results and findings of this study also support the framework for value networks by V. Allee (2002). Service producers in the service systems for home care do indeed operate in networks that widen as their own service offerings expand. Also the intensive exchange of intangibles, i.e. knowledge and benefits, applies very well for home care businesses and for the underlying service systems. Communication and the benefits from these information streams are not only critical success factors – they are also compulsory elements for home care producers. The value networks and the value streams within the service systems could well be captured by the illustrative value network maps, and these could well be combined with the utilized concepts of the Business Model Generation (and Business Model Canvas).

It seems that the framework by G. Hamel (2000) for business models in connection with innovating business concepts would have been too challenging for this case study. It could be more useful at later stages, when planning how to enter into a specific municipal service system based on an innovative approach. Also, this framework is particularly suited for single companies for differentiation purposes, and less suited for generalization, which is the case in this study.

Those results and findings that relate to quality are difficult to verify against the theoretical frameworks. The general design of the service voucher system in Finland supports the views of Rust et al. (1994), according to which high quality among companies *should* lead to increases in customer amounts and revenues, as well as enable higher prices. The general design of the service voucher system in Sweden, in turn, is more in line with the service-profit chain presented by Heskett et al. (2008). According to this view the consequence of high internal quality *should* be revenue growth, which comes from customer satisfaction and customer loyalty. Nevertheless, this study does *not* find clear evidence that high quality among the service producers in the service systems would lead to increases in customer amounts or revenues, or to higher service prices. The outcomes of the customer satisfaction indices and the customer amounts do not show direct correlation in the Swedish case-municipalities. Also, the fact that there are price differences between service producers for specific service sets (specific combinations of service types and service times) in the Finnish case-municipalities may relate to quality, but they may equally well relate to other things. Altogether these findings indicate that service producers do not *automatically* strive to improve their quality performance, especially if the impacts on customer amounts and revenues are limited. In case end customers are indifferent towards quality information on service producers in the service systems, then the benefits of good quality communication are largely lost.

Neither is this study able to verify the impacts of quality on the costs of service producers, i.e. whether additional quality improvements would increase or decrease their total costs of quality (Deming 1982; Harry et al. 1999). The continuous development of quality that is applied in the Swedish service systems speak in favor of decreasing total costs of quality. Also the imposing of fines to service producers for recorded failures in the provision of

adequate services in Huddinge suggests decreasing total costs of quality. But what the results and findings of this study *do* prove is that the total costs of quality are *clearly higher for home nursing* than for home help services – both in the Finnish and Swedish case-municipalities. This may well be the main reason why many smaller service producers choose only home help services, if/when enabled by the service systems. To summarize, these findings indicate that service producers do not *automatically* strive to improve their quality performance, especially in such service systems or in such specific situations where the quality improvements lead to increasing costs rather than decreasing costs.

9.2 Utilization of the Results

As already mentioned, the results of the study demonstrated a large variety in the municipal service systems, meaning that they are all more or less unique. This means that private service producers of home care both in Finland and Sweden need to analyze the situation separately and in detail for each service system and municipality, as to clarify the premises for conducting business on the local level. There is consequently a genuine need for a tool that helps private producers to assess business conditions and to plan their businesses across municipalities. Also the findings, according to which the service systems are in general highly specified and provide limited degrees of freedom for operators therein, calls for proper assessments in advance by private service producers.

Private companies can utilize the results of this study in different ways. The most obvious area of use is a private service company interested in entering into the service system for home care either in Lahti, Hyvinkää, Uppsala or Huddinge. Likewise, a service producer already operating in one of the case service systems (and case municipalities) can utilize the results as a part of its internal business development – the findings may stimulate the service producer to adjust or redesign its current operational model. In both of the aforementioned areas of use the results of the analyses would be used as such. A third alternative – and perhaps more probable area of use – is to apply the analyses to home care service systems in other municipalities. Filling in either own subjective assessments or alternatively collecting external opinions or views into the analyses generates different results for each service system and municipality. The analyses can be carried out either for the current situation (A1-A3) or

for the future development (B1-B3), or both. Anyhow, the important thing is to utilize the analyses and the results on an aggregated level (A1-A3 or B1-B3), and not separately for single analyses only (e.g. only A1 or B3). The implication of a single issue, for instance in the service area (part of A1), has impacts on operations (A2) and also on overall quality (A3) – and vice versa.

It is worth stressing that the tool, which emerged in this study for assessing business preconditions and for business planning, is subject to a number of restrictions. Firstly, the tool is currently applicable only to home care services and services closely related thereto. Applying the tool to other types of services would require adjustments to all separate analyses (A1-A3 and B1-B3). Secondly, the tool is currently tailored for and focused on statutory home care offered through dedicated service systems. This means that the completely private market for voluntary home care services is neither included in nor assessed by this tool. Also here the inclusion of private home care would require adjustments to all separate analyses, or alternatively making of parallel analyses for this business area. And thirdly, the tool has been designed to be a generic tool applicable to municipalities in both Finland and Sweden. It currently incorporates features prevailing in both service voucher systems (Finland) and systems of choice (Sweden). The tool is thus not applicable as such to other types of home care service systems in Finland or Sweden, neither is it *as such* applicable to home care service systems outside these two countries.

Another characteristic of the business assessment and business planning tool, which evolved in this study, is that it is generic for all kinds of companies. It does currently not distinguish between e.g. large companies and small companies or growth companies. In the assessment of the aggregated results for each service system it became clear that large companies and small companies have often ended up with partly different operating models. It is probable that municipalities target certain kinds of service producers for their service systems, and the companies being targeted can be different across municipalities.

Based on the study and its results, it appears that also municipalities could be able to apply the Business Model Canvas when designing, developing or evaluating their service systems for wellbeing services such as home care. A municipality that designs or develops a service

system entirely from its own perspective – i.e. without accounting for the needs and aspirations of external service producers such as private companies – may end up with a poorly functioning service system with too few or too small service producers.

It is justified to make a couple of critical remarks on the reliability of the analyses (A1-A3 and B1-B3) and on the results of this study. The first remark concerns the individual matters addressed in the analyses that relate to the different areas of the Business Model Canvas and quality. The individual matters addressed in the analyses represent subjective choices, meaning that they are subject to personal bias. There is no guarantee that the lists would be sufficient in amounts of matters covered, nor that the matters covered would be of most relevance. A second remark is associated with the assessments of the individual matters in the analyses. Even if many of the current situation assessments (analyses A1-A3) are based on undisputable and even numerical underlying facts, the assessments are nevertheless subjective and thereby contain personal bias. Also the future situation assessments (analyses B1-B3) are, despite their uniform character enabled by the multiple choice answers, subjective assessments of municipal representatives. E.g. the answer “Increases significantly” on a single matter could by different, e.g. “Stays the same”, if it was made by some other person(s). Moreover, e.g. “Increases significantly” is a relative answer and not an absolute answer. A last remark is made on the comparability of the numerical results between analyses A1-A3 and B1-B3. Although the numerical scoring points range between -3 and +3 for both groups of analyses, the answers are not comparable as such. E.g. a matter or an area that is currently “Positive” and in the future “Worsens slightly” can numerically be expressed as +2-1 = +1, but these types of additions are not very adequate from a scientific perspective. The comparison of combined current and future results between municipalities (e.g. +6-2 = +4 versus -1+5 = +4) is obviously not very adequate either. Keeping the results of the current and future analyses separate provides the most benefits without risks of blending the results.

9.3 Recommendations for Future Research

The study and its analyses can be developed into several different directions. The most natural basis for developing the analyses is to maintain the private company perspective. The theoretical framework of the Business Model Generation is intended for companies with conventional aims for their operations – to generate or to grow their customer amounts, service/product volumes, revenues and profits.

A first path for future research would be to introduce relative weights (e.g. 10%-100% or 1-10) into the analyses, and to combine them with the individual matters/assessments. In this study the individual scoring points had equal weights. Individual matters/assessments were given scoring points, after which average scoring points were calculated for the separate areas of the Business Model Canvas and quality. This is likely to overweight the importance of some areas and to underweight others. In this study e.g. a scoring point of +1 (Slightly positive) for the area “Channels” would be offset by a -1 (Slightly negative) for the area “Revenues”, which does not necessarily reflect the reality. The inclusion of relative weights could e.g. increase the relative impact of “Revenues” and decrease the relative impact of “Channels”. The scoring points (-3, -2, -1, 0, +1, +2, +3) could remain the same.

The introduction of scoring points implicitly suggests that the analyses should be made for single companies. It appears logical to trim and tailor the analyses to correspond to the specific situation of a single company. The outcomes of the analyses in this study are a compromise, as they cover both small and large companies. No companies are fully identical, and this undermines the benefits of a generic business assessment and business planning tool. While the tool that emerged in this study can be used as such to gain a quick first impression of a home care service system in a Finnish or Swedish municipality, the inclusion of a separate tailored tool would be justified if or when a company proceeds to the business planning phase. The tailoring of a separate tool could also involve adjustments related to the underlying service system. This means that the tool would be different for Finland and Sweden. The Finnish version could for instance place more emphasis on pricing issues, while the Swedish version could rather accentuate quality issues.

This study revealed that the service systems for home care were not the only businesses of the companies operating therein – all of them offered home care also on the private market, and many of them provided also other related statutory or private wellbeing services. Thereby it would be justified to enlarge the scope of the analyses to better reflect the actual situation among private companies in the wellbeing sector. Expanding the focus to other related businesses would bring more complexity to the analyses, but on the other hand it could be useful as cross-selling, shared resources and shared activities are common themes in wellbeing businesses and services businesses in general. Because of assessments on multiple or parallel levels, this research pattern might be best to carry out on a more general level and for illustrative purposes. Here the inclusion of scoring points and relative weights might confuse the wholeness, whereby the discovery and assessment of potential synergies between businesses, services and markets could be missed.

A final potential path for future research has already been mentioned in brief – to develop the analyses and the tool for municipal purposes. Municipal producers of wellbeing services are supposedly not the main targets in here, given that the primary purpose of the service systems is rather to downscale the roles of the municipal producers on their local markets. Apart from using the tool that emerged in this study for assessing municipal service systems as such, municipalities could be interested in using it as a communication medium with the service producers. The tool identifies and assesses critical issues for service producers, whereby municipalities could use selected parts of it as a basis for dialogues with (or surveys to) qualified operators in their own service systems. A structured approach and proper documentation of the communication and responses could help municipalities with developing their service systems into the right direction. The benefits would accumulate by carrying out the structured communication or surveys on a regular basis, e.g. once a year, and by taking corrective actions while simultaneously monitoring for changes in the service systems.

10 SUMMARY

10.1 The Basis for the Study

The use of home care services – i.e. services delivered to, at or near the homes of individuals – is increasing. The production of statutory healthcare and social services, such as statutory home care services, is still dominated by the public sector in both Finland and Sweden. But the role of private companies and NGOs is nevertheless strengthening, as their customer amounts and service volumes are in both countries growing rapidly from previous low levels.

The increasing privatization of statutory home care services is shifting from traditional exclusive service contracts with limited amounts of service producers towards customer-oriented service systems with multiple and alternative producers. The service systems are named service voucher systems in Finland and systems of choice in Sweden. Service systems for home care services launched by municipalities have been particularly popular.

