A PARTICIPATORY APPROACH TO THE PARALLEL EVALUATION OF PUBLIC AND PRIVATE WELL-BEING SERVICES

Inka Lappalainen[1], Minna Kansola[2]
VTT Technical Research Centre of Finland, Finland
[1]Inka.Lappalainen@vtt.fi
[2]Minna.Kansola@vtt.fi

Abstract

The objective of this paper is to describe a participatory approach for evaluating public and private well-being services in parallel in order to support the adoption of multiple supplier models. The study was carried out as a case study, based on multiple data-collection methods such as thematic personnel interviews, customer surveys and activity-based cost analysis. The study produced two main findings. Firstly, it provided concrete and contextual results for case representatives in intensive residential services for the elderly and in primary health care. Secondly, an integrative evaluation framework was created, along with a participatory process with methods for benchmarking and facilitating multiple suppliers in well-being services. Thus the study provides new insights, from practice to theoretical discussion, as well as multi-voiced knowledge, participatory evaluation methods and benchmarking possibilities for case organisations, municipalities and political decision-makers and, ultimately, for all interest groups in well-being services.

Keywords: participatory evaluation, benchmarking, multiple supplier models, well-being services

1. INTRODUCTION

Public services, and particularly municipal well-being services, are facing critical future challenges in Finland, as in other western countries. The pursuit of multiform municipal service structure *reform towards multiple supplier models* is now under way to tackle these complex demographic, economic and structural challenges. Additional interactive evaluation and development practices are required in order to manage this complex reform and the increasing co-operation between public and private players.

Furthermore, the *quality and economic performance* of well-being services relate closely to the ongoing systemic and structural service reform. Common criteria for services are necessary when adopting multiple supplier models in order to insure and develop the quality and economic performance of services. Looked at positively, a great deal of effort has been put into quality and cost management in well-being services, with the support of multidisciplinary research activities. However, the development and utilisation of quality and economic performance perspectives has occurred relatively independently. Consequently, there may be a risk that economic performance is optimised at the cost of quality, or the other way round.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

For this reason, integrative schemes are needed for assessing and developing *both* the quality *and* the economic performance of services. These integrative evaluation frameworks enable *comparison and benchmarking* between different providers. These are critical means for developing well-being services at three main levels: with customers (end users), within service providers, and finally between different service providers and municipalities. Thus ***the aim of the study*** *was to develop a participatory and integrative approach for evaluating, benchmarking and facilitating public and private suppliers in well-being services.*

This paper starts with a brief overview of the ongoing structural reform of municipal well-being services and the approaches of assessing well-being services to highlight the relevance of our study. Secondly, the implementation and main results of our case study are described by illustrating the processes and the outcome of the new, developed evaluation approach. Finally, theoretical and practical contributions are discussed, along with the validity of our study.

2. THEORETICAL BACKGROUNDS

The recent economic recession has brought an increase in the pressure for transformation towards multiple supplier models, particularly in Finland, where progress has been different than in other Nordic countries (see Kivisaari & Saari 2009a). National legislation and strategy, local politics and a traditional communal decision-making culture are typically seen as the main inhibitors, especially for the radical and systemic innovations that are needed (see Bessant & Maher 2009).

The subject of public versus private sector services has been the target of numerous debates, even though a comprehensive and valid knowledge base is lacking. This may be the main reason for co-operation with private service providers facing fierce resistance at the municipal level. Novel interactive evaluation and development practices are needed in order to manage this ongoing complex reform and the necessary increasing co-operation between public and private players (Bessant & Maher 2009; cf. Kivisaari & Saari 2009b; Buur & Matthews 2008). This paper presents a participatory approach for evaluating public and private well-being services in parallel in order to support the adoption of multiple supplier models.

As said in the introduction, both the quality and economic performance of well-being services are important in the ongoing systemic and service reform, and since so far they have been developed independently, integrative schemes are needed to assess and develop both at the same time (see Laine & al.2005a). This paper focuses on the two modified integrative evaluation frames, which are based on the **total quality and cost management approaches** and **a balanced scorecard model** (Peiponen 2004; Hasu 2009). Although both frames have their background in private business, during the past ten years they have been utilised more and more in the public sector and in well-being services (Radnor & Barnes 2007).

At least two main trends can be traced in the evolution of the **quality paradigm** in well-being services: 1) quality management systems and quality awards focusing on organisational and essentially employee and management perspectives, having their origins in manufacturing industry and 2) quality defined as a condition of the patient and needs for care. Standardised measurements, such as RAI (Resident Assessment

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Instrument) and its competing Finnish tool RAVA (developers RAjala-VAissi) in elderly care, have been developed and increasingly taken in use in order to evaluate, as well as plan, nursing and nurturing more purposefully from the point of view of customers and resources. (see Laine & al. 2005a).

