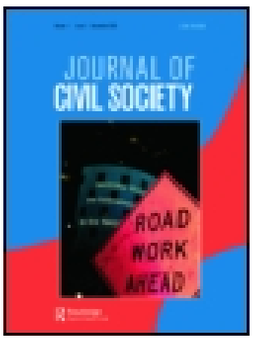

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Open Tenders in Public Procurement of Welfare Services: Professionalization, Standardization, and Innovation among Civil Sector Providers

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ABSTRACT

In the article we discuss the increased use of open tenders in the public procurement of welfare services in Norway in order to determine if this implies standardization, professionalization, and/or innovation among civil sector providers and if this differs between welfare areas. The study is based on a review of public documents over the last 40 years and interviews with both purchasers and providers of welfare services in two welfare areas: SUD treatment and vocational rehabilitation. We emphasize the systemic and in part organizational levels, focusing on what the purchaser and management of the provider perceive as the result of these changes in the procurement regime. In light of neo-institutional theory and theories on innovation, we find that the increased use of public procurement and tenders have professionalized and standardized non-profit organizations while also providing room for innovations, according to our informants. We find a kind of dual process, where organizations become more alike in structure, administration, and – to some degree – treatment while also becoming more specialized and, in some cases, arriving at new and innovative solutions regarding content.

KEYWORDS

Welfare services; public procurement; non-profit organizations; professionalization; standardization; innovation

Introduction

According to Pestoff (2014, p. 1417; see also Considine, 2003), the previously 'cosy relationship' between civil associations and authorities has been more or less terminated by the New Public Management (NPM) that has swept across Europe. Anheier and Salamon (2006, p. 93) argue slightly differently, emphasising that NPM has moved non-profits 'to the center of the policy debate and have come to be viewed as central instruments of development and welfare state reform'. Among the Scandinavian countries, we find growth in for-profit providers of welfare services and a marginalization of the civil sector in Denmark and Sweden. In Norway, several private actors have become more involved in welfare areas, such as care for the elderly, child care, substance use disorder treatment and rehabilitation, and vocational training (Lorentzen, 2004; Sivesind, 2016,

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2017). However, the dual trend described in Sweden and Denmark – namely, increase of for-profit and decrease of non-profit actors – is far less profound Norway (Sivesind, 2017). Yet this development implies, as Pestoff (2014) emphasizes (see also Evers, 2005), an increased hybridization of welfare providers in a third sector, where the boundaries between public/private and non-profit/for-profit are blurred. Such a development opens up new roles for civil associations, especially regarding the potential for complementary services, and not as mere supplements to or substitution of the public welfare provision (Dahlberg, 2005; Loga, 2018).

In this article, we focus on possible outcomes among civil sector providers of increased public procurement for services in Norway. We tentatively identify three possible outcomes that are not mutually exclusive: professionalization, standardization including bureaucratization, and/or innovation. According to Smith and Grønbjerg (2006, p. 225) government resources and regulations help non-profit organizations professionalize to meet the demand for public goods. Thus, increased professionalization both of the organizational structure and in the services provided can be seen as a consequence of increased public procurement of services (Bergsgard et al., 2010).

Furthermore, in light of neo-institutional theory, standardization and similarity between organizations in an organizational field may be the result (Scott, 1995). Civil associations tend to become more alike if they are dependent on a single (public) key supplier of funding (DiMaggio, 1991; DiMaggio & Powell, 1983/1991). The driving force behind these processes is the emphasis on the organizations' appearances in relation to their institutional environment – doing the right thing, establishing the accepted organizational structure – and not necessarily being the most efficient or innovative. Increased bureaucratization may be a result.

However, innovation may as easily be the result of the increased public procurement of services. This takes place both as a 'demand-side innovation policy instrument in the form of an order, placed by a public organization, for a new or improved product to fulfill its particular needs' (Edquist et al., 2015, p. 1). More generally, giving credits to tenderers who presents innovative solutions. The traditional assumption is that innovation and increased efficiency occur when entrepreneurs meet the market – in this case, a market-like situation created by the government's tendering regime.