Private companies need to understand the overall preconditions for operating in the service systems for home care created by municipalities, and separately for each case. A structured assessment to support the decision-making process of private home care companies regarding municipal service systems in Finland and Sweden would thus be useful. In parallel it would be interesting to gain a thorough understanding of some existing service systems.

The primary aim of this study was to assess the current preconditions for conducting private business in municipal service systems for home care in Lahti and Hyvinkää in Finland, and in Uppsala and Huddinge in Sweden. The second aim of this study was to assess the implications of quality-related issues on the preconditions for conducting private business in the service systems in question. The third aim of this study was to clarify the future development (future situation) of the service systems in question, regarding both preconditions for conducting private business and implications of quality-related issues.

The municipalities of the study were either mid-sized or large, and forerunners in customer-based service systems for home care. Further, this study was limited to municipal service systems, and it excluded the private market for home care (non-statutory home care). The

current situation analyses referred to autumn 2011, whereas the future situation analyses refered to a time period ranging from 2012 to 2014-2016.

This study was completed as a case study, with separate, independent and identical analyses for each of the four municipalities. The analyses and assessments of the study were mainly qualitative, while the quantitative methodologies were more supportive and indicative. The data utilized in the study consisted of publicly available information and material, and also of data provided by the municipalities in the form of answers to multiple choice questions on the service systems.

The main theoretical framework for the study was the Business Model Canvas -concept – an elementary framework for structuring, designing and assessing business models among companies. The other theoretical frameworks of the study related to quality – to benefits of quality and to costs of quality.

All analyses and assessments in this study utilized the Business Model Canvas and the nine components therein. The various issues of the municipal service systems for home care were allocated among the different Canvas components. The separate issues were then assessed in writing and/or with scoring points. Scoring points were given in all separate analyses and for all municipal service systems. Combined scoring points for the separate analyses allowed for comparison of outcomes between municipalities. The written assessments and the associated scoring points reflected the perspective of private companies. All analyses were based on subjective assessments made by either the author of the study (current situation analyses) or by municipal representatives (future situation analyses).

10.2 Case Lahti

The current disadvantages of the service system in Lahti were, according to the results, the difficulty to target or focus on specific customer or service segments, the competitive landscape, and challenges related to managing the customer relationships and to managing the network of cooperation partners. Current advantages were the service offering and issues related to revenue generation. Expected future areas of improvement were the service offering

itself, the average amounts of service hours per end customer, the technological solutions within the service system, the compensation levels (i.e. service voucher values) and the cost structure.

The current implications of quality included some drawbacks. Additional quality costs will arise from few tools and little support for quality work from the service system itself, and from emphasizing ongoing processes rather than quality development. Tightening requirements for both service quality and producer quality implied that quality-related costs will rise. The service system enabled service producers to shift quality into service prices, which was positive. But the lack of public information on recorded quality among service producers was a clear handicap for all quality-focused operators.

The aggregated results of the current situation analyses ranked Lahti 3rd out of 4, which reflected the actual situation only to some extent. 15 producers, mostly private companies, operated in the service system for home care (in November 2011), which was positive. Furthermore, there were many varieties in the service times but also in the partnerships (outsourcings) among service producers. Home nursing had a negative impact on the overall results of the analyses. Small companies were able to enter the system and operate on a limited scale, but the service system was suitable for large companies as well.

10.3 Case Hyvinkää

The results on the possibilities for conducting business in the service system for home care in Hyvinkää were mostly negative. Major current advantages were the wide service range and the good possibilities to outsource activities to external service partners. Current disadvantages in turn included e.g. the low amounts of service hours per person, the low amounts of end customers, the dominating position share of the municipal producer, the operational challenges relating to both services offered and customer segments served, as well as the low level of technology in the service system. The most promising issues regarding the future development were a broadening of the service offering, a rise in service hours per person, an addition in customer segments, and especially a clear increase in the amount of elderly persons served. The most unfavorable future changes involved an increase in the

number of service producers, a strengthening position of the municipal producer, as well as a weakening position of home care in relation to substitutive wellbeing services.

Quality implications on business operations were largely unfavorable. The quality requirements on services and service producers were burdened by home nursing, but this service category was optional. Service producers could in theory gain from quality through higher prices or end customer inflows, but existing and potential end customers had in practice nearly no access to objective quality data on the producers. Expected tightening of quality requirements in the future predicted growing duties and costs for service producers.

The aggregated results of the current situation analyses, which ranked Hyvinkää 4th out of 4, corresponded well to the real situation. A total of 4 producers operated in the service system for home care (as of November 2011), which could be seen as a modest amount. All producers were small- or micro-firms, whereas mid-sized or large firms were lacking from the service system. It seemed as if the drawbacks of home nursing had motivated some producers to choose only home help services. Challenges related to quality were likely a key reason for this. Apparently only small companies were potential operators in the service system for home care in Hyvinkää, while larger companies would be less interested in entering it.

10.4 Case Uppsala

The results for the current situation in Uppsala identified the wide service range, the high amounts of elderly person customers and service hours per person, the low levels of investments, and the technological advancement in the service system as the most favorable elements for service producers. Unfavorable elements included the high customer concentration, operational challenges related to the service offering, and the managing of the broad cooperation network. Revenues and costs, in turn, were somewhat harmed by service producers' inability to price their services and to adjust their costs accordingly. The future development seemed to remain quite stable on the whole, but included a few areas with improvement. Examples were the forecasted significant increase in the amount of elderly persons receiving home care, and the increase in technology solutions in the service system.

The implications of quality on business operations in Uppsala were somewhat mixed. The service system itself made quality the main competition factor for winning more end customers. But in practice there was no clear evidence of this. The quality requirements will become slightly stricter in the future.

The aggregated results of the current situation analyses, which ranked Uppsala 1st out of 4, were at least to some extent valid for the service system. There were 15 producers in the service system in October 2011, which was a reasonably good amount. Roughly half of all producers had chosen only domestic services, while the others offered also personal care and home nursing. Smaller companies were not so actively in home nursing. Also, smaller companies with less than 10 customers were excluded from the customer satisfaction surveys, which made quality communication more difficult for them. The service system for home care in Uppsala should in principle have interested both large and small companies. Nevertheless, new service producers needed to attract a critical mass of end customers as soon as possible, as to shorten the average transportation distances in the wide service area.

10.5 Case Huddinge

The current preconditions for conducting business in the service system in Huddinge were mostly favorable. The service offering itself, including the wide service range and the high amounts of service hours, were among the best elements. Also some customer issues, e.g. amounts of elderly person customers and private producers' access to the customer base in Huddinge were positive for service producers. The most significant drawbacks were the intense competition and the concentrated customer base among the private producers. Also the modest level of technology within the service systems seemed to affect the activities of service producers. The future development looked mostly promising, as increases were expected in the amount of elderly person customers, and in the utilization of technological solutions. The largest risks related to a significant increase in the amount of service producers, i.e. to an escalation of the competitive situation.

The strict quality requirements for the services offered incurred risks and direct costs. But then again the design of the service system should itself have rewarded producers for quality

with inflows of end customers. Also the communication channels operated by Huddinge Municipality highlighted quality issues among service producers. But the benefits of quality could not be proven in practice. Forecasted increases in the quality requirements were likely to impose incremental costs to service producers in the future.

The results of the service systems, which ranked Huddinge 2nd out of 4, were quite well in line with the current situation. 13 private companies offered home help services for elderly persons, which was a good amount. The pool of companies was heterogeneous, consisting of large companies, mid-sized companies and of a couple of micro-firms. The vast majority of the companies operated in all service districts, which reflected the attractiveness of the entire municipality. Roughly half of the companies also offered home help services for disabled persons in the parallel service system. It appears that the lack of home nursing from the service system was not a major loss for the service producers, and the inclusion of other home-related and personal services may even have been more beneficial for them.

The companies emphasized quality communication, as special competences and own quality declarations were commonly declared. Quality communication was nonetheless challenging for smaller companies with less than 10 customers, as these were excluded from the customer satisfaction surveys for statistical reasons. The lack of home nursing from the service systems lowered the costs of quality for all service producers, in particular for small companies. Both small and large companies were potential candidates for operating in the service systems for home help services in Huddinge.

10.6 Summary of All Cases

Table 54: Aggregated results of all analyses for service producers in all municipalities

A1-A3 & B1-B3: Summary of All Analyses *	Max./Min.	Lahti	Hyvinkää	Uppsala	Huddinge
Services and Operations	27/-27	-1	-3	4	3
Implications of Quality	9/-9	-2	-2	2	3
A1-A3: Services and Operations incl. Quality	*36/-36*	*-3*	*-5*	*6*	*5*
Services and Operations in the Future	21/-21	9	2	5	5
Implications of Quality in the Future	3/-3	-3	-2	-1	-2
B1-B3: Services and Operations incl. Quality in the Future	*24/-24*	*7*	*0*	*4*	*3*
Combined Current and Future Results (Total)	60/-60	4	-5	10	8

** = Each figure in the table represents a scoring point avarage (or sum), which is here presented as a rounded figure.*

The summarized results from all analyses revealed that all four municipal service systems were unique. There were clear differences between service systems in Finland and Sweden, but also between service systems in the same country. The current premises for conducting business in the municipalities were in relative terms clearly better in Sweden than in Finland. The occurrence of differences was partly expected, given the distinct differences between the service systems (service voucher systems vs. systems of choice). The outcome pointed out Uppsala as the most feasible municipality and Hyvinkää as the least feasible for service producers in the current situation. Huddinge and Lahti were in between. The inclusion of quality aspects into the assessments did not change this set-up. The results concerning the future development were partly different. The preconditions for conducting business seemed to improve in all municipalities in the future, but increasing quality requirements would erode a part of these benefits. The most promising future outlook was held by Lahti, followed by Uppsala and Huddinge, while Hyvinkää had the least favorable prospects. The combination of the results from the current and future analyses is not very appropriate because of incompatibility issues.

The study and its findings also detected that quality was a critical yet inseparable element of service systems, and thereby also for private service producers. The basis was that quality was more highly rewarded for in Sweden than in Finland. Municipalities could raise their quality requirements above the minimum levels determined by e.g. legislation. Communication of quality was primarily determined by the municipalities themselves, and the Swedish case-

municipalities seemed more advanced in this area. But the current situations of quality were not permanent – all municipalities expected to raise their quality levels in the future.

Furthermore, the study revealed that most private companies in the four service systems for home care offered also other wellbeing services in parallel service systems, and that all companies operated also on the private market for home care. These observations suggested that the service systems for home care were not the only service areas or businesses of the private companies, rather they were one among many.

10.7 Utilization of Results and Research Recommendations

Private producers of home care both in Finland and Sweden need to analyze the situation separately for each service system and municipality as to clarify the premises for operating therein. The theoretical framework set by the Business Model Generation (Business Model Canvas) did in this study prove to be a viable tool for private service producers to utilize for specific service systems in specific environments. Also the integration of scoring points into the Canvas proved to generate at least reasonably comparable results between service systems and municipalities. Private companies can utilize the results directly in the case-municipalities. Alternatively they can apply the analyses to home care service systems in other municipalities. It appears that also municipalities could be able to apply the analyses or the Canvas to their service systems.