These first-mentioned quality management systems and quality awards are based on the philosophy of **total quality management** (TQM), whose main principles are customer-orientation, process thinking, continuous and collaborative development of operations and quality as integrated in strategic planning and management. When developing organisational quality, it is essential to have a collective understanding of its systemic and dynamic nature with multiform appearances. Experiences and research results from TQM systems in public well-being services have been contradictory, indicating the complexity of public service processes with different and even conflicting drivers and mechanisms relating to policy, professional and managerial issues. Consequently, there have been difficulties in defining different stakeholders and intangible processes with clear measurements as well as committing management to the philosophy. On the other hand, the clear need to ensure certain standards and to manage the quality of services has brought pressure to develop these TQM models and tools to serve the special characteristics of well-being services, supported by national programmes, recommendations and regulations. (see Peiponen 2004; Dey & Hariharan 2006; Natarajan 2006; Rantanen & al. 2007; Fryer & al. 2007.)

A good example of this kind of TQM model specification provides **the quality criteria in 24-hour care and services for the elderly**, which was chosen and applied in our study. The framework developed by Peiponen (2004), based on the European Quality award (EFQM), but also including the customer perspective with specific RAI- and RAVA- measurements, mentioned above. Thus the framework was intended to provide a highly comprehensive and context-specific evaluation base for our case study considering intensive residential services for the elderly. After a certain amount of modification, the main evaluation areas, with specific criteria and indicators, were as follows; 1) strategy and operating principle, 2) management model and leadership, 3) personnel and organisation of the work 4) customer-oriented process development and management 5) partners, resources and facilities, 6) customer perspective, 7) economic assessment and 8) societal impact (cf. EFQM 2010). The chosen integrative frame thus includes not only the qualitative but also the cost management perspective, as follows.

The economic performance and cost management can also be measured from many perspectives, demonstrated in particular by the economic research tradition in health (see Laine & al. 2005b) with sector-specific indicators. On the other hand, productivity and the rest concepts related to it have been criticised, especially at the operative level of managing nursing and nurturing, for being too simple and failing to describe the complex input-output-effect relations truthfully. Behind these statistical indicators there are many key factors with an influence on economic performance, such as organisation of nursing care and the division of labour among personnel (Chutchain-Ferranti 1999).

When moving towards multiple supplier models in municipalities and at service producer level, there is a growing need for the implementation and monitoring of systematic cost controls as a management tool at different levels of purchaser-provider co-operation. This requires a breakdown of cost structure, especially in the municipal sector, at different levels within the service system; branch (e.g. primary heath care or elderly care) and production unit. At the same time, economic surveillance as a natural

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

part of action planning and control at every level of the service system brings improved cost-consciousness among the personnel.

Our integrative evaluation frame targeted bringing out these factors behind the statistical indicators that influence economic performance and creating the solution for more systematic cost control. Here we added to the qualitative perspective a wider financial analysis than that provided by productivity alone. The financial analysis was carried out using **activity-based costing (ABC),** which is based on the belief that there are processes that require functions in order to happen and that the functions then use resources that cause costs. With accounting-based costing, costs are directed to the exact function (or functions) that has incurred them by means of the 'polluter pays' principle, thereby giving more precise cost data for every performance level of the organisation (Cooper & Kaplan 1991; Macheridis 2004.) Activity-based costing and its operative exploitation in particular, require a comprehensive resource review realised with the monitoring of working hours.

ABC and the monitoring of working hours allows factors influencing the economic comparability of nursing and nurturing to be reached; in intensive residential services for the elderly, for example, this means the organisational methods within the target organisations, and the way personnel hours are divided among nursing (basic care, recreational activities, terminal care, nursing, medication), other immediate work (cleaning, dining, garment care) and indirect work (treatment planning, development activities, reporting). It is therefore important to open the cost structures and pricing methods of the services, and their relation on the one hand to the organisation of work and division of labour, and on the other to the goals and boundary conditions of the action.

Another good example of an integrative evaluation and management tool used in the municipal sector is the **balanced scorecard (BSC),** a combination of four perspectives: process, personnel, customer and economy. BSC was originally a strategic management tool for business to supplement basic monetary indicators, although nowadays it is also widely used in the public sector, both in municipal level strategy work and at the branch level, for example in social and health services. The strength of BSC, according to Kaplan and Norton (1996), lies in its ability to form an entire management system out of a measuring system. In social and health care the strengths of the balanced scorecard are its ability to increase the transparency of the activities and to support the action of the personnel (Simonen 2004; see also Hasu 2009). Thus for the purposes of our case study the balanced scorecard was intended to be suitable for evaluating the quality and economy of the primary health care services. In addition, the branch-specific indicators were defined for those four perspectives.

To summarise, we have identified that both TQM and BSC models have a common purpose in supporting the comprehensive evaluation and management of organisational activities, including well-being services, with the same basic elements (see Figure 1). The **quality of well-being services** is understood and defined as a multiform phenomenon, which appears essentially as an increase in the entire well-being and empowerment of *customers*, purposeful and effective nursing and nurturing *processes*, and professional competence, well-being and renewability of *the personnel and the work community*. The main differences between the two models is that in the selected TQM model *facilities*, *networks* and wider *societal impact* are taken into account as separate elements, emphasising their significance in well-being services and the multiple supplier context. The **economic performance** can also be measured from the

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

many perspectives discussed above, but we have *mainly chosen the cost perspective*, which is also related to the other elements. The aim is for a comprehensive understanding of the economic conditions and the potential of service providers. Differences between the TQM and BSC models can therefore rather be seen as terminological, while both models are flexible, allowing context-specific modifications. They also share basic principles of dynamic and complex relations within the organisations (service providers), and within their environment.