A premise of this article is that different outcomes (i.e., professionalization, standardization, innovation) are also a result of the welfare areas we discuss. Thus, the history and institutional constraints of each welfare area need to be considered. We will explore the expected outcomes following governmental procurement in two welfare areas: vocational rehabilitation and substance use disorder (SUD) treatment. These two areas have different historical paths when it comes to the relationship (or mix) between public and private welfare providers. The selection of these two cases can give us insights into the interplay between the governmental tendering regime and control system as well as providers in the civil sector. Based on a review of public documents from the last 40 years and interviews with both purchasers and providers of welfare services in these areas, we will answer the following two research questions:

> Does the increased use of governmental procurements of welfare services lead to professionalization, standardization, and/or innovation among civil sector providers?

Does this result vary among different welfare areas?

Our focus is on how relevant employees involved in these procurement processes, from both the government and the civil sector side, perceive the different outcomes. Thus, we have not interviewed street-level bureaucrats or users, for instance, to determine how many actual innovations have taken place. Our focus is the systemic level – namely, the procurement regime and process – and partly the organizational level – namely, organizations' responses to this regime and process. We use the term civil association (CA) to include the spectrum of organizations related to civil society, from NGOs to humanitarian and voluntary associations, religious groups, organized interests, trade unions, and business associations. For this article we focus on traditional voluntary organizations (user organizations), humanitarian (religious or philanthropic) associations (e.g., Red Cross, Blue Cross, Church City Mission), and idealistic non-profit organizations (e.g., Tyrilistiftelsen, Borgestadklinikken). These organizations offer welfare services to public purchasers in competition with commercial actors (and sometimes public institutions). The term non-profit organization is an internationally used reference to these civil welfare providers and will be used when we refer specifically to the organizations included in our study. The study is part of larger research project titled 'Pluralisation, the welfare state and civil associations' that was carried out between 2014 and 2018.

First, we will review the background for the article and our research questions; then we will present the theoretical perspectives and methods used for answering these questions. We then present and discuss each welfare area separately, starting with a short story of the institutional constraints before presenting the purchaser's view and the provider's assessment. In the discussion, we pull the threads from our two welfare areas together and analyse them in light of our theoretical approaches. In the final section we sum up our findings in relation to our two research questions.

Background

In the era of globalization and pluralization, the expansive, service-intensive, and universalistic Norwegian welfare state faces new challenges. The principle of universalism was carved out at a time when homogeneity and egalitarianism were the defining features of Norwegian society (e.g., Kildal & Kuhnle, 2005), but over the past few decades Norway has become increasingly diverse and pluralistic. This is due partly to migration, but also to the general societal changes of late modernity with increased individualism and pluralization of interests, social groups, identities, and lifestyles. Furthermore, even in an oil-driven economy such as Norway's, there are limits to welfare state budgets and, according to Lorentzen (2004), the combination of scarce resources, growth aspirations, and diverse needs have made private actors more attractive to public authorities. These developments coincide with the introduction of more market-like management in public administration since the 1980s (inspired by management objectives and New Public Management) that became dominant in many Western countries, including partly in Norway. As a result, we find an increased use of open tenders and competition in the procurement of welfare services for non-profit and for-profit actors. These changes can to a certain degree relate to the

introduction of EU directives and stronger national legislation related to public procurement (Bock Segaard, 2016).

The backdrop for this article is the change in the welfare mix between public, for-profit, and non-profit providers in the welfare area in Norway. The shift is not substantial, however; despite a tendency for public shares to decrease and for-profit providers' shares to increase, the public employed nearly four out of five people in the welfare area in 2013 (Sivesind, 2016, Table 4). Meanwhile, the shares employed in non-profit providers are relatively stable. In this article, we will explore the welfare mix in two welfare areas, emphasising the relationship between government procurers and civil sector providers.