The primary path for developing the analyses is to maintain the private company perspective. One possibility for future research would be to introduce relative weights into the analyses, and to combine them with the individual matters/assessments. It would also appear logical to trim and tailor the analyses to correspond to the specific situations of single companies. Also, tailoring the analyses to only Finland or Sweden, instead of both, could improve their overall reliability. It could also be interesting to enlarge the scope of the analyses by allowing for multiple services and markets, as to better reflect the reality of private companies in the wellbeing sector. Another potential path for future research is to develop the analyses and the tool for municipal purposes.

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APPENDICES

(1A – 4B)

LAHTI

Table 55: Value propositions in Lahti (Lahti 2010 a, p. 1-3; Lahti 2010 d, p. 1-5; Lahti 2010 e, p. 1-3)

Value Propositions within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Home care can be offered as two (2) alternative types: i) As both *temporary* and *regular home care* ii) As only *temporary home care* • Home care includes *both* (1) home help services and (2) home nursing, in the way these two are defined in their respective laws. Service producers shall offer both service categories (1+2). • *The home help services* are meant to help end customers getting along with daily activities and to support their independent living at home. Home help services consist of seven (A-G) different sub-services bundled together: *A) Personal hygiene:* Includes assisting in the shower once a week, small washes daily, taking care of the oral hygiene, greasing of the skin, hair care, shaving and cutting nails. *B) Dressing:* Assisting in dressing and undressing, arranging proper clothing. *C) Nutrition:* Supporting healthy and diverse food, ordering of meals or obtaining convenience food, preparing of breakfast, snack meals and evening snacks, provision of liquids, warming of ready meals, and provision of pre-dozed medicines. Food is only prepared for customers with special health diets. *D) Textile care:* Washing of clothes if a washing machine or laundry room is available, use of laundry services in some cases, changing bed linen once a month or more often if required. Other textile care shall be directed to family or to external parties. *E) Cleaning*: Vacuuming the floor twice a month, dusting or vacuuming TVs and computers twice a month, mopping the floor when required, cleaning the bathroom and toilet once a week or when required, doing dishes, cleaning the kitchen, taking the garbage, cleaning the fridge regularly. The home care is responsible for such basic cleaning that maintains a sufficient level of hygiene. For more thorough cleaning the use of private service providers are recommended. In cleaning services, family members are preferred over service producers. *F) Running errands and other duties:* Bookings by phone, helping with shopping lists, picking up the mail, plowing snow but only to a minimum extent, fetching firewood and warming with it, fetching water and regularly controlling the fire alarm. Shopping shall be conducted by the end customer itself, family members or the shopping service of City of Lahti. Running errands shall primarily be conducted by the end customer or family members. Service producers run errands only in exceptions.

G) Activities outdoors and accompanying: Going outdoors, but also accompanying to the doctor, hospital or laboratory, if required by the care process and if possible by the service producer. In accompanying, family members and voluntary workers are preferred over service producers.

The personnel shall accompany the end customer to the doctor, hospital or laboratory, in this is necessary and no family members or voluntary workers are available for doing this.

- *The home nursing services* are included in the regular home care and they are carried out as ordered by a doctor. The services consist of five different sub-services (H-L) bundled together. Home nursing can be summarized as treating the health of the client, the monitoring the symptoms, and contacting the responsible doctor if necessary.

H) Medicinal treatment includes: medicinal treatment and dozing of medicines, provision of medicines, fulfillment and follow-up of doctors' orders, following the effects and side-effects of medicines, and renewal of prescriptions.

I) Special treatments (medical treatments) include: wound treatment, ostomy treatment, catheterization, removal of stitches, ear flushes, liquid feeding and other activities belonging to home nursing. Such treatment forms, which can be made by the patient itself or which reduce professional treatment times are preferred. Measuring results are recorded and forwarded to the responsible doctor.

J) Health monitoring includes: general health measurements such as blood sugar and blood pressure, monitoring urinary and stomach functions, following issues such as weight, falling, dizziness, pain, memory and mental state, as well as making laboratory tests and sending them onwards.

K) Other health-related services: Vaccination, contacting other medical professionals, procedures with assistive devices, arranging of treatment supplies, ambulance arrangements, long-term monitoring and co-ordination of subsequent treatments.

L) Night care: This is offered only to persons who necessarily require it. The services include: assisting with toilet visits, changing diapers, catheterization, changing lying positions, responding to security alarms, monitoring the customer condition.

- Service producers can choose between different service times, separately for home help services and for home nursing:

  i) Mon-Fri 07:00-18:00
  ii) Mon-Fri 18:00-22:00
  iii Sat 07:00-18:00
  iv) Sat 18:00-22:00
  v) Sun 07:00-18:00
  vi) Sun 18:00-22:00
  vii) Mon-Sun 22:00-06:00 (Night care only)

- Home care during *evenings and weekends* shall be kept at minimum levels, and a rehabilitative approach shall be upheld in the work.

- The service vouchers *do not* apply to support services connected to home help, such as meal service, shopping service, laundry service, elementary cleaning, window washing, cooking food or sauna service. The production and offering of these support services is concentrated to City of Lahti. However, those end customers that *are not* granted support services but still want them, can acquire them separately from the service producers but at their own expense.

Table 56: Customer segments in Lahti (Lahti 2010 a, p. 1-3; Lahti 2010 d, p. 1-5; Lahti 2011, web-pages)

Customer Segments within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The end customers are primarily old persons living alone or couples, whose functionality is reduced either temporarily or permanently to such extent that they require external help with living at home. Apart from reduced functionality, the customers usually also have multiple illnesses and consequently also require home nursing. • Home help services are also offered to a limited amount of war veterans, whose need for help and social services in their daily life is high. • Home help services are to a small extent offered to such families with children, which meet certain service need criteria. For regular home help services City of Lahti is the service producer, whereas for temporary home help services end users can also choose a private service producer. • Certain end customers groups (e.g. persons with mental illnesses, war invalids) – which are offered regular home care only once or twice a week – are entirely served by the City of Lahti, and they are thus outside the service voucher system. • Temporary home care is granted and provided to end customers only for a certain period, where the maximum length is two weeks. Temporary home care is typically granted when demobilizing patients home from hospital care, or when a care-giving family member or relative is ill. • Those end customers who receive only temporary care are primarily directed to the private service producers. • Regular home care is offered to those persons who do not get along with the daily activities by themselves, or by help from family members or other parties. The need for care has to be recurring, usually daily or several times a week.

Table 57: Customer relationships in Lahti (Lahti 2010 a, p. 2-5; Lahti 2010 c, p. 4)

Customer Relationships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service providers shall appoint a *responsible care person* for each end customer, in order to enable a continuous employee-customer relationship. The end customer itself and a family member or relative shall know who the responsible care person is. • Notable changes in the service needs of end customers shall be reported to the City of Lahti officers. City of Lahti officers conduct service needs assessments to new end customers for 1-3 months onwards, thereafter the assessments are made for a maximum period of 12 months onwards.

APPENDIX 1A: Main Terms and Conditions for Service Producers in Lahti

Table 58: Channels in Lahti (Lahti 2011, web-pages; PalveluSantra 2011, web-pages; Lahti 2010 a, p. 1)

Channels within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The service system (service voucher system) itself forms a communication and sales channel for the statutory home care services in Lahti. The Internet-portal PalveluSantra and dedicated offices of City of Lahti are the infrastructure of these channels. • Service producers are allowed to utilize subcontractors in the provision of services to end customers, given that these subcontractors are qualified service producers within the service system. This means that producers are able to use both the own channel *and* partner channels in the distribution of services.

Table 59: Revenue streams in Lahti (Lahti 2010 a, p. 3-4)

Revenue Streams within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions *Compensation principles:* • Compensation is based on the amount of provided hours of services. However, any provided hours exceeding the amount of granted hours are *not* compensated to the service producers. • The amount of service hours provided may deviate from the amount of service hours granted by a maximum of 10% during a two week period. Service hours exceeding that may not be charged for. • The service prices *shall include* times and costs for trips to and from end customers, meaning that trips cannot be additionally charged for. However, service producers *are allowed* to charge end customers separately for the trips if these live more than 10 km outside the city center. • The minimum charge for all services is a half hour service, and this entitles to no more than a 50% charge for the service voucher. Interrupted services cannot be charged or compensated for. • Services produced with service vouchers are exempt from value-added taxes. On the other hand, the services produced with service vouchers are not tax deductible for end customers. *Compensation levels:* • The service producers themselves determine their prices for both temporary and regular home care services. However, a certain categorization scheme for the prices must be followed, as described in the next point. The prices are given as EUR per hour of provided service (EUR/h). • The prices (and the associated compensation levels) for the different services can be categorized based on three factors; *service category*, *day of the week* and *time of the day*. The service categories are split into: *home help services*, *home nursing* and *night care*. The weekdays are split into workdays (Monday-Friday), Saturday and Sunday. The time of the day is *day* (7:00-18:00), *evening* (18:00-22:00), as well as *night* (22:00-06:00). Night times are applied only for night care.

- City of Lahti decides the values of the service vouchers and changes thereto. The value of the service voucher for temporary home care is fixed at EUR 24 per hour. The value of the service voucher for regular home care is end customer -specific, and varies between EUR 7-24 per hour depending on the personal income level.

- If a service price is above the value of the corresponding service voucher, the service producer charges the end customer (citizen) for the difference. The service producer charges City of Lahti for the collected service vouchers afterwards once a month. And if a service price is below the value of the voucher, then the service producer charges only City of Lahti and only for the service price.

- The service producer can adjust its prices only *once* per calendar year, and end customers need to be informed about this at least one month in advance.

Table 60: Key resources in Lahti (Lahti 2010 c, p. 1-6; Lahti 2010 d, p. 2)

Key Resources within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • *Human resources:* The service producers have to possess personnel that meet the requirements for providing statutory home care. Personnel resources shall be sufficient with respect to both quality and quantity of the services provided. Employees need to have the know-how required by the profession, which is obtained through applicable education and/or work experience. The personnel shall have sufficient know-how of geriatric illnesses and issues, up-to-date knowledge in services to the elderly. Persons providing home help services require the status of practical nurse or equivalent, while persons providing home nursing require the status of public health nurse, nurse, practical nurse or assistant nurse. Alternatively this competence needs to be attainted through acquiring home nursing from another qualified service producer. Ability and flexibility to work with end customers is required from the personnel, even if conditions are challenging. The personnel need to assess the functionality of the end customer continuously, and adjust to daily and long-term deviations in the service need. Producers with more than three employees require managers to have a higher degree in social or health sciences, sufficient leadership skills, and at least one year of work experience of similar tasks. The personnel shall have sufficient language skills in Finnish and in other languages if serving some ethnic customer groups. • *Physical resources:* City of Lahti owns and upholds certain IT-systems, such as the customer information system Pegasos, into which the service providers make their own filings. The internet-based service portal PalveluSantra is owned and operated by a service producer co-operative on a non-profit basis. Service producers offering home nursing need to have basic and up-to-date medical equipment. • *Intellectual resources:* The service producers shall have valid liability insurances and patient indemnity insurances for their operations.