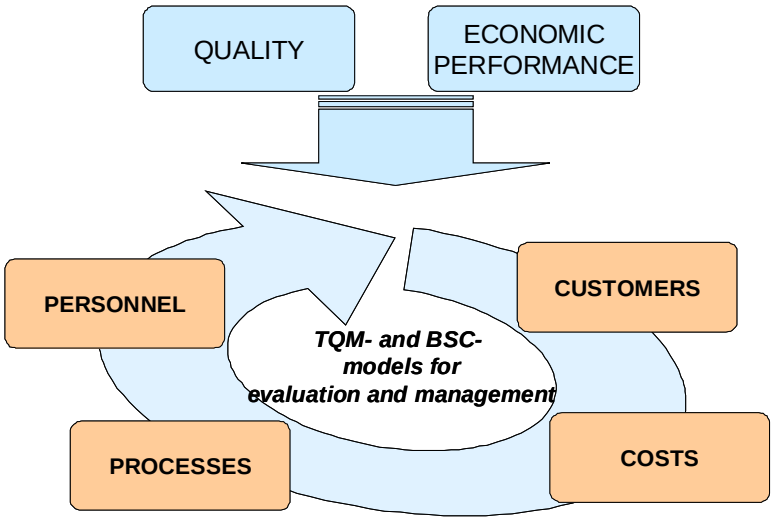

Figure 1. Quality and economic performance in well-being services

Not only means but also **purposes and roles of evaluation** have opened up from purely descriptive, normative and self assessment towards being comparable, participatory and development-oriented in nature.

Comparable and parallel evaluation, also defined as external benchmarking, is becoming ever more necessary when adopting multiple supplier models for biding providers, and for ensuring the quality and economic performance of the selected providers, as well as for serving political decision-making at municipal and state levels. In addition, according to Kay's (2007) research review, external benchmarking has been seen as a valuable tool for heath care organisations for comparing an organisation's performance against competitors in the particular branch of health care, or even in other businesses. However, this tool is not only an auditing practice, but can be used as a continuous process for identifying, understanding and adopting outstanding practices. Thus external benchmarking supports open comparison and sharing to allow continuous development and mutual learning. Practitioners, aware of developments elsewhere, can develop practice with minimal effort and a faster learning curve, avoiding typical mistakes and concentrating resources on new areas for practice development (Kay 2007). When social and health services are being required more and more to ensure uniform provision of high-quality and productive services, benchmarking activities provide the means for redefining those criteria and standards collaboratively (among service providers and municipalities) and thus coordinating the development of quality and economic performance of services. However, as Kay (2007) stresses, this should be guided by clearly defined municipal policy efforts and responsibilities, aligned with national policies. (see also Natarajan 2006.)

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

A *multi-level and participatory* approach is necessary when evaluating and developing complex heath care and social services (Bessant & Maher 2009; Kivisaari & Saari 2009b). This refers to involving all the main interest groups in an assessment process in order to gain a comprehensive view of current performance, and to bring out particularly conflicting interests and issues that inhibit the goals set at different levels of the service system (cf. Nuutinen & Lappalainen 2010). In the case of well-being services, the main interest groups are the customers, personnel and management of the target organisation. In the public sector, with its hierarchical management structures, the involvement of representatives from all main management levels is important in order to ensure access to the required data, resources and the decision-making authority for changes. Finally, municipalities, as purchasers and legally responsible for arranging basic social and health services, play a central role in the evaluation process by guiding and ultimately utilising results at a municipal level.

Development-oriented evaluation is necessary to involve and empower the main interest parties, not only for producing knowledge or feedback, but for collaborative exploration and development of current practices and services in pursuit of continuous improvements as well as more radical and complex changes in the long term (cf. Dey & Hariharan 2006; Kivisaari & Saari 2009b; Nuutinen & Lappalainen 2010). Acknowledging the time-dependency of the evaluation and the dynamic nature of the service system, focus should be future-oriented. Merely gaining a comprehensive view of current organisational performance, including main gaps and development needs in terms of quality and economic perspectives, will not, therefore, suffice. Future customer needs and opening potentials should also be continuously re-evaluated against changing laws and regulations. This will entail redefining goals and performance criteria among service providers and municipal bodies. In addition to the contribution to shared understanding of the necessary change, goals and operative actions, participants will be able to *learn more interactive and systematic* evaluation and development methods and practices. (cf. Nuutinen & Lappalainen 2010; Buur & Matthews 2008.)

The ongoing change towards multiple supplier models calls for totally new competencies for all parties in the multi-level service system, as described above. *External support* is needed, for example with bidding processes, in defining performance criteria, agreements and suitable bidding practices, as well as related organisational changes in the municipalities. Consequently, there is a growing need for external and impartial support for evaluation due to the complexity of the change, with conflicting interests and open issues that need to be solved more interactively (cf. Kivisaari & Saari 2009b). We therefore claim that an external researcher could provide not only impartial knowledge, but the concept and process management support for the change towards multiple supplier models.