Theoretical Perspectives

Relationship Between Government and Civil Society Associations

In the book *Non-Profits for Hire. The Welfare State in the Age of Contracting* (1995), Smith and Lipsky concluded: 'The challenge (…) is to find the proper balance between the efficiencies of markets and the inventiveness of the voluntary sector, and the legitimate role of the state in raising revenues, setting standards, and allocating resources' (pp. 231–232; see also Evers, 2005). This article deals with this balance, focusing on both the balance between market efficiency and civil associations' inventiveness and the relationship between government regulations and the standardization and professionalization of civil associations. In *Partners in Public Service: Government–Nonprofit Relations in the Modern Welfare State*, Salamon (1996) focused on the government's increased reliance on third parties like non-profit providers in the fields of health and welfare services – what he called 'third party government'. The other side of the coin is that non-profit organizations became dependent on funds from the government and, hence, more vulnerable to shifts in policies. Yet 'less is known about the impact on agencies contracted into government. In particular, we know almost nothing about the extent to which participation in the delivery of social service programs changes the operational style and mission of non-profit agencies' (Considine, 2003, p. 64). Some 20 years after Smith and Lipsky (1995) addressed the balance between government involvement and CAs' autonomy, Pestoff addressed the same issue: 'But promoting coproduction and new governance techniques can also challenge the management of hybrid organizations, as they expose themselves to additional institutional and organizational forces and face risks of failing to balance multiple goals and/or the interests of various stakeholders' (2014,, p. 1421). In his conclusion, Pestoff put forward different hypotheses on how the possible challenges can affect CAs, and he ultimately called for more investigation into these matters. Our article contributes to the literature on the impact of the increased use of public procurement of welfare services on civil associations.

Smith and Grønbjerg (2006) identified three different models of government–non-profit relationships, with the demand and supply model being the most relevant in our case. This can be divided in two ways: a market niche model seeing civil sectors' contribution as mainly an alternative that complements government services, and a transaction model encompassing the civil associations' services as both a complementary alternative and a supplement to existing public services to increase the capacity (see also Dahlberg,

2005). The transaction model resembles our approach here. Civil sector providers are thus seen as important for identifying and covering some of the shortcomings of public welfare services. With references to the American political scientist Lester Salamon, Smith and Grønbjerg wrote that 'government funding and regulation of non-profits make it possible to plug at least some of these holes, while still allowing nonprofits to maintain distinctive goals' (2006,, p. 226). In this article, we discuss the possibility and challenges of such a two-fold approach to government regulation while maintaining distinctive goals.

The welfare mix and delivery systems vary among nation-states and among different policy fields (Smith & Grønbjerg, 2006). The gradual inclusion of new areas into the 'core tasks' of the welfare state since the Second World War has limited civil associations' role as welfare providers in Nordic countries (Stryjan & Wijkstrom, 1996). However, this has changed in recent decades. Moreover, as we shall see, these changes have had different effects in different welfare areas. We will present two theoretical perspectives to highlight these differences – one emphasising isomorphism and standardization and the other emphasising innovation.

Standardization and Isomorphism among non-profit Organizations

Neo-institutional theory provides an important perspective for understanding how 'organisational fields' are constructed and contribute to organizational changes (Scott, 1995). DiMaggio (1991) underscored that the neo-institutional approach is relevant in studies of government agencies and non-profit organizations (see also DiMaggio & Anheier, 1990). DiMaggio and Powell (1983/1991) focus on three types of mechanisms: (1) coercive isomorphism implies that organizations in an area must adapt to the structure and regulation of the key suppliers in that area (i.e., the government); (2) mimetic isomorphism implies that organizations during a period of change (technological/economic) and uncertainty (ambivalent or unclear goals) imitate what seems to be the most successful and/or legitimate organizations; and (3) normative isomorphism is based on the increased professionalization in managing organizations derived from recruiting people with the same understanding of how an organization ought to be managed. Isomorphic processes can be top-down or bottom-up.

