Perspectives on Purchaser-Provider Co-Operation in the Local Welfare Regimes in Finland

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ABSTRACT

This paper presents a baseline picture of the co-operation between service purchasers and private elderly care and primary health care providers both at the national level and at the level of local welfare regimes in Finland. Data from two national surveys and from interviews conducted in six municipalities are analysed. The perceptions of the co-operation during the contractual period differed substantially between the private providers and the municipalities. The differences were evident especially between the for-profit providers and the municipalities. In general the private providers would be willing to work together with the municipalities, but to them it seems that the municipalities lack interest in this. The municipalities, in turn, considered that contracting is mostly a tool to reduce administrative responsibilities. However, in order to be able to gain benefits from contracting, to avoid excessive transaction costs and to co-ordinate the network of different service providers, the municipalities should invest in contract management and also be active during the contractual period.

Keywords: Contract Management, Contracting Out, Mixed Methods, Public-Private Partnership, Public Sector Reform

INTRODUCTION

This paper explores the co-operation between service purchasers (i.e. municipalities) and private for-profit and not-for-profit elderly care and primary health care providers in the context of the local welfare regimes in Finland. We use the term co-operation to refer to a concept that might also be labelled Public-Private Partnership (PPP). However, due to its ambiguous character (e.g. Weihe, 2008) we prefer a more general term co-operation. At the operational level we have divided co-operation into four dimensions: information sharing, trust, evalua-
tion of the contract and its implementation and co-development of services. These particular aspects are among the most commonly discussed issues in the literature on PPP and can also be easily identified from our data.

This study draws on data collected in Finland, a service system in which municipalities are responsible for funding, coordinating and commissioning the services for their residents. The municipalities also own and manage most of the provider organisations. In recent years these local welfare regimes have, however, experienced several structural changes as the municipalities have been reorganising their service structures (Vuorenkoski et al., 2008). One major development has been the marketization of health care and social service policies. This means the institutionalization of market-like mechanisms in the public sector in the forms of purchaser-provider splits, vouchers and contracting out the services. (Anttonen & Häikiö, 2011.)

Another change in the local service delivery structures has been the increase in the volume of services contracted out to the private sector (Ministry of Social Affairs and Health, 2012). Municipalities have been free to contract with private providers since 1984 in social services and since 1993 in health care services. However, due to a deep economic recession in the 1990s the issue of contracting did not become topical in the local health and social policy until the early 2000s. Since then the municipalities have expressed a growing interest in contracting out their services with private for-profit and not-for-profit providers. Sheltered housing and home help for the older people are typical examples of services purchased from the private sector. Recent studies of the municipalities in Finland suggest that health and social care managers as well as politicians express several arguments for involving private providers in the public service provision. These include, e.g. willingness to boost local economy, to enhance competition between providers, to develop the public service provision and willingness to provide more diverse combinations of services for the service users. (Tynkkynen, Lehto, & Miettinen, 2012; Vaara & Mikkola, 2012).

The local market structures have also changed. Traditionally a major part of the housing and home help services has been provided by not-for-profit providers or small entrepreneurs. However, changes in the legislation (e.g. EU competition law) as well as the increased interest of the for-profit providers in the growing market of elderly care services have changed the market structures. The entry of big, multinational, for-profit companies in the health care and social services market in Finland has directed the development towards a more consolidated market as the large companies have increased their share of the market. This has undermined the traditional much less competitive purchaser-provider relations between the municipalities and not-for-profit organisations.

Contracting between the municipalities and private providers may take various forms in Finland. The most common types of contracts are direct contracts paid by capitation or fee for service basis and framework contracts. In direct contracting a certain set of services is purchased from a private provider for a certain period of time. In elderly care the provider is usually paid on capitation bases. Certain procedures (e.g. physiotherapy, cataract surgery, eye examinations) and emergency services are paid for by fee for service basis. Framework contract is a type of contracting in which the characteristics and unit prices of the services are defined, but the volume of the service use and thus the income of the providers vary according to the number of clients actually referred to the provider during the contractual period. The selection of the private providers involves a process of competitive bidding organised by the public sector if the value of the purchase exceeds 100,000 Euros. The contracts are draft by the municipalities and the average duration is 2-5 years. However, the proportions vary between municipalities and between geographical areas within the country.

In 2009 the market shares in sheltered housing were at macro level 46%, 32% and 23% for the municipalities, for-profit providers and not-for-profit providers respectively. In primary health care the volume provided by private providers is in turn smaller. However, the share
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