APPENDIX 1A: Main Terms and Conditions for Service Producers in Lahti

Table 61: Key activities in Lahti (Lahti 2010 a, p. 4; Lahti 2010 c, p. 1-6; Lahti 2010 d, p.2)

Key Activities within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Dedicated "home care folders" shall be applied for each end customer, and they shall be kept updated by the responsible care person. The home care folders are physically at home, and they shall follow the end customer to hospitals, special treatments etc. The personnel shall record data from the end customer visits to the IT-based customer information system Pegasos. • When service producers invoice City of Lahti they shall submit written service reports as attachments, containing end customer signatures. Possible interruptions or deviations in the services shall also be expressed in the service reports. • A patient register containing statutory patient data has to be upheld. The documents have to be made, stored and dealt with in accordance with the personal information law, the archive law and the patient law. A person responsible for the information security has to be appointed. Service producers offering home nursing need to mark the medical procedures into the patient register, as stated in legislation. • Service producers offering home nursing need to have written medication plans and the personnel needs to be qualified for carrying out medicinal treatment. • Service providers uphold the professional skills of the personnel and arrange updating education. • Service providers participate in the training seminars arranged by City of Lahti or PalveluSantra (1-2 times per year). They participate in the marketing and training costs of the PalveluSantra -portal through payment of a yearly fee.

Table 62: Partnerships in Lahti (Lahti 2010 a, p. 1; Lahti 2010 c, p. 5)

Partnerships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Such service producers, which are not able to offer medical services (home nursing) due to absence of personnel with healthcare competence, need to attain a service partner for these services. Service partners need to be service producers in the service voucher system and qualified with respect to home nursing. • Service producers offering home nursing need to agree on co-operation and communication issues with the hospital laboratory of City of Lahti or with some other laboratory. • Co-operation with family and close friends shall be agreed upon in the service contract. Participation in the service provision by family and close friends is supported, and communication between the parties shall be upheld. • End customers shall be directed to other appropriate care units if their service need change and require such actions.

APPENDIX 1B: Main Quality-Related Issues for Service Producers in Lahti

Table 63: Quality issues in Lahti (Lahti 2010 a, p. 1-6; Lahti 2010 c, p. 1-6)

Quality Requirements within Home Care	Position in Canvas
• Home care is offered as a customized service based on the specific service needs of each customer. • The service provision shall have a rehabilitative approach; it shall utilize end customers' own resources and support their self-motivation. • The handling of end customers' keys has to be agreed upon. • If the service includes cash management for the end customer, the procedures need to be documented in written form. • The personnel make sure that the security systems, assistive devices and fire alarms are functioning. • The end customer, together with family members or similar, shall be advised in applying for other services to the elderly and other social and healthcare services. • The personnel, together with the family members or similar, make sure that the customer receives public allowances he or she is entitled to.	Value Propositions
• Service providers shall have a readiness to start serving new customers one day after making a service contract.	Customer Relationships
• Service providers shall fulfill the statutory criteria regarding private social services and/or private healthcare, and be filed in the regional authority's registers.	Key Resources
• *All requirements and terms* listed in the service producer guide shall be met. • Systematic methods for monitoring the service quality prevail, as well as agreed methods for taking corrective measures. • End customer feedback shall be gathered regularly and documented. This information shall also be submitted to City of Lahti. • Written customer complaints shall also be forwarded to City of Lahti for notification purposes. • Written instructions shall exist regarding the documentation of end customer data, the creation of patient documents and social service documents, the storage and regarding the confidentiality of the documents. Legislation regarding confidentiality and information security shall be followed.	Key Activities

• Instructions regarding the creation, upholding and handing out of patient data or end customer data, as defined by City of Lahti, shall be followed. • Relevant information concerning own operations, or changes or development plans related thereto shall be reported to the City of Lahti. • The personal records of recruited persons shall be controlled from the registers of The National Supervisory Authority for Welfare and Health. • For each calendar year predetermined information and material about the operations (contact information, personnel amount, updating education, customer amount) shall be provided to City of Lahti. • In case City of Lahti decides to migrate to a digital service voucher system, the service providers are committed to take into use and share the costs of a digital service voucher. • Each operating site or facility of a service producer requires an own service application.	

HYVINKÄÄ

Table 64: Value propositions in Hyvinkää (Hyvinkää 2011 a, p. 1-8; Hyvinkää 2011 b, p. 1-6; Hyvinkää 2011 c, p 1-5; Hyvinkää 2011 i, p. 17; Hyvinkää 2011, web-pages)

Value Propositions within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decision • Service producers shall offer home care as a bundle consisting of two (i+ii) service types; i) temporary home care and ii) light regular home care. They can additionally choose to offer a third service type as well; iii) support for informal care (in the form of home care), although this service is in practice subject to its own service system. • Home care encompasses three different service categories; 1) home help services, 2) home nursing, and 3) night care. All service producers are obliged to offer home help services (1). Additionally they can choose to offer also home nursing (1+2). And those service producers who offer both home help services and home nursing can choose to offer night nursing as well (1+2+3). • Home help services (A-F): *A) Personal hygiene and dressing:* Washing or assisting in e.g. daily washes and in taking care of the oral hygiene. Greasing of the skin, skin control and cutting nails. Assisting in toilet visits and using the catheter. If needed, changing the diaper and emptying the catheter bag. Assisting in the caring and use of the hearing device. Cleaning of the eye prosthesis. Assisting in dressing and undressing, including support hoses. Hair care and shaving. *B) Nutrition:* Preparing of breakfast, snack meals and evening snacks, warming of lunch and dinner. If needed, assisting in eating and drinking. Managing of groceries and assisting in shop orders. Controlling liquefaction, advising in nutrition and diet matters. If needed, controlled provision of pre-dozed medicines. *C) Domestic care*: Managing the cleaning, putting items in place, removing larger rubbish items, making the dishes, taking the garbage. Making the bed and changing bed linen. Washing clothes with the washing machine and hanging them to dry, or shipping the clothes to a laundry. *D) Safety and accessibility:* Controlling the functioning of the safety/security phone, the door watch, the stove watch, the falling watch, the safety bracelet, the assistive devices, and the fire alarm, which the customer may have in use. Managing, advising and assisting in the acquisition and use of assistive devices and in home renovation work. Assuring for unobstructed moving and controlling for security. *E) Mental and physical vitality:* Mental support by listening and being present. Taking physical and mental concerns into consideration and observing the end customer. Discussing and supporting in everyday matters and problem situations. Working methods that uphold and develop the functionality of the end customer. Implementing rehabilitation plans (e.g. supporting self-motivation, supporting own activities, activation of discussions and assisting in personal exercises). *F) Other matters during end customer visits:* Making appointments to foot care, hairdressing, massage etc. Advising and supporting in various public matters such as care benefits, housing benefits, transportation services etc. Opening the mail as agreed. Co-operation with family members and relatives, producers of support services and other parties involved in the services (e.g. personal assistants, trustees). Accompanying to the doctor, hospital or laboratory, if it is necessary for the treatment of the end customer.

- Home nursing (G-L) implies the planning, implementation, managing and advise related to the medical treatment. The medicinal treatment is implemented according to doctor instructions.

  G) Medicinal treatment: Dozing of medicines into a dispenser. Provision of medicines in different forms. If needed, assisting in the starting of a mechanical medicine dozing and in the management of the medical oxygen treatment. Securing and monitoring the fulfillment of doctors' instructions. Following the effects and side-effects of medicines, renewal of prescriptions and arranging errands to the pharmacy.

  H) Special treatments:
  Among others treatments of different wounds, ostomy treatment, catheterization, removal of stitches and liquid feeding.

  I) Co-operation and informing: Consultation of other professionals and experts in problem situations. Assisting the doctor in home visits or at a reception point (designated district doctors employed by City of Hyvinkää are responsible for the implementation of the doctor services).

  J) Assessing needs of treatment supplies and arranging them:
  Assessing the need for treatment supplies, diabetes supplies, ostomy supplies, diapers and other supplies, as well as arranging the delivery or acquisition of these. City of Hyvinkää carries the costs for the supplies.

  K) Monitoring: Measuring the blood sugar and blood pressure. Monitoring urinary and stomach functions. Following issues such as swellings, pain, falling, dizziness, incoherence, memory and mental state.

  L) Other home nursing services:
  Making laboratory tests and taking them to the laboratory. Making appointments to doctors and examinations. Taking blood samples as agreed.

- Night care (M): Caring the patient according to the service and care plan. Controlling that that the end customer is both physically and mentally well during the home visits.

- Service producers can choose between different service times, separately for home help services and home nursing (i and ii are alternatives, while iii is optional):
  i) Mon-Fri 07:00-18:00
  ii) Mon-Sun 07:00-22:00
  iii) Mon-Sun 22:00-07:00 (Night care only)

- Hyvinkää is divided into four service districts: North, South, West and East. The service system (and service vouchers) for home care applies to all four districts. Service producers thus operate in the entire municipality.

- Home care shall be produced in such way, that both home help services and home nursing shall be provided to end customers during the same home visit.

- Doctor services are not included in the home care produced by service vouchers, as those duties are allocated to designated district doctors employed by City of Hyvinkää.

Table 65: Customer segments in Hyvinkää (Hyvinkää 2011 a, p.1-5; Hyvinkää 2011 b, p. 1-6; Hyvinkää 2011 c, p. 1)

Customer Segments within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The end customers consist of persons receiving either *temporary home care* or *light regular home care*. The service producers shall accept end customers for both temporary home care and for light regular home care. Accepting customers for *support for informal care (in the form of home care)* is compulsory only for service producers who have chosen to operate also within that separate service voucher system. • The end customers within home care are primarily old persons living alone, whose functionality is reduced either temporarily or permanently to such extent that they require external help with living at home. • Home care produced by service vouchers is granted only to those end customers who are capable of making decisions about the service producers independently, or together with a family member or relative. Severe physical or mental illnesses of end customers may exclude the service voucher system. • Temporary home care is only granted and provided for a certain period, where the maximum length is one month. Temporary home care can be granted e.g. when demobilizing patients home from hospital care. • Light regular home care is granted to those end customers, whose service need is continuous but less than 8,00 hours per month. End customers with service needs (service plans) rising above 8,00 hours per month will be served by City of Hyvinkää, i.e. they are shifted outside the service voucher system, unless they choose to pay for all the services themselves. • The intermediate customers within support for informal care are caregiving family members or relatives who accumulate statutory holidays, for which they are granted support for informal care. The end customers, who receive services within support for informal care, represent all age categories. • Within support for informal care, the caregiving family member or relative is entitled to three holidays per month. Three days is thus the maximum amount of home care services per month provided to end customers within this service form.

Table 66: Customer relationships in Hyvinkää (Hyvinkää 2011 a, p. 4-5; Hyvinkää 2011 f, p.1-4)

Customer Relationships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service providers shall appoint a responsible care person for each end customer. The end customer itself and a family member or relative shall know who the responsible care person is. • All service contracts between service producers and end customers have a due date, which is stated by the underlying service needs assessments. Ongoing customer relationships in light regular home care the service contracts need to be renewed at least once per 6 months. City of Hyvinkää officers conduct the regular service needs assessments for end customers receiving light regular home care (at least once per 6 months). • Service producers shall report changes in the service needs of end customers to City of Hyvinkää officers. • The service producer can terminate the service contract in two months, while the end customer can terminate it in two weeks. Service contracts violated by either party can be terminated immediately.