The overview of theoretical backgrounds and practical relevance concludes with the notion that holistic and participatory approaches are needed in order to support evaluating, benchmarking and for developing new, different service models and multi-level co-operation in well-being services. These integrative evaluation frameworks with their coherent criteria enable comparison and benchmarking between different providers. These are critical means for developing well-being services at three main levels: with customers (end users), within service providers and between different service providers and municipal bodies.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

3. DATA COLLECTION AND METHODS: CASE STUDY

A case study-based approach was applied in order to construct a new holistic framework and participatory approach for parallel evaluation of well-being services (see Yin 1994; Eisenhardt 1998). Two cases were selected on the basis of surveyed communal needs and theoretical relevance. The first case was related to intensive residential services for the elderly, and the second to primary health services. In both cases, the main focus was on a public service provider with a comparable private service provider serving as a benchmarking target. Combining multidisciplinary expertise, the study sets out to assess and develop well-being services comprehensively, with a view to different player groups within both public and private service providers, as well as representatives of communal bodies.

The first case focused on intensive residential services for the elderly in the city of Pori, which is located on the western coast of Finland and has about 82,900 inhabitants. About two years ago, Pori was undergoing the comprehensive municipal transformation of its basic health and social services and related development of multiple provider co-operation. Furthermore, a great deal of effort had already been expended in responding to the growing need for services for the elderly by investing in new residential service units and renewing the existing services to match changing needs. Local authorities were also interested in benchmarking public and private providers in terms of costs, quality and increased attention to the customer perspective. Future goals were set not only for cutting costs, but for renewing services for the elderly to provide more flexibility and choice for citizens, as well as innovative working communities, given the name 'living labs'.

Thus the purpose was parallel evaluation of a public and private provider of intensive residential services for the elderly. The process aimed at assessing service quality and cost in both target organisations, making use of benchmarking knowledge and tools serving both organisations and municipal authorities. The prime criterion in the selection of target organisations was the choice of a public provider established no more than one year before and considered as a pioneer for other new providers. A similar private provider was then chosen from among current partners of the municipalities, with the same kind of operating principles, customer profile, and personnel, and at a similar stage of development. The specification of the TQM model, presented earlier as the quality criteria in 24-hour care and services for the elderly (Peiponen 2004), was applied for the evaluation framework. All main interest parties, such as the employees and management of the providers, customers (residents and their relatives) and representatives of municipalities (line management, finance, a purchaser, a member of the municipal council) were included in the evaluation process.

Another case focused on basic health services in the city of Tampere, one of the largest cities in Finland with 210,000 inhabitants. As a part of ongoing change in basic health care the local authority is planning to renew the organisation of work in public health services from a team model towards a nurse-doctor work pair model. Thus they were interested in suitable, local benchmarking targets to contribute to their planning. Currently, in addition to public production, health services are purchased from two private providers, while another one already operates a nurse-doctor work pair model and engages in proactive development of the practice. The municipal authority for health services was consequently interested in evaluating the services of this provider and comparing them with respective public services. The public service provider was then chosen from among current units with the same kind of customer profile in terms

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

of community-based responsibility and age distribution. However, the public and private providers differ from each other with regard to these operational models (team/work pair) and related customer appointment systems (centralised/dispersed).

The purpose, therefore, was to evaluate the quality and economic performance of the heath service providers in parallel, benchmark the main similarities and differences and, finally, define development needs with optional solutions, primarily for the chosen public provider, and generally for the municipalities. The assessment was nonetheless also seen as a valuable learning opportunity from the private provider's perspective. Furthermore, the aim was to assess co-operation between the private provider and the municipal purchaser of services. The balanced score card, with its four main perspectives (customer, personnel, process and economic), was applied as the framework for the assessment. In addition, all main interest groups were involved in the evaluation process, including the personnel and management of the target health organisations, and customers, as well as the municipalities representing the purchasing and financing roles.

The evaluation process comprised **three main phases** in both the intensive residential services for the elderly case and the primary heath care case. Firstly, critical analysis and further development were applied to the chosen integrated evaluation models, BSC and TQM frameworks, taking into account qualitative and cost perspectives with service-specific indicators. The main player groups were then identified and oriented into a roughly pre-defined process, during which data-gathering and the analysis of researchers, as well as collective processing and the co-creation sessions of key player groups, were carried out alternately. Multiple quantitative and qualitative data collection and analysis methods were applied. In both cases the main methods included thematic personnel interviews, municipal interviews, customer surveys and activity-based cost analysis, described in more detail in Table 1.