As we highlight the relationship between government and non-profit organizations, we assume that coercive isomorphism dominates the empirical material. For example, Considine (2003) found a convergence in service delivery strategies among non-profit agencies due to government contracting regime. However, a highly institutionalized environment with a strong state, as in the Nordic social democracies, may also indicate a decoupling of activity from structures in organizations (Meyer & Rowan, 1977). It becomes more of a ritual conformity, internally and externally, where organizations 'decouple structure from activity' (p. 361).

Innovation in Welfare Services

The civil sector's role in welfare is situated in a triangle consisting of the relationships between CAs and users (i), CAs and the government (ii), and the government and users (iii). As mentioned, we focus mainly on the relationship between the government

and civil associations (ii). Government tenders with competition are a major instrument in the outsourcing of welfare services. These are replacing former agreements for welfare services with selected providers without competition and/or general support for operating within the welfare area. To discuss whether innovation is considered a possible outcome of these changes, we need to address partly *what* type of innovation and mainly *why* it takes place, especially relating to systemic features and organizational factors.

The term *social innovation* is often used to describe innovation in health and welfare areas. In social innovation, the goal is not to realize profit through new products and new markets, but to address unmet social needs by offering new services, new methods, and new forms of organising the activity (Tjønndalen, 2016, 2018). Thus, social innovation implies the adoption and implementation of changes which are new to the organization and its relevant environment (Knight, 1967), including both incremental changes in service delivery and larger changes in the content and process of welfare services.

Economic organization theory can be useful for understanding some of the reasons why sectors differ regarding their organization, involvement of civil sector organizations, and the room for and sources of innovation. Williamson (1985) argued that decisions regarding organizational mode for making transactions vary in terms of asset specificity, uncertainty, and frequency. Market solutions may be evaluated as inefficient if human and physical assets are very specialized to certain users with substantial costs bringing the services to the market. Bradach and Eccles (1989) argued that not only prices (markets) and authority (organizations), but also trust are mechanisms that coordinate economic transactions among actors. Trust is an expectation that reduces the fear that a partner may behave opportunistically and is part of the social context of transactions.

Trust may also lead to a network forming to organize the services. Thus, the manner in which the civil sector and public welfare institutions interact will probably vary due to the different welfare areas' policies, history, and traditions. When network solutions are the preferred mode, innovations may arise through the collaboration and exchange of knowledge, which is termed *collaborative innovations*. Social innovations from collaboration resemble the term *bricolage* that Garud and Karnøe (2003; originally from the French structuralist Levi-Strauss) used to emphasize that entrepreneurship is often a 'process of moving ahead on the basis of inputs of actors who possess local knowledge, but through their interactions, are able to gradually transform emerging paths to higher degrees of functionality' (p. 296). Even if structures are embedded in the services, they also open up possibilities because they are, at least partly, created by the actors themselves: 'embedding structures do not simply generate constraints on agency but, instead, provide a platform for the unfolding of entrepreneurial activities' (Garud et al., 2005, pp. 962–963). Being part of institutional fields does not, as argued earlier, imply just constraints, repetitions, and isomorphism, but also the possibility to alter the rules and regulations – what is termed *institutional entrepreneurship*.

Methods

We conducted 26 interviews with people from the welfare provider side (18) and the governmental side (8) in two welfare areas: SUD treatment (17) and vocational rehabilitation (9). These form the main empirical basis for this article. The interviews were divided

equally between the two authors. We developed two semi-structured guides for these interviews: one for interviewees from the government and one for interviewees from non-profit organizations. Along with the guides, we wrote a letter of consent for the informants with information regarding the content and goal of the study. We contacted the manager of the division/organization or, based on our existing knowledge, the one who seemed to be the most relevant informant for our study and requested an interview. The main part of the interviews was carried out in 2016. Each interview lasted between 60 and 90 min and was recorded and transcribed. The National Data Protection Official for Research (NSD) was notified of the study.