Table 67: Channels in Hyvinkää (Hyvinkää 2011 a, p. 4)

Channels within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The service system (service voucher system) itself forms a communication and sales channel for the statutory home care services in Hyvinkää. The web-pages and the dedicated offices of City of Hyvinkää are the infrastructure of these channels. • Service producers are allowed to use subcontractors or contract workers in the provision of the services. Subcontractors or contract workers acting as service partners are committed to the same conditions and criteria as the service producers themselves.

Table 68: Revenue streams in Hyvinkää (Hyvinkää 2011 b, p.2-7; Hyvinkää 2011 e, p. 1)

Revenue Streams within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions *Compensation principles:* • Compensation is based on the amount of provided hours of home services. However, any provided hours exceeding the amount of granted hours are *not* compensated to the service producers. • The service prices shall include times and costs for trips to and from end customers, meaning that trips cannot be additionally charged for. • The accuracy of the invoicing shall be at least a half hour. • For customer visits where end customers have cancelled the services too late, service producers can charge customers for their share of the total fee. • City of Hyvinkää takes no responsibilities for unpaid invoices of end users. • Services produced with service vouchers are exempt from value-added taxes. On the other hand, the services produced with service vouchers are not tax deductible for end customers. *Compensation levels:* • The service producers themselves determine their prices for both temporary home care and for light regular home care. But for support for informal care there is a maximum price limit of EUR 31.33 per hour (a fixed value of EUR 30 per hour for the service voucher and a maximum customer charge of EUR 10 for every 8 hours). All service prices shall be given as EUR per hour of provided service (EUR/h). • City of Hyvinkää decides the values of the service vouchers and the changes thereto. The value of the service voucher for temporary home care is fixed at EUR 24 per hour. The value of the service voucher for regular home care is end customer -specific, and it varies between EUR 0-24 per hour depending on the personal income level. For support for informal care the value of the service voucher is fixed at EUR 30 per hour. • If a service price is above the value of the corresponding service voucher, then the service producer charges the end customer (citizen) for the difference. And if a service price is below the value of the voucher, then the service producer charges only City of Hyvinkää and only for the service price. The service producer charges City of Hyvinkää for the collected service vouchers afterwards once a month. • The service producer can adjust its prices only according to real changes in costs. Price adjustments require informing the customers in writing at least two months in advance and also acceptances from them (for price increases).

Table 69: Key resources in Hyvinkää (Hyvinkää 2011 a, p. 2-3; Hyvinkää 2011 b, p. 1; Hyvinkää 2011 c, p. 4-5; Hyvinkää 2011 d, p. 1-2; Hyvinkää 2011 g, p. 1-3)

Key Resources within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • *Human resources:* Personnel know-how and personnel resources shall be sufficient with respect to both quality and quantity of the services provided. The personnel of the service providers meet the same qualifications that would be required by social services or healthcare professionals employed by the municipality for performing the same duties. Persons providing home care services require a legitimized status of public health nurse, nurse, practical nurse or assistant nurse. Persons providing medical treatment shall have the right to practice the profession of a nurse or a public health nurse, as specified by law. The legitimized healthcare professionals have the aggregated liability for the medical and medicinal treatments of the end customers, including decisions, management, advising and monitoring of the treatments. These professionals can perform duties within the limits of their education and according to proven skills and written permissions. Some of the home nursing duties do not necessarily require competence of a nurse or a health nurse, as they can on certain conditions be carried out by a practical nurse or equivalent. Such duties are e.g. medicinal treatment, insulin injections, catheterizing, wound care and measuring of blood pressure and blood sugar. However, the performance of these duties additionally requires a written and valid permit granted by a doctor. Students of healthcare and social services can on certain conditions be utilized as temporary workforce, as specified by the National Supervisory Authority for Welfare and Health. The personnel shall have sufficient language skills in Finnish and in other languages if serving some ethnic customer groups. • *Physical resources:* Service producers shall create and uphold an own (paper-based or electronic) customer database for collection and storage of relevant information on the end customers and the customer relationships. For service producers offering home nursing the customer database can also function as a patient register. The facility/facilities of a service producer can be situated anywhere in the country. • *Intellectual resources:* The service producers shall have valid liability insurances and patient indemnity insurances (home nursing producers) for their operations.

APPENDIX 2A: Main Terms and Conditions for Service Producers in Hyvinkää

Table 70: Key activities in Hyvinkää (Hyvinkää 2011 a, p.1-9; Hyvinkää 2011 c, p. 1-5)

Key Activities within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • When invoicing City of Hyvinkää, the service producers shall submit the service vouchers as attachments, containing dates, service hours and end customer signatures. Possible days of absence or interruption shall also be expressed. • An own patient register containing statutory patient data has to be upheld. Service producers offering home nursing need to mark the medical procedures into this patient register, as stated in legislation. The documents have to be made, stored, archived and disposed in accordance with municipal standards, the personal information law, the archive law and the patient law. Service producers shall mark patient data and performed services to the patient register (customer database), as specified by City of Hyvinkää. • A person responsible for upholding the patient register (customer database) has to be appointed. Also, a person responsible for the information security has to be appointed. • Service providers uphold the professional skills of the personnel and arrange sufficient updating education. • Service producers need to have a written medication plan. • If City of Hyvinkää decides to make changes to the service voucher system or to terminate the entire system, it has a force majeure right to terminate the qualifications of the service producers without any period of notice.

Table 71: Partnerships in Hyvinkää (Hyvinkää 2011 a, p. 3-4)

Partnerships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service producers are allowed to use subcontractors or contract workers in the provision of the services. Subcontractors or contract workers acting as service partners are committed to the same conditions and criteria as the service producers themselves. • Service producers are obliged to co-operate with family members or close relatives of the end customers.

APPENDIX 2B: Main Quality-Related Issues for Service Producers in Hyvinkää

Table 72: Quality issues in Hyvinkää (Hyvinkää 2011 a, p. 1-9; Hyvinkää 2011 b, p. 1-6; Hyvinkää 2011 c, p. 1-5)

Quality Requirements within Home Care	Position in Canvas
• Home care is meant to support the overall wellbeing of end customers and their independent living at home. It is also meant to maintain and improve end customers' physical, mental and social capabilities. • Home care shall be offered as a customized service based on the specific service needs and wishes of each customer. • The service provision shall have a rehabilitative approach through a utilization of end customers' own resources. • The service work shall apply generally accepted treatment guidelines. • Service producers have to secure that (new) end customers can be demobilized safely when they are transferred home. • The personnel, together with the family members or similar, make sure that the customer receives public allowances he or she is entitled to. • Routines for handling of end customers' keys have to be agreed upon. • End customers shall be assisted in the management of their personal finances if needed, and this has to be agreed upon.	Value Propositions
• Service providers shall have a readiness to start serving new customers one or at most two days after making a service contract.	Customer Relationships
• Service providers shall fulfill the statutory criteria regarding private social services and/or private healthcare, and be filed in the regional authority's registers. • Service providers shall have sufficient personnel resources to arrange the services also during exceptional situations, e.g. during sick leaves and vacations.	Key Resources
• *All requirements and terms* listed in the service producer guide shall be met. If not, the qualification of a service producer can be cancelled. • Quality requirements and quality goals for the own operations shall be defined. • Service producers shall apply some form of assessment system to their services. • Tracking data on the quality of the home care (e.g. deviation reports) shall be provided to City of Hyvinkää. • Service producers shall install and uphold own customer feedback systems containing statutory personal file descriptions.	Key Activities

• End customer feedback shall be gathered on a continuous basis. This information, including customer complaints and information on what corrective measures have been taken, shall be submitted to City of Hyvinkää. • An end customer survey, as specified by City of Hyvinkää, shall be conducted each year. An associated monitoring and audit performed by City of Hyvinkää shall be allowed. • The business and service operations shall be based on quality recommendations on services for the elderly and on guides on secure medicinal treatment issued by the Ministry of Social Affairs and Health. • Regulations, advices, programs, guidelines and steering documents for quality and patient security generated by the National Institute for Health and Welfare and City of Hyvinkää shall be followed. • Confidentiality, secrecy and regulations on data security, as defined in their respective laws, shall be followed. • Written instructions shall exist regarding the following activities; the documentation of end customer data, the creation of patient documents and social service documents, the storage and regarding the confidentiality of the documents. • Statutory insurance premiums and taxes shall be paid, and other duties in the society shall be fulfilled properly. • Personnel working with customer or patient data are bound to secrecy, as defined in legislation, and they will not hand out such data to external parties. • The validity of the permits and licenses of the personnel shall be secured. • Service producers, which offer home care to families with children, are obliged to control the criminal records of its employees addressed for this end customer segment. • Documents on the end customer data and patient data shall be provided to City of Hyvinkää. • Relevant information concerning own operations and services – including changes or development related thereto – shall be reported to City of Hyvinkää. • Information on – how the professional skills of the personnel are upheld, how the reserve employee system is arranged, and on how the employee healthcare and labor protection are arranged – shall be provided to City of Hyvinkää. • For each calendar year predetermined information and material about the operations (contact information, personnel amount, updating education, customer amount) shall be provided to City of Hyvinkää. • Each operating site or facility of a service producer requires an own service application.	

UPPSALA

Table 73: Value propositions in Uppsala (Uppsala 2011 a, p. 4-35; Uppsala 2010 a, p. 3-4 & 14; Uppsala 2010 b, p. 3-10)

Value Propositions within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Within the Uppsala system of choice, the range of home care services offered have been divided into two groups; one consisting of personal care, safety alarm services and home nursing, and the other consisting of different services with a domestic emphasis. The service producers are able to choose which of the prevailing service bundles listed below they choose to offer their customers. • Personal care and home nursing services consist of two *alternative service bundles (A1 or A2)*: A1) *Personal care + safety alarm services (24 hours per day) + home nursing (between 7:00-22:00)* A2) *Personal care + safety alarm services (between 7:00-22:00) + home nursing (between 7:00-22:00)* The basis for all personal care efforts is that they shall pay large attention to individual customer needs and needs for personal integrity. All efforts shall be formed in a mutual agreement with the customer. Personal care efforts are divided into seven sub-services: - Preparing of meals (warming up, simple cooking, setting the table, serving the meal, doing the dishes and cleaning up). A substitute to the meal service with delivery presented below. - Meal support (feeding, accompanying, stimulating the appetite) - Dressing on and off - Personal hygiene (mouth hygiene, shaving, combing, cutting nails, cleaning glasses, assisting with the hear-aid, cleaning prosthesis) - Showering (skincare, cutting of nails, washing and conditioning hair) - Toileting (toilet visits, change of sanitary pads, emptying of portable toilet, change of urine bag) - Attention/Visiting of such persons who face significant risks of incurring falling accidents at home. *Safety alarm services:* Implies acute home visits with personal efforts and assistance as required. The orders for the acute home visits come from a joint call center administrated by City of Uppsala. *Home nursing:* Implies delegated medical treatment and healthcare services at home for a period of *more than 14 days*. Performed by nurses, occupational therapists and physiotherapists. Advanced home nursing and healthcare teams are produced and offered entirely by City of Uppsala, and thus unavailable for service producers. *Rehabilitation:* Implies rehabilitation services at home. Performed by occupational therapists and physiotherapists. Day rehabilitation, an intensive form of rehabilitation performed at or outside the home, is produced and offered entirely by City of Uppsala, and thus unavailable for service producers.