Method	**Case: intensive residential services for the elderly** Personnel: 37/32, Residents: 56/53 (2009/2010)	**Case: primary health care** Core personnel: 7/8 Population resp.: 10,890/11,107 (2009)
Thematic personnel interviews in both organisations	• Management in individual interviews • A half of nursing staff, cleaning and kitchen staff in pairs	• All staff and management in individual interviews • In addition, a personnel survey
Thematic municipal interviews	• The purchaser, the financer, line managers, a member of the municipal council	• The purchaser, the financer
Customer surveys	• Within a public provider: Residents' interviews, relative survey • Within a private provider: Utilisation of customer survey data conducted previously • In addition, statistical data of customers (Rava indicator, etc.)	• Utilisation of customer survey data gathered previously • Mini customer satisfaction survey of customer appointment systems • In addition, statistical data of customer profiles and customer appointment systems
ABC-analysis	• Based on three weeks' monitoring of working hours and data on cost structures and annual costs.	• Based on two weeks' monitoring of working hours and data on cost structures and annual costs.

Table 1. Main data collection methods.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Other available material from case companies, such as information from their websites, previous research reports and organisation-specific documents (contracts, strategies, service descriptions, etc.) were also utilised as complementary data. Participatory methods were introduced to commit key player groups to the process. This iterative and interactive process took over a year to complete, from June 2009 until August 2010. Finally, the concluding results were discussed and shared at all levels of the service system. The lessons learned were also generalised for utilisation and further development.

4. RESULTS AND CONCLUSION

The study produced two main results: firstly, it provided concrete and contextual results for case representatives; secondly, it created an integrative evaluation framework, a participatory process and methods for benchmarking and facilitating multiple suppliers in well-being services, being the focus of this paper.

Contextual results for case organisations were reported confidentially, but the main results are briefly presented in a VTT publication (Lappalainen & al. 2011). The results showed that in terms of cost and quality of services the differences between public and private providers are not straightforward; private provider solutions are not necessary cheaper, and public services are not always better in quality or better-resourced. The main differences between providers were caused primarily by strategic decisions (focus, philosophy) and secondarily by different organisational and management solutions in core tasks and in support functions. Premises also appeared to play a significant role in either supporting or inhibiting renewals.

Integrative evaluation frameworks, TQM- and BSC-based models, were modified for sector- and case-specific needs with suitable evaluation criteria and indicators. Case representatives also took part in the definition process. Frameworks appeared to be quite successful in obtaining multiple and relevant information on targeted issues. Several ideas for further development were nevertheless identified during evaluation processes, for example consideration of the customer perspective with suitable indicators.

A participatory evaluation process with suitable methods was predefined at the beginning and specified in the cases during the process. The main levels and phases were the same in both cases and appeared to be suitable (see Figure 2). Some *critical benefits and challenges* were identified during the process in addition to case- (and branch-)specific differences. These should be taken into account when developing the approach further. In the following, these main phases with critical points are described according to three main levels: service provider, customer- as well as purchaser-provider co-operation, and the benchmarking level between providers.

Evaluation within a service provider

Kick-offs in the target organisations aimed at *communicating and committing* the personnel and management to the assessment process. In the case concerning care for the elderly, a specific project group with management and employee representatives was appointed for both providers in order to plan and coordinate the process in more detail with these *local "change agents"*. This proved unnecessary in the case concerning primary health care owing to the small number of personnel in the target organisations.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Thematic personnel and municipality interviews served not only our knowledge needs, but were important means of getting to know one another. Interviews also provided them with the opportunity for *critical reflection on their work with ongoing changes* as well as *discussion on motives* and methods of the evaluation. Thus it was an essential step in building mutual commitment and trust into the process. The interviews could be complemented with a personnel survey, as in the case concerning primary health care. The results were presented in the organisational workshops and elaborated further. For example, in the case concerning care for the elderly all personnel were involved in the unit-level group work to consider results and related development needs, guided by researchers.

ABC-analysis was based on monitoring working hours over a period of 2-3 weeks. Work task categories were driven from interviews and specified within the project group and contact persons. Even though great effort was invested in modifying monitoring forms and informing the staff, there appeared some difficulty in filling them in correctly. Furthermore, during the ABC-analysis the acquisition of cost data (accuracy, resource allocations, comparability) from the relevant parties proved somewhat problematic. These reflect typical challenges in cost management, especially in the public sector, and moreover when moving towards *transparency within and between organisations* (see. Rantanen & al. 2007). It seemed that more specific data requirements, with named responsibilities, were required at the very beginning of the process in order to conduct the analysis effectively. Results were discussed at the organisational management level in both cases and also in a workshop for personnel in the case concerning care for the elderly. The monitoring of one's work seemed to be a somewhat sensitive issue with negative images. Open and constructive communication between management and personnel on the purpose and results is, therefore, essential.

Furthermore, in the public provider case concerning care for the elderly all results (personnel, cost and customer) were combined and elaborated collaboratively as *an organisational development plan*. This took the form of an interim review in the long evaluation process, in particular providing a practical tool with shared development objectives, tasks, responsibilities and schedule.

A Customer perspective

In both cases participants shared the view of current services already being customer-oriented. Furthermore, when allowing citizens more freedom of choice in future with regard to service providers, customer understanding, and customer involvement in evaluating and developing these services, becomes essential.