The governmental system included the regional and local levels. Among the non-profit organizations we considered the size and history of the organization, which means we included both newcomers and more traditional organizations as well as larger and smaller organizations. We also sought a variety of value orientations, whether religious, philanthropic, or social-political. The interviews took place in two larger municipalities (and their surrounding areas), with approximately the same number of interviews conducted in each area. We selected two geographical areas as cases for partly pragmatic reasons. In addition, it gave us the possibility to obtain information from both sides inside the same welfare area in a distinct regional area.

This study is part of a larger project that includes two other work packages in addition to the one focusing on civil sector providers. As a part of this larger project, we carried out an analysis of important milestones in the public policies in the two welfare areas in question for the last 40 years (1970–2010) and of the relevant public documents connected to these milestones (see Uhre & Rommetvedt, 2019). This information is included in the analysis in this article, especially in the part on institutional constraints.

Substance Use Disorder Treatment

A Short Story of Institutional Constraints

Traditionally, care for alcoholics has been dominated by non-governmental and non-profit organizations, often based on religious, diaconal, and/or philanthropic ideologies. The temperance movement's prominent position is important (Bergsgard et al., 2010). Major organizations in this field (e.g., Blue Cross, Salvation Army, Kirkens Bymisjon [The Church City Mission]) have been modernized and professionalized and are now important actors in specialist health care for SUD treatment, while others still emphasize a Christian and diaconal profile and, thus, non-medical rehabilitation. Since the 1960s, the large-scale introduction of illegal drugs has contributed to an increased pluralism in the field. Newcomers have brought alternative approaches to substance use disorders and treatment with no Christian or temperance profile, but with a more social-political and activist ideology. Therapeutic societies and the collective movement are central here. The latest organizations in the field are user- and interest-oriented organizations (like RIO and LAR-nett) that have developed services. The development over the last century has thus gone from religious organizations with an emphasis on individual salvation and philanthropic organizations with a focus on giving aid to individuals in despair, via more collective and expressive organizations, to more social-political

movements aimed at changing society – a development also found in other welfare areas (Ravneberg, 2000).

The government's involvement increased in the 1960s and 1970s because of the introduction of new illicit drugs. The government wanted the treatment of addiction to become part of psychiatric treatment; still, it developed as a special care with varied professionalization among the actors (Ravndal, 1994). In the 1980s, regional counties were given more comprehensive responsibility in the treatment of people with a substance use disorder. With the implementation of the Drug Reform in 2004 (Ministry of Health and Care Services, 2002, 2004), this changed, and the responsibility for the treatment of people with a substance use disorder were transferred to the national health care system under the term 'interdisciplinary specialized substance use disorder treatment' (Lie & Nesvåg, 2006). As a result, people being treated for addiction were given legal rights as patients under the Specialist Health Care Act. In addition, an ideological shift in the field of SUD treatment has moved towards increased medicalization (in the use of both medicine and medical professions) with an emphasis on harm reduction, partly at the expense of total abstinence from drug use as the final goal of treatment. The reform also implied the increased use of procurement procedures (Bergsgard et al., 2010).

Increased government involvement and the 'medicalisation' of drug addiction treatment implicate standardization in a field previously occupied by a variety of actors with different levels of professionalization and medical capacity. More focus has been on specialization and professionalization among the providers. Still, in combination with the long tradition of the involvement of multiple non-profit organizations, this may also foster innovation. Specialization and professionalization imply collaboration, trust, and structures that act as a platform for entrepreneurial activities (Garud et al., 2005). This possible outcome is strengthened by the trend of de-institutionalization in the welfare area of SUD treatment. The government emphasizes shorter treatment, more use of treatment institutions located near the user, and the transfer of more of the responsibility for rehabilitation (not treatment) of people with SUD to the municipalities.

Purchasers' Views

What are SUD treatment purchasers' reflections on the different outcomes of increased procurement of services? A representative from one municipality stated that over a long period they had used a long list of specifications and quality indicators in their procurement of private services in SUD treatment:

> And then, of course we have kind of defined the needs, which target groups we should buy services for, and we say something about what we believe is right for the quality of services (…). It's quite clear and predictable what we want and what we emphasise in relation to services.