APPENDIX 3A: Main Terms and Conditions for Service Producers in Uppsala

- "Services" are grouped into four *separate bundles of sub-services (A-D and combinations of these).* These services are offered between 7:00-22:00:

  B) *Cleaning, making the bed and doing laundry*: Vacuuming, mopping the floor, cleaning of kitchen and bathroom. If required, also wiping of and cleaning of surfaces and kitchen appliances. Making the bed, doing dishes and taking the garbage. Periodically also cleaning of toilet, windows and changing of curtains. Cleaning activities are primarily performed together with the end customer. Normal washing of clothes and bed linen, including hanging up and placing of clean clothes. If washing is not possible at the customer, then laundry services can be used. Also ironing and simple sewing of clothes.

  C) *Meal service, including delivery:* Meal service implies the delivery of prepared meals to customers as an integrated part of the home care services.

  D) *Grocery shopping, running errands:* Regular shopping of grocery products, preferably once a week. May also include planning of weekly meals, making a shopping list and placing of groceries in the cupboard. Also shopping of pharmaceutical products, clothes etc. Running errands on behalf of the customer or assisting the customer with this outside the home.

  E) *Socializing, activities indoor and outdoor:* These efforts are formed individually, with the aim of developing the social network. Outdoor activities can be a walk or a visit somewhere outside the home, accompanied by home care personnel. Socialization is granted individually, with a large emphasis on customer needs and preferences. It can be normal discussions, solving crossword puzzles, reading books or magazines aloud, or some activity that develops the social network.

- As a general rule, end customers' needs for efforts from therapists and physiotherapists shall be satisfied. Service producers can arrange these services either through own production or through directing the end customer to Uppsala Vård & Bildning or to some other service producer.

- The service providers are committed to operate in the *entire region* of Uppsala municipality. Geographical limitations are thus not possible. However, for certain customers and certain services City of Uppsala applies a geographical split of the whole region into four areas, with a designated service producer for each area. This sub-system applies to i) customers who cannot or prefer not to choose their service producer, to ii) customers only having the safety/alarm service, to iii) customers with services only between 22:00-7:00, to iv) customers with services between 22:00-7:00 who mistakenly choose a service producer operating only between 07:00-22:00, and to v) customers only needing assistive devices or assessment at housing adaption. The service producers in this sub-system are the four largest organizations in the service system.

- Personnel or some other suitable person shall accompany the end customer to do visits outside the home.

- All service producers except for Uppsala Vård & Bildning are allowed to offer additional services to the end customers. The subscription of additional services by individuals has to be entirely voluntary, and these individuals compensate their service producers directly. The range and contents of the additional services are neither regulated nor supervised, whereby service producers are free to determine those issues by themselves.

Table 74: Customer segments in Uppsala (Uppsala 2011 b, p. 17; Uppsala 2011, web-pages; company web-pages)

Customer Segments within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Legislation itself does not specify any definite types of individuals being entitled to home care. The basis is that those persons, who are not able to satisfy their basic needs themselves in any other way, are entitled to home care services that ensure a fair standard of living (The Social Services Act). • Although home care can be offered to all kinds of citizens in Uppsala, it is concentrated to two broadly defined customer segments; *elderly persons* and *disabled persons*. These two customer segments are valid also within the system of choice for home care, meaning that service producers serve them two jointly. • City of Uppsala has voluntarily taken a part of all home nursing activities from Uppsala County Council into its own area of responsibility. Uppsala Vård & Bildning and all qualified service producers can offer *home nursing services to persons aged 17 years or more (adults),* and *who require healthcare services at home* for a period of *more than 14 days*. All home nursing services with treatment periods lasting 14 days or less remain at the responsibility of Uppsala County Council. • Service producers are *not* able to exclude certain customer segments or to select their end customers – they are obliged to serve *every* end customer being appointed to them within the service system. • Service producers *are* allowed to select their end customers and to concentrate on certain customer segments *only outside* the service system, i.e. on the private market for non-statutory home care services.

Table 75: Customer relationships in Uppsala (Uppsala 2010 a, p. 5; Uppsala 2011, web-pages)

Customer Relationships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service providers are obliged to accept and to serve all individuals who have chosen them as their service provider. This is the cornerstone for all customer relationships within service systems based on the Act on System of Choice, in Uppsala and all other municipalities. • Service providers are obliged to appoint a *designated contact person* for each end customer. Also, the service producers that provide personal care need to appoint a *designated care-responsible nurse* for each end customer. • Persons who receive home care services are allowed to split the services between several service providers. An end customer can thus choose to have simultaneously one or several service providers assigned, and the service providers can not affect these decisions.

APPENDIX 3A: Main Terms and Conditions for Service Producers in Uppsala

Table 76: Channels in Uppsala (Uppsala 2010 a, p. 10; Uppsala 2011, web-pages; company web-pages)

Channels within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The service system (system of choice) itself forms a communication and sales channel for the statutory home care services in Uppsala. Web-pages, various printed material and dedicated offices of City of Uppsala are the infrastructure of these channels. • Service producers are allowed to utilize subcontractors in the provision of services to end customers, given that these subcontractors meet the relevant qualification requirements that apply to service producers within the service system. This means that producers are able to use both the own channel *and* partner channels in the distribution of services.

Table 77: Revenue stream issues in Uppsala (Uppsala 2010 a, p. 9-10 & 15-17)

Revenue Streams within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions *Compensation principles:* • Compensation is based on the amount of provided hours of home services. However, any provided hours exceeding the amount of granted hours are *not* compensated to the service producers. • Service producers are compensated for the *direct time*, i.e. for the actual provision of services while being *at home* or *outside* the *home* but together with the end customer. • Service producers are compensated for the *indirect time* (related to compulsory support activities such as documentation or cooperation with external healthcare parties) *only* for those home nursing support activities that are performed by legitimized personnel, i.e. by nurses, occupational therapists and physiotherapists. • Service producers do not charge end customers for granted services outlined in the service plan, they only charge for possible additional services chosen by end customers. • Provided statutory home care services are exempt from value-added taxes. *Compensation levels:* • The compensation levels are determined by City of Uppsala, and they are valid for one calendar year at a time. The basis for the compensation levels are the compensation levels to Uppsala Vård & Bildning, onto which compensations for value-added taxes (VAT) are added. • The compensation level is primarily a fixed amount of SEK per hours, but for some services/efforts the compensation is fixed and upon completion, such as for meal service (SEK/delivery), doing laundry, shopping and running errands (SEK/completion). • For each service, the compensation price is given separately for i) Uppsala town area and for ii) the sparsely populated area. • Additional services can be priced freely by the service producers.

APPENDIX 3A: Main Terms and Conditions for Service Producers in Uppsala

Table 78: Compensation levels for service producers in Uppsala in 2011 (Uppsala 2010 a, p. 9-10)

	Town area	Sparsely populated area
Personal care + delegated home nursing + alarm services + services between 07:00-22:00	347 SEK/h	401 SEK/h
Personal care + delegated home nursing + alarm services between 22:00-07:00	441 SEK/h	513 SEK/h
And compensation per visit between 07:00-22:00	87 SEK/visit	94 SEK/visit
Home nursing between 07:00-22:00	353 SEK/h	405 SEK/h
Services, excluding meal service	329 SEK/h	380 SEK/h
Meal service, including delivery *	64 SEK/delivery	64 SEK/delivery

** Compensation per delevery, not per hour.*

Table 79: Key resources in Uppsala (Uppsala 2010 a, p. 3-21; Uppsala 2010 b, p. 2-10; Uppsala 2011 e, p. 9)

Key Resources within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • *Human resources:* Sufficient staffing – that secures the quality level set by legislation, regulations and other documents, and also the carrying out of the operations according to the contract – shall exist. The educational and practical competence of the personnel required for the duties shall be secured. This applies to both service personnel, managers and to operational executives. Sufficient know-how, managing and control of assistive devices have to exist. • *Physical resources:* City of Uppsala owns and upholds a number of IT-systems and technology solutions that enable the functioning of the service system. The service producers are bound to adapt these in their operations, but Uppsala provides the associated licenses, software and training free of charge. Main IT-systems and technology solutions are i) Prator (an information transfer system between the healthcare and the social services functions in Uppsala, with co-ordination and messaging regarding individuals who shift between the service units), ii) Time Registration & Personnel Lock (IT-based time registration system connected to a technology solution for a personnel lock), iii) the System for Assistive Devices (IT-system for managing the pool of assistive devices), and iv) Klipp (IT-system for managing the allocation of trainees and students among service producers in the Uppsala region). In 2012 a new ERP-system Siebel is taken into use, and its users consist of Uppsala City officers, service producers and of end customers. Siebel incorporates all (service production) orders, all documentation, all deviation reporting and some service planning. Siebel enables end customers to switch service producers and to monitor their planned and completed home visits and also their invoices. When acquiring or leasing new vehicles, the service providers shall choose environmental cars that fulfill national standards. The service producers also need to acquire and maintain certain basic medical-technical equipment, as specified by City of Uppsala. The service producers are free to arrange their facilities according to their own preferences.

- *Intellectual resources:*
  The service producers shall have valid liability insurance for their operations.

- *Financial resources:*
  No particular minimum requirements are set for the service producers.

Table 80: Key activities in Uppsala (Uppsala 2010 a, p. 3-21; Uppsala 2010 b, p. 2-10)

Key Activities within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service producers shall make service plans for each end customer and monitor the execution of these. • Education related to the services offered has to be provided to the personnel. • All service producers are able to set capacity limits for the services they provide. The limits are expressed in hours of home care services provided, and they apply to the chosen service offerings as a whole. The capacity limits can be readjusted on request. The readjustments require transition periods of three months in case of capacity limit reductions and two weeks in case of capacity limit increases. However, capacity limits cannot limit increases in the service provision to existing customers. • The length of the frame contract for operating in the system of choice is three years upon signing.

Table 81: Partnership issues in Uppsala (Uppsala 2010 a, p. 3-21; Uppsala 2010 b, p. 2-10)

Partnerships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • City of Uppsala allows service producers to utilize subcontractors in the provision of services to end customers, given that these subcontractors meet the relevant qualification requirements that apply to service producers within the service system. • The personnel shall co-operate with healthcare planners at hospitals and with social service planners at City of Uppsala. Routines shall exist between different functions and levels of the care chain. Contact with a medical doctor shall be taken, if required. • As a general rule, co-operation shall be conducted with other service producers, organizations and the non-profit sector. • Co-operation with family and close friends shall exist in the form requested by end customers.