The customer perspective consisted of different means for building a *broad view of the quality of services from the customer point of view*. First of all, the customer perspective naturally formed an important part of the personnel and municipal interviews. Secondly, both cases involved the utilisation of statistical knowledge on customer profiles and structure, forming the basis of services. For example, in the case concerning care for the elderly, Rava- and other related indicators were explored in order to evaluate current and future needs for nursing and caring in relation to resources. Some difficulty arose in terms of accuracy and comparability of data between providers.

Customer satisfaction on current services was also evaluated in both cases. In the case concerning care for the elderly, the public provider's previous measurements were updated to cover comprehensive experience of the intensive residential service, from the

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

first appointment through to nursing and physical, psychological and social care of the elderly. The same measurement was applied in the residents' interviews and in the questionnaire for their relatives. The *measurement can also be repeated and improvements followed* over the long term. The results with development needs were elaborated in a personnel workshop as well as in *joint events* for residents and their relatives. This was seen as fruitful in terms of *open dialogue and concrete development needs*, although containing some difficulties regarding the active long-term involvement of relatives. Previous customer survey results were applied in the case of the private provider. In the case concerning primary health care, the previous customer survey on quality of services was also applied, to cover both providers. When sharing particular interest in organisation of the work and related systems of appointment, additional data were collected by interviewing customers in both units complemented with statistical data of visitors and phone calls. The results were discussed mainly in the management and municipal/purchaser level.

A Purchaser – provider co-operation and benchmarking between providers

Researchers had the main responsibility of the data collection and the analysis as well as the coordination of the evaluation, but with co-operation of *contact persons* from local authority and service providers. Their role appeared to be very important concerning communication, motivational and data access issues.

In Elderly care-case external benchmarking were conducted only at the end of the process, because organisational evaluations in the public and the private provider were progressed in different schedules. The results were presented and discussed first with management meeting of both providers and municipal representative. Then main results are shared in personnel workshops when closing the assessment and delivering a final report. In addition benchmarking visits for the staff were suggested to support ongoing *dialog and development between and within providers*. Instead in the Primary health-case benchmarking along the process focused more on the management and municipal purchaser level. The assessment was closed on personnel workshops in both providers.

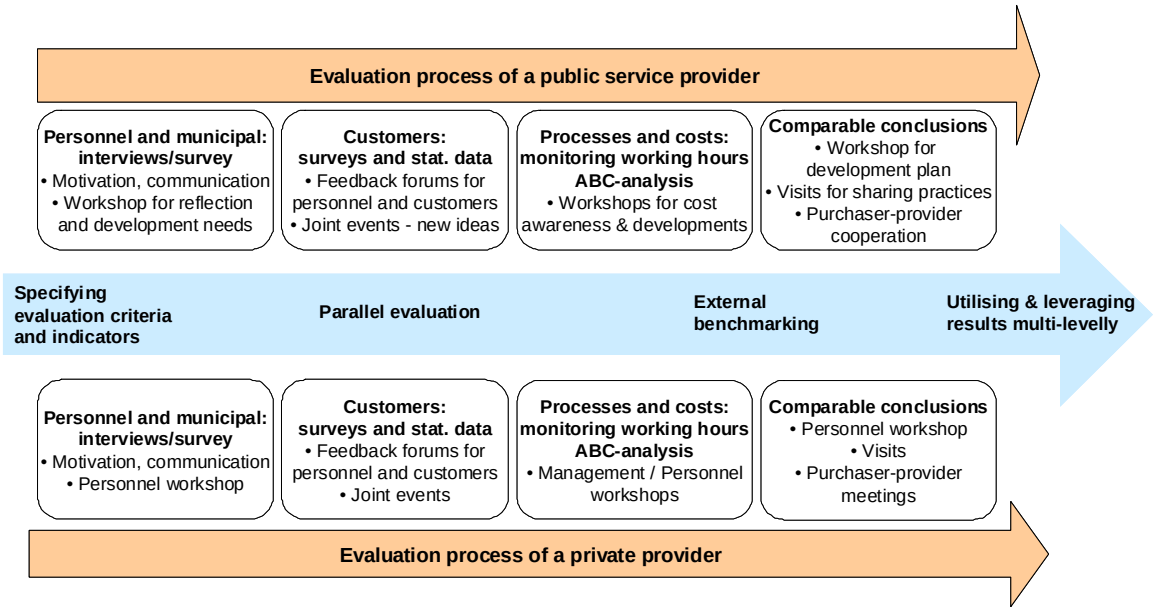

Figure *2. The evaluation process model.*

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Leveraging results for local and municipal authority and decision-makers

In the case concerning care for the elderly, the results contributed to the ongoing planning process for bidding intensive residential services for the elderly. In addition to comprehensive parallel evaluation, the main assessment conclusion was summarised by a so-called "*Top ten for purchaser-provider co-operation*". These were meant as guidelines for the planning process, which was conducted for the first time in a participative manner among service providers and municipalities. The open seminar will also be arranged in order to share main results and best practices by means of enhancing regional co-operation with neighbour cities. The evaluation was therefore useful for the multi-level renewing of intensive residential services, also covering regional co-operation. However, the utilisation of results will always be challenging in the midst of comprehensive municipal transformation involving changes in key personnel.