The interviewee was asked whether they saw some kind of homogenization among non-profit organizations that deliver services to the public, and the answer was yes: 'So I would assume that there would be a tendency that it becomes more and more conformed yes. Like standard programs.' The informant emphasized that the way they followed up institutions and what they required in terms of quality and performance (e.g., there

should be an individual plan) fostered standardization, saying, 'It is sort of in the nature of things.'

Standardization and homogenization were both related to the procurement of services and to the field itself:

> I used to say that SUD treatment is one of the most cemented kinds of care I know. (…) There are certainly many reasons for this, it is a very complex and difficult, and a challenging field to work in. (…) It is not so easy to be innovative in this area.

However, they included innovation as an extra criterion in the tender documents: 'So we give points for providers that can come up with innovative proposals. How to do things differently. So we've outlined what we mean by innovation and what gives points. But to be honest I have not seen (innovation yet)'. The interviewee was rather reluctant to describe the acclaimed uniqueness of the non-profit organizations and did not see much that was new in the field.

> Now we must remember that the largest idealistic (institutions) are corporations with huge revenues. The part of the corporation to which we relate is as professional as any large commercial corporation. There is no idealism and there are no volunteers there. They [the volunteers] work in other parts of the corporation.

And in relation to an ongoing competition, the interviewee continued:

> I cannot say that I have seen anything revolutionary. Something that you sort of have thought, gosh, this was extremely smart and innovative. I have not yet had that experience, but that there may have been elements that could have been very good, but so often these are elements which we know from before, and very much is about creating an intrinsic motivation … .

The interviewee still believes that 20 years with procurement and tenders in the municipality improved the quality of the services, especially as the providers with poor quality have been excluded from the competition: 'those who pulled down the average have been ousted. I have thought many times which result the 20 years have given. Then this has been my consolation.' For example, the criterion in the tendering regime that a minimum of 40% of the employees ought to have at least three years of higher education has caused professionalization and standardization of the non-profit providers.

However, an interviewee from a regional health authority answered affirmatively to the question on the possibility for innovation:

> Yes, I think there are many examples of it. Specifically, I can take R (a SUD treatment institution) as they received some extra funds from us as well, but they started to strengthen such outpatient detoxification where they went in two teams with the municipalities and directly to the doctors, so that not everyone would need a 24-hour entry for the detoxification. It is an example of a project that is innovative and fresh … .

The interviewee also described H (another SUD treatment institution) as innovative because it was the first to apply for user-controlled beds. This implies that some beds at an institution are not tied to any pre-agreement, but can be used by the person needing treatment. The interviewee argued that providers' technical demands can pave the way for such innovative initiatives.

An interviewee at another regional health authority, a large procurer of services for SUD treatment and rehabilitation from non-profit and for-profit organizations,

confirmed that there was an opening for flexible solutions and that it was included in the tendering regime:

> Yes, at least when we have acquired, we have made clear demands that you should take care of the transitions that you will have before and after the treatment, and you must be user-oriented also. (…) Then we chose to open even more, and spend that money flexibly towards exactly ambulatory teams, and the work before and after admission because we thought it was important.

Thus, the standardization and professionalization following the drug reform and the increased use of tenders still leave room for innovation. The shift from time-limited tenders to running framework agreements, however also based on competition, which has taken place among many purchasers of services (Norwegian Labour and Welfare Administration [NAV], regional health authorities), seems to be important. As we will see, such agreements allow room for experimentation with new initiatives.

Service Providers' Experiences

According to one non-profit organization, efficiency criteria like volume and patient delivery schedules point to new activities. The most innovative activities, according to this organization, are leisure activities for users under treatment offered by a 'street-level' department run by the same organization. This combination of specialist and general care is much appreciated by the users. Another organization told us that the new activities include a stabilization unit for people between detoxification and being sent to long-term treatment. The government had demanded such specialization.