APPENDIX 3B: Main Quality-Related Issues for Service Producers in Uppsala

Table 82: Quality requirements in Uppsala (Uppsala 2010 a, p. 3-21; Uppsala 2010 b, p. 2-10)

Quality Requirements within Home Care	Position in Canvas
• The services shall be provided in a flexible manner, and allowing the end customer for maximum influence. End customers shall be allowed to do what they regard meaningful. • Personal care shall be provided in safe, co-arranged and integrated forms with a clear liability distribution between the parties involved. • Nutrition- and energy contents of the meals, as well as meal transportations, shall follow guidelines set by City of Uppsala. Adopted diets shall be applied on request, and serving times are primarily determined by the end customer. • A responsibility prevails to secure that end customers remitted from hospitals are able to return to their homes. • Routines for safe handling of end customers' keys have to exist. • According to legislation (The Social Services Act), home care services contain *personal care, services and efforts that stimulate social activity.* • Legislation (The Social Services Act) forms the basis for the home care services to be provided, but it does not specify the services in detail. It states that the services shall be formed so that they facilitate individuals to live and age at home in a safe manner, and to keep contact with other people. The services provided shall satisfy those basic needs, which individuals themselves are not able to arrange in any other way. • The services shall support and strengthen the end customers' resources from a rehabilitative perspective. The end customers' participation in the service provision shall thus be optimized. Also, end customers shall be stimulated to get along by themselves and to strengthen their independence.	Value Propositions
• Own support systems, which secure the quality on a continuous basis, have to be in place. • An ombudsman for the non-profit sector and for culture has to exist. • An authorized interpreter needs to be available on request.	Key Resources
• *All requirements* listed in the service producer guide shall be met on a *continuous basis*. • Regulations, advices, programs, guidelines and steering documents for quality and patient security generated by the National Board of Health and Welfare and by Uppsala municipality shall be followed.	Key Activities

APPENDIX 3B: Main Quality-Related Issues for Service Producers in Uppsala

• Quality development shall be practiced at all levels of the operations. • Corrections of observed faults and shortcomings shall be made immediately. • Documented routines shall exist and reporting shall be conducted every four months for the following tasks; notification of service shortcomings, notification of service deviations, complaints handling and handling of absent efforts. • Predetermined information and material about the operations shall be provided to City of Uppsala every four months, but also on separate requests. • The (relevant) activities shall be documented according to regulations by the National Board of Health and Welfare and City of Uppsala. • Financial statements, action reports and auditor's reports shall be available, and they shall be provided to City of Uppsala on request. • Accounting shall be conducted regarding the environmental impacts of the driving activities, and outcomes shall be reported to City of Uppsala on a yearly basis. • Support and guidance shall be provided to the personnel concerning the provision of rehabilitation. • Person registration records shall be ordered in connection with recruitments. • Actions shall be taken and reporting shall be made if employees are suspected for crimes against end users. • A readiness shall exist for crises and accidents, including risk analyses. Action plans, statistical records as well as systematic fire prevention work shall be carried out. • City of Uppsala shall be informed if an end customer receiving services (home help services) appears to have needs for personal care or home nursing.	
• The "Policy for Uppsala municipality's co-operation with the non-profit sector" has to be followed.	Key Partnerships
• City of Uppsala and/or third parties shall be compensated for contract violations and for damages related thereto.	Cost Structure

HUDDINGE

Table 83: Value propositions in Huddinge (Huddinge 2011 a, p. 6-12; Huddinge 2011 b, p. 7-33; Huddinge 2011 d, p. 8-24; Huddinge 2010 a, p. 4-18; Huddinge 2009 c, p. 8)

Value Propositions within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The service offering and service delivery for home help services are different for elderly persons and for disabled persons. The points below refer to home help services for elderly persons. Home help services for disabled persons will be referred to and mentioned in separate points. • Home help services have been bundled together with a number of other home-related services. Producers of home help services are bound to offer a service bundle consisting *of i) personal care, ii) domestic services, iii) meal service, iv) housing support, v) support for informal care, vi) safety alarm services and vii) accompanying services.* Three of these seven separate services – personal care, domestic services and meal service – can be regarded as conventional home care services. • The home help services – in practice its three sub-services (A-C) – shall facilitate the daily life of end customers and enable them to live at home. Help and support should be provided only for those activities causing challenges for end customers. *A) Personal care:* -Help with dressing on and off. -Meal support: feeding, accompanying, stimulating the appetite. -Personal hygiene: Daily hygiene activities such as washing, hair care and shaving. -Assisting in bathing or showering. -Assisting In toileting and changing of sanitary pads. -Help with turning in bed. *B) Domestic services:* -*Cleaning:* Implies help with keeping the home clean. Vacuuming, mopping the floor, dusting, cleaning in bathroom, kitchen, pantry, fridge and oven. Also making the bed, doing the dishes, sorting and taking the garbage. Normally 2 hours 45 minutes per month. -*Washing:* Normal machine washing of clothes and bed linen, including hanging up and placing of clean clothes. Normally 2 hours 45 minutes per month. -*Shopping/Running errands*: Helping with making purchases to the home or carrying out duties outside home. End customers can participate in the planning and in the activities outside home. Normally 2 hours 30 minutes per month. *C) Meal service:* -*Meals:* Preparation of meals for end customers who are not able to cook themselves or to receive meals delivered home. Help before, during and after each daily meal. 30 minutes per meal. -*Meal delivery service*: Home delivery of prepared meals. No time frames given. Three meals and three snack meals (3+3) distributed evenly over the day is recommended for individuals. *D) Housing support:* -Services with an emphasize on social efforts to create a sense of security, to break isolation, to stimulate and to satisfy mental and social needs. -Housing support can also be provided outdoors, e.g. as joint walks outside home. -Calling end customers to increase sense of security.

E) Safety alarm/duty services:
The service is granted to persons living at home who are not able to call for help. The safety alarm services imply visiting end customers and taking measures, as ordered by the safety alarm center operated by Huddinge Municipality for each specific alarm situation. Service providers shall be present at end customers during installation, service and un-installation of safety alarms. The service shall ensure safety and security for persons living at home.

F) Accompanying services:
The service is meant to help persons who due to disabilities have difficulties to manage to/from activities outside home. The service is always formed individually and provided personally, and it does not include care or medical efforts.

G) Support for informal care:
Replacement services for caregiving persons (family members, relatives or similar). The services are offered at or around the home. Three hours per day is generally a maximum for this service.

- Service producers can choose between two alternative service times for serving end customers:
  1) Monday-Sunday 07:00-22:00
  2) Monday-Sunday 00:00-24:00 (24 hours)

- Service producers can choose among five geographical districts (A-E) for serving end customers, with a minimum of one district and a maximum of five districts (Huddinge as a whole). Service producers can change their existing service districts, but they require a 30/90 days transition period in case of reduction/increase.
  Area A: Sjödalen, Fullersta, Flemingsberg and Visättra
  Area B: Stuvsta and Snättringe
  Area C: Segeltorp
  Area D: Trångsund and Skogås
  Area E: Vårby

- Home help for disabled persons differs from that for elderly persons in a couple of issues. Firstly, the home help services for disabled persons are limited to personal care, domestic services and meal service (services A-C). Secondly, service producers can choose which of the three sub-services (A, B or C or combinations of these) they will offer. Thirdly, no other home-related services are bundled together with the home help services. Fourthly, the possible service times for disabled persons are Monday-Sun 07:00-19:00 and/or Monday-Sunday 19:00-22:00. Fifthly, the geographical service area is Huddinge as a whole (Areas A-E), i.e. no smaller or separate districts can be chosen when serving disabled persons.

- Domestic services, which include cleaning, washing textiles, shopping/running errands and meal service – are granted to end customers as frame hours. End customers themselves determine how the frame hours shall be distributed over the month.

- Healthcare efforts or medical treatment can be carried out only if delegated from municipal healthcare units. Stockholm County Council is responsible for the healthcare at home, and it does not compensate external service producers for such activities.

- Service producers are allowed to offer additional services to the end customers. End customers shall receive information on the costs and contents of the additional services in advance. The information shall be in line with current legislation.

Table 84: Customer segments in Huddinge (Huddinge 2011 a, p. 3-6; Huddinge 2011 d, p. 8-23; Huddinge 2011 e, p. 3-4)

Customer Segments within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Elderly persons aged 65 years or more can be granted home help services of different kind, as outlined by individual needs assessments. • The system of choice for home help services to elderly persons applies only to persons living at home, *not* to persons living in service houses. • Disabled persons aged less than 65 years can be granted a certain home help services, in case these are specified in individual needs assessments. • Persons of all ages having mental disabilities can be granted housing support – a home help sub-service with focus on social wellbeing.

Table 85: Customer relationships in Huddinge (Huddinge 2011 b, p. 20-25; Huddinge 2011 c, p. 3-10)

Customer Relationships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service producers are obliged to accept all end customers who have chosen them as their service provider, and also to provide the end customers with services according to their service plans. • Service providers shall appoint a *designated contact person* for each end customer. The appointment of the contact person shall occur within seven days from when the service provision has started. The contact person shall regularly be in contact with the end customer and family members or other close persons. • Disabled persons receiving home help services are allowed to split the services between several service producers. They can thus choose to have simultaneously one or several service producers assigned, and the service providers can not affect these decisions. But elderly persons receiving home help services are not allowed to split the services between several service producers, they can only have one producer for all their services. • Service producers shall without delays report permanent changes in service needs of end customers to Huddinge Municipality officers for elderly services. • The term of notice is seven days if/when end customers terminate their service contracts, e.g. if they change another service producer. • Service providers, for which shortcomings in the operations have been discovered, are not distributed with new end customers until the shortcoming issues have been solved.

Table 86: Channels in Huddinge (Huddinge 2011 a, p. 7-18; Huddinge 2012, web-pages)

Channels within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • The service producers should communicate their service *profile* on Huddinge Municipality web-pages, as to indicate what additional features they possess to the basic services. The profile can emphasize special competences, language skills or customer focus such as persons with disabilities. On the same web-pages the service producers are also able to raise *quality issues* and own *quality declarations* related to their operations or services. Expressing the profile, quality issues and/or quality declarations are thus primarily a marketing and communication method for the service producers, which can increase end customer interest and customer amounts. • Service producers are allowed to utilize subcontractors in the provision of services to end customers, given that these subcontractors meet *all* the requirements that apply to service producers within the service system. This means that service producers are able to use both the conventional own channel *and* the partner channel in the distribution of services.

Table 87: Revenue stream issues in Huddinge (Huddinge 2011 b, p. 14-25; Huddinge 2011 c, p. 5-9; Huddinge 2011 f, p. 27; Huddinge 2011 g, p. 31-32; Huddinge 2010 a, p. 18)

Revenue Streams within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions *Compensation principles:* • Service producers are compensated for *service provision time*, where the services provided are determined by the service plan. The times associated with the granted services constitute the maximum service provision times for the service producers. • Service producers charge Huddinge Municipality for the provided services afterwards once a month. Service producers do not charge end customers for granted services outlined in the service plan, they only charge for possible additional services chosen by end customers. • Provided statutory home care services are exempt from value-added taxes. *Compensation levels:* • The compensation levels are determined by Huddinge Municipality, and they are valid for one calendar year at a time. • The compensation level is primarily a fixed amount of SEK per hours. Only for the meal delivery service the compensation is a fixed amount of SEK per delivery. • The compensation levels are split into four different time slots; i) Monday-Friday 07:00-19:00, ii) Monday-Friday 19:00-22:00, iii) Saturday-Sunday 07:00-22:00, and iv) Monday-Sunday 22:00-07:00. • The compensation levels are slightly different for producers serving elderly persons and for producers serving disabled persons. Uniform compensation levels apply for all home help services and all other home-related services offered to elderly persons. On the other hand, the compensation level for home help services to disabled persons is separate from the compensation levels for other home-related services (such as accompanying services and housing support) for disabled persons.