In the case concerning primary health care, the final results were first presented and discussed by the municipal board responsible for primary health care issues, and will be communicated further to municipalities as well as citizens. The assessment provides in-depth knowledge for re-organising operative work in health care units, as well as planning for new premises taking into account nurse-doctor pair work conditions. Furthermore, the study provided more specific knowledge of purchaser-provider co-operation. The open seminar will also be arranged to support more *transparency and proactive development* of well-being services among providers and municipalities.

5. DISCUSSION

With these being case studies, results could be applied carefully to other settings with the same contextual criteria. However, some generic conclusions could be made which were supported by previous studies. These case results concerned the complexity of quality and economic performance in terms of differences between public and private providers. (Sinervo & all. 2010; Vohlonen & al. 2010.) Therefore, instead of straightforward interpretations, it is essential to evaluate well-being services from multiple perspectives, and with all important interest groups, in order to interpret and build shared understanding of the main differences, their backgrounds, and the suitable development needs and solutions.

The case study approach guided by Eisenhardt (1989) appeared suitable for this purpose. The long evaluation process, with multiple methods and multi-level participation, provided a comprehensive base for the assessment, and thus for the validity of the results. In addition, continuous dialogue within the multidisciplinary research group and the management board, as well as feedback from the case representatives, have provided the means for testing the relevance and validity of the emerging approach (see Eisenhardt 1989).

However some critical limitations were identified in the methods selected. The time-dependency of the results should be taken into account, especially with dynamic change, such as occurred in the case concerning care for the elderly. In addition, the application of different measurements left comparability and benchmarking between service providers at a rather general level, for example regarding customer perspective in the case just mentioned. Comparability in costs structures and customer profiles was also somewhat challenging in both cases. These notions are supported by previous studies, indicating the need for redefined and unified performance criteria within the branch (see

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Boemer 2005; Laine & al. 2005b). These unified criteria with indicators would encourage both private and public providers to renew their services, aligned with shared vision and municipal policy, furthermore contributing to benchmarking possibilities and transparency of services multi-levelly from municipalities to customers.

In spite of limitations, the created approach appeared suitable and relevant. The selected integrated frames, TQM and BSC, are well known and flexible enough to modify for branch-specific needs, including well-being services. The model of a participatory process also appeared to provide a base for parallel, multi-voiced and development-oriented assessment. In order to manage the process purposefully, some critical issues were identified. Above all, the base for the successive multi-level process seemed to be mutual commitment and shared but clearly defined ownership of the assessment. These could be guaranteed only by purposeful resource allocation in the assessment work, clear responsibilities covering all interest parties, and negotiated goals and means. In this way, specific needs, access, modification and delivery of data from different sources could be managed effectively. Furthermore, involvement of the main interest parties concerns not only knowledge production, but proactive exploration, benchmarking and piloting of new innovative practices. This participatory process covers the service system from customers to purchaser-provider collaboration under the guidance of external researchers. As our cases showed, this multi-level assessment process can be applied to very different well-being services and case-specific needs in terms of focus areas, involvement and development orientation (cf. Nuutinen & Lappalainen 2010; Kivisaari & Saari 2009b).

In practice it appears that this kind of comparable and participatory assessment is still typically a more project-based activity, rather than continuous improvement activity integrated into daily practices and systematic innovation activities at every level of the service system. This obviously reflects the current change towards multiple supplier models where innovative approaches are really required, proactively explored and exploited in order to achieve more systematic incremental improvements, as well as radical systemic service innovations.

Thus in this paper we aimed to: 1) provide a brief review of the available and developed integrative evaluation frames and perspectives; and 2) describe the developed parallel assessment process as the participatory and development-oriented learning process within the dynamic multi-level service system. Consequently, this study and paper new provides new insights from practice through to theoretical discussion by increasing understanding and best practices with novel evaluation approach when renewing well-being services towards multiple supplier models. Furthermore, it provides multi-voiced knowledge, participatory evaluation methods with concrete tools and benchmarking possibilities for case organisations, municipalities and political decision-makers and, ultimately, for all interest groups in well-being services. The results of the study are promising but require further research and development.

6. ACKNOWLEDGEMENT

The authors wish to thank their colleagues in VTT and TSE (Turku School of Economics Pori) and the case organisations for their fruitful co-operation. The research has been funded by TEKES, participating organisations and VTT.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

7. REFERENCES

Bessant J. & Maher, L. 2009. Developing radical service innovations in healthcare – the role of design methods. *International Journal of Innovation Management,* vol. 13, No. 4 (Dec. 2009) pp. 555–568.

Boemer R. 2005. Medicine's service challenge: Blending custom and standard care. *Health care management review* 30(4): pp. 322–330.

Buur J. & Matthews B. (2008) Participatory innovation. International Journal of Innovation Management, Vol. 12, No. 3, pp. 255–273.

Chutchain-Ferranti, J. 1999. "Activity-Based Costing." *Computerworld.* August 1999.

Cooper, C. & Kaplan, R. S. 1991. Profit Priorities from Activity-Based Costing. *Harvard business review*, May-June 1991, pp. 130-135.