- If/when safety alarm is the only home-related service for an end customer, then the compensation level to the service provider is determined by the weekday and by the time of the day of the associated customer visit. The compensation itself is time-based, where the minimum charge is 30 minutes.

Table 88: Compensation levels for service producers in Huddinge in 2011 (Huddinge 2011 f, p. 27; Huddinge 2011 g, p. 31-32; Huddinge 2010 a, p. 18)

	For elderly persons	For disabled persons
Home help services, Monday-Friday 07:00-19:00 (daytime)	293 SEK/h	285 SEK/h
Home help services, Monday-Friday 19:00-22:00 (evenings)	310 SEK/h	302 SEK/h
Home help services, Saturday-Sunday 07:00-22:00 (weekends)	340 SEK/h	331 SEK/h
Home help services, Monday-Sunday 22:00-07:00 (nights)	633 SEK/h	-
Meal service, including delivery *	42-50 SEK/delivery	42-50 SEK/delivery
Other home-related services (accompanying services, housing support etc.)	Same levels as for home help services (293-633 SEK/h)	Separate levels from home help services

** Compensation per delevery, not per hour.*

Table 89: Key resources in Huddinge (Huddinge 2011 b, p. 9-33)

Key Resources within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • *Human resources:* Service producer managers need to have a higher degree in social or health sciences or at least three years of work experience of care activities. Personnel amounts and personnel qualifications shall be adequate to meet the requirements for providing good home help services. If a service producer hires a family member, relative or close person to an end customer, the responsibilities towards and of this person is the same as for other employees. • *Physical resources:* When acquiring or leasing new vehicles, the service providers shall choose environmental cars that fulfill national standards. Service producers need to have a fax machine, as the communication with Huddinge Municipality (e.g. receiving and confirming customer orders, and other communication) has previously been carried out by faxing. However, Huddinge Municipality has recently launched an integrated ERP-system with connections to external service producers. The ERP-system is currently used mainly for transmission of service needs assessments and service plans between the two parties.

- *Intellectual resources:*
  Service producers or their representatives shall present three separate service contract references in the service producer application.

  The service producers shall have valid liability insurance for their operations.

- *Financial resources:*
  Service producers need to have a credit rating of "A" or higher (where "AAA" is the highest possible). If not, service producers need to show an adequate sufficient bank warranty, group warranty or conditional shareholder contribution.

Table 90: Key activities in Huddinge (Huddinge 2011 a, p. 8-12; Huddinge 2011 b, p. 13-29; Huddinge 2011 c, p. 4)

Key Activities within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions
• Service producers shall, within seven days from being selected, make a service plan for and together with each end customer, and also monitor the execution of this. Service producers shall send a finalized service plan in electronic form to relevant officers at Huddinge Municipality. An individual service plan shall be reviewed at least once a year.
• The monthly invoices sent to Huddinge Municipality shall include specifications of the services provided. Also information about possible deviations from the service plans shall be specified. All reported non-attended service times shall be signed by the end customers. The invoices shall be paper-based but the related reporting to Huddinge Municipality shall be in electronic form.
• Service producers shall be prepared to accept changes in the terms and conditions for the system of choice over time. Service producers not accepting imposed changes need to terminate their frame contracts and their operations in the service system. Huddinge Municipality usually updates the terms and conditions once a year. Huddinge Municipality withholds the right to terminate the system of choice, in case such political decisions would be made.
• Service producers are able to set *capacity limits* for the services they provide. The limits are expressed in hours of home care services provided per month, and they apply to the chosen service offerings as a whole. The capacity limits can be readjusted on request. Service producers can change their existing capacity limits, but they require a 90/30 days transition period in case of reduction/increase. However, capacity limits cannot limit increases in the service provision to existing customers.
• Service producers shall enable training for the personnel on a continuous basis.
• Service producers are allowed to market their home help operations, services and additional services externally. However, the marketing activities need to follow legislation, directives and good marketing practice. This prohibits certain types of communication activities and customer approaches.
• The length of the frame contract for operating in the system of choice is two years upon signing, with options to prolong the contract for two plus two (2+2) years.

Table 91: Partnership issues in Huddinge (Huddinge 2011 b, p. 18)

Partnerships within Home Care
Requisites, boundaries and available options set by legislation, general guidelines or by municipal decisions • Service producers are allowed to utilize subcontractors in the provision of services to end customers, given that these subcontractors meet *all* the requirements that apply to service producers within the service system. This means that service producers are able to use both the conventional own channel *and* the partner channel in the distribution of services. • Service producers shall co-operate with the municipality, the primary healthcare organization, family members, relatives or close persons, and with other persons and organizations important for an end customer. • Service producers shall co-operate with the healthcare organization of Stockholm County Council concerning terminal care for end customers. • Service producers terminating their operations in the service system shall co-operate with Huddinge Municipality to ensure a smooth transition for all involved parties.

APPENDIX 4B: Main Quality-Related Issues for Service Producers in Huddinge

Table 92: Quality requirements in Huddinge (Huddinge 2011 b, p. 9-34; Huddinge 2011 c, p. 6; Huddinge 2009 c, p. 13)

Quality Requirements within Home Care	Position in Canvas
• The integrity, participation and safety of end customers shall be secured. • End customers shall participate in the planning of the service provision. • Service producers shall follow the guidelines for food and meals within elderly care, as defined by Huddinge Municipality. • Although end customers choose what and when they decide to eat, service providers shall strive to provide good and well prepared meals in line with municipal recommendations. • Cleaning and other domestic services shall be performed in a professional manner. Environmentally and allergy marked cleaning equipment is recommended, in case own equipment is used. • Routines for upholding sufficient basal hygiene shall exist.	Value Propositions
• Service producers shall have a readiness to start serving new end customers one day after making a service contract. In acute cases service producers shall have a readiness to start serving new end customers already on the same day. • Each end customer shall have a predetermined time for phone calls, and the service producer shall during that time take calls from the end customer. • End customers shall be informed about possible news or changes in the operations. Also utilization of other than the regular care- or service persons shall be reported to an end customer. • The term of notice is seven days if/when end customers terminate their service contracts, e.g. if they change to another service producer.	Customer Relationships
• The foodstuff operations of service providers and possible subcontractors shall be registered or approved by authority. The personnel shall have adequate knowledge in cooking, foodstuff hygiene and in nutrition. • Service producers have to acquire adequate technical equipment required by the personnel providing services.	Key Resources
• *All requirements* listed in the service producer guide shall be met on a *continuous basis*. • All relevant legislation needs to be followed. Apart from legislation, also regulations, policies, advices and guidelines by the National Board of Health and Welfare and by Huddinge Municipality shall be followed. Fundamental values with respect to *meaning, respect, security, know-how* and *good treatment* – as outlined by Huddinge Municipality – shall be shared and followed.	Key Activities

APPENDIX 4B: Main Quality-Related Issues for Service Producers in Huddinge

• The definition of *good quality*, as specified by legislation, shall be followed. Good quality is also to achieve the municipal goals (of the Elderly care council) and to satisfy the needs and expectations of end customers, citizens and fellow workers. • The operations need to have *management systems for quality*, as defined in legislation on social services and healthcare. Service producers shall continuously and over the long-term develop and assure the quality of the operations. A clear organizational structure, stated and clear responsibilities, documented routines, identified processes and routines for monitoring shall exist. The management system for quality concerns the following areas; quality assurance of social services, availability, co-operation, documentation for individual persons, defects in the operations, feedback and complaints on the operation, personal and competence maintenance, monitoring and evaluation of the operations. • Work processes for social services, as defined by the quality statement of Huddinge Municipality, shall be followed. • A *person responsible for the daily operations and the management* shall be appointed. The duties and responsibilities of this person are associated with; organizing the work, good ethics and treatment, competence and guidance and training of the personnel, good working environment, routines for customer feedback and conflicts, planning and monitoring the operations, and development of the operations according to legislation and scientific studies. • The management system for quality shall assure that there are adequate routines for dealing with and documentation of the process related to a service effort to an end customer. • The management system for quality shall assure that there are routines that clarify the responsibilities for internal and external co-operation. External cooperation refers to the municipality, the primary healthcare, family members or close persons, NGOs and other relevant organizations. • The management system for quality shall assure that there are routines for how defects in the operations are identified, documented, analyzed, corrected and monitored. Also defects that might occur from the planned development of the operations shall be identified. • The management system for quality shall assure that there are routines for collecting and utilizing feedback and complaints from end customers, authorities and organizations. Service producers are obliged to collect feedback and complaints coming from external parties, and to assist in this process. • The management system for quality shall assure that there are routines for continuously controlling that sufficient staffing is available, that the personnel has sufficient competence, and that the personnel can receive continuous training. • The management system for quality shall assure that the provided products and services are of good quality. Areas of special focus are; the safety alarm services, visible ID-cards of personnel, safe handling of keys, handling of private belongings, food and meals, cleaning and environment.	

• The systematic quality work shall include methods for monitoring and evaluation of the planning, execution, results and development of the operations. Service providers shall participate in the monitoring activities conducted by Huddinge Municipality. Main monitoring activities are financed, planned and managed by Huddinge Municipality. The results are submitted to the service producers for evaluation and possible development activities or corrections. Corrective measures shall be submitted back to Huddinge Municipality. • Service producers shall assure that all employees are aware and familiar with the responsibility to report abuses and shortcomings in the elderly care to the managers and to the municipality. Also, corrective measures shall immediately be taken. • Service producers can also formulate their own quality statements in addition to those defined by Huddinge Municipality. These statements will be published by Huddinge Municipality through predetermined models. • Service providers shall once a year submit a report on their operations to Huddinge Municipality. • It is recommended to provide Huddinge Municipality with interim reports, in case a service producer regularly prepares such documents. • Service producers shall submit true and relevant information about its operations to Huddinge Municipality. The information provided shall be up-to-date. • Huddinge Municipality withholds the right to audit the operations of the service producers, and these shall co-operate and assist in possible auditing processes. • Huddinge Municipality monitors the quality of the meal service through regular customer surveys and occasional meal samples, and service producers shall co-operate and assist in these processes. • Service producers are obliged to participate in municipal crisis planning and crisis exercises. These efforts typically require one working day per year. • Service providers shall be prepared to co-operate with and migrate to electronic ordering- and invoicing systems that are being developed by Huddinge Municipality. • Service producers are responsible to ensure that all employees have knowhow in legislation related to secrecy and follow this, and also that employees confirm their non-disclosure obligations in written form. • Service producers shall strive to reduce the environmental burden of their operations. This may require co-operation with Huddinge Municipality. • All statutory duties with respect to registration, taxes and fees have to be met.	
• A delayed customer visit within the safety alarm service, i.e. arriving at an end customer home more than 30 minutes from the alarm center call, leads to a SEK 2000 fine. • Huddinge municipality and/or third parties shall be compensated for contract violations and for damages related thereto.	Cost Structure