Dey, P.K. & Hariharan, S. 2006. Integrated approach to healthcare quality management: a case study. *The TQM Magazine*, vol. 18 No. 6, 2006, pp. 583-605.

Eisenhardt, K. M. 1989. Building theories from case study research, *Academy of management review*. Vol. 14, No. 4, pp 532–551.

EFQM Excellence model 2010. EFQM Publications.

Fryer, K. J., Antony, J. & Douglas, A. 2007. Critical success factors of continuous improvement in the public sector. *The TQM Magazine*, vol. 19. No. 5. S. 497-517.

Hasu, S. 2009. *Evaluating the suitability of applying the Balanced Scorecard to public health care organisation*. The case of Medical District of Helsinki and Uusimaa (HUS). Dissertation. University of Wolverhampton Business School.

Kaplan, R.S. & Norton, D.P. 1996. *The Balanced Scorecard: Translating strategy into action*. Harvard Business School Press. Boston, Massachusetts.

Kay, J. 2007. Health Care Benchmarking. *Medical Bulletin,* vol 12, No 2, February 2007.

Kivisaari, S. & Saari, E. 2009a. Hybrid Actors in Developing System Innovations Case of Primary Health Care Management. *Paper for the 1st European Conference on Sustainability Transitions*: "Dynamics & Governance of Transitions to Sustainability" Amsterdam 4–6 June 2009.

Kivisaari, S. & Saari, E. 2009b. Can system innovations be facilitated by societal embedding? *ECCE 2009*, 30 September–2 October 2009, Helsinki, Finland.

Laine J., Linna, M., Häkkinen, U. & Noro, A. 2005a. Measuring efficiency and clinical quality of institutional long-term care for elderly. *Health economics* 14: 245-256.

Laine, J., Linna, M. Noro, A. and Häkkinen, U. 2005b. The Cost efficiency and clinical quality of institutional long-term care for the elderly. *Health care management science* 8, 149-156.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi

Lappalainen, I., Lappeteläinen, I, Wiili-Peltola, E. & Kansola, M. 2011. *Multipro – vertaileva arviointikonsepti hyvinvointipalvelujen laadun ja taloudellisen tekijöiden arviointiin*. VTT Tiedote. Helsinki. (forecoming).

Macheridis, N. 2004. *The Specific Costing Problems of Project Form. How those can be managed with activity based costing*. Lund Institute of Economic Research, Working Paper Series 2004/2.

Natarajan, R. N. 2006. Transferring best practices to healthcare: opportunities and challenges. *The TQM Magazine*, vol. 18 No. 6, 2006, pp. 572-582.

Nuutinen, M. & Lappalainen, I. 2011. A framework for supporting transformation from products to services – An organisational culture point of view. *International Journal of Service Quality*. (submitted 2010).

Peiponen A. 2004. *Vanhusten ympärivuorokautisen hoidon ja palvelun laatukriteerit. Helsingin kaupungin sosiaalivirasto*. Tutkimuksia 2004:2. ["The quality criteria in 24-hour care and services for the elderly".] Helsinki.

Radnor, Z. J. & Barnes, D. 2007. Historical analysis of performance measurement and management in operations management. *International Journal of Productivity and Performance Management*, vol. 56. No. 5. S. 384-396.

Rantanen, H., Kulmala, H. I., Lönnqvist, A. & Kujansivu, P. 2007. Performance measurement systems in the Finnish public sector. *International Journal of Public Sector Management*, vol. 20. No. 5. S. 415-433.

Simonen, O. 2004. *Tasapainotettu tuloskortti (BSC) hoitotyön johtamisen viitekehyksenä – käytössä olevat mittarit ja niiden yhteys strategioihin*. HYKS, Jorvin sairaalan julkaisuja. Sarja A 03/2004. ["Balanced scorecard (BSC) as a frame of reference in managing nursing – the indicators in use and their relations to strategies". Publications of Jorvi hospital.]

Sinervo, T., Noro, A., Tynkkynen L-K., Sulander, J., Taimio, H., Finne-Soveri, H., Lilja, R. & Syrjä, V. 2010 *Yksityinen vai kunnallinen palveluasuminen? Kustannukset, asiakasrakenne, hoidon laatu ja henkilöstön hyvinvointi*. Terveyden ja hyvinvoinnin laitos (THL), Raportti 34/2010. Helsinki. [Sheltered housing – private or municipal? Costs, clientele structure, quality of care, and well-being of the personnel]. National Institute for Health and Welfare.

Vohlonen, I., Komulainen, M., Vehviläinen, A. & Vienonen, M. 2010. Ulkoistetun avosairaanhoidon toimivuus ja tulokset Kouvolassa. *Suomen Lääkärilehti* 65 (9); 817-827. [Evaluation of outsourced municipal ambulatory care].

Yin R. K. 1994. *Case study research. Design and methods*. 2nd Ed., Sage Publications, Thousand Oaks.

Inka Lappalainen VTT, Tekniikantie 2, Espoo
P.O. Box 1000, FI-02044 VTT, Finland
Tel. +358 20 722 6780, fax +358 20 722 7604, inka.lappalainen@vtt.fi