As previously mentioned, in one of our regional case areas the municipal welfare department included innovation as a criterion in the tender process. However, according to one of the non-profit organizations, this has not substantially affected the content: 'For the welfare department, in the last competition now, it was like, where innovation (was) a headline, then you should describe how to work innovative within that organisation.' It was more about describing what was done rather than presenting any new initiatives, according to this interviewee. Another organization argued the same way:

> The last tender now, the municipality had an employee who had … probably got an education in innovation so they had a long and comprehensive part on innovation. But then it was the first to describe what innovations T (the SUD treatment institution) had done in recent years and … how did that benefit the users and how it was, of course, also economic savings in it.

Yet in some cases, when the government asked for specific services, the results were new solutions, especially when there was a shift from specific and limited assignments to running framework agreements. This was, as already mentioned, the case for the regional health authorities purchasing SUD treatment from private providers in our two case regions. One organization explained that 'they have now entered into running agreements, eh … I think that's a very good thing, because then I think the dialogue will be different so you can develop things much more together.' Furthermore,

> I think when … once the agreements have been concluded, I feel that we have … have a large room within it to try out new things. So, innovations can be small things, and it may be to create a new type of conversation group or create a new project around or something that we

> think the users need. … So what our clients are concerned about is that we continue to do what we have said we are going to do, and so inside there is still quite a big room (for innovation). And I perceive that they appreciate when we … when we do new things or when we try out new things.

An interviewee from a different SUD treatment institution noted the ongoing negotiations included in a running frameworks agreement:

> However, maybe it's more with the follow-up that we have in relation to the regional health authority, because we have three meetings every year. … But it is clear that there are some crossroads. And this is a matter of professionalism. For example, like now, we are very focused on what is called mentalisation-based therapy. And it's about innovation.

Furthermore:

> Yes, it's a negotiation all the way. And it is a dialogue in a way. They (the public procurer) have a choice in a way, what they want us to deliver. They could have chosen, for example, that 'no, now we have a vacant department at the hospital after we opened DPS here'. Then they could choose to open their own department—for example, detoxification. They are free to do that.

The general picture is still that the drug reform followed by increased public procurement of services implies standardization and professionalization of the civil society organization. This is mainly seen as positive. More standard routines and regulations as well as increased use of professional employees, especially in medical professions, have brought about better services for the user. In addition, and more as a spinoff due to the more specific demands from the purchaser, new solutions occur. Nevertheless, what can be considered a distinctive character of the non-profit organization is sometimes lost in the process (e.g., the visible technology of the organization has eroded).

Vocational Rehabilitation

A Short Story of Institutional Constraints

In the early 1990s, there was an increase in the unemployment rate, absenteeism because of sickness, and people in rehabilitation. This resulted in 'the working line' as the dominant ideology in welfare policy. 'The working line' was not a new premise for welfare policy; however, the increase in expenditures and reduced income established it as a principle. Work should be the ultimate goal of labour market policy, on both an individual and system level. A tightening of the right to benefits and an emphasis on active vocational measures were the result. It also highlighted the need for strengthening the cooperation among government-supporting regimes, social benefits, social security, and vocational rehabilitation. In the 1990s, several governmental initiatives were taken, and the process concluded with the NAV reform in 2005 (Ministry of Labour and Social Affairs, 2002, 2004). The NAV reform with the establishment of the new NAV was in large part an organizational reform in which three separate public directorates, at both the central and local levels, merged to form one large organization. The objective was to give more comprehensive and coherent support and activity to its users.

Vocational rehabilitation has been dominated by governmental and semi-governmental actors (e.g., municipality-owned corporations, inter-municipality corporations, corporations owned both by municipalities and private actors). The NAV reform,

especially the reform of content following the administrative reform, implies new and standardized vocational programs open to more private contributions (Ministry of Labour and Social Affairs, 2006). In addition, the new ECC regulation on public procurement led to a shift from the use of preapproved institutions with regular contracts (i.e., sheltered workshops with a nearby monopoly in providing a large part of the services related to vocational rehabilitation) to tender-based regimes with more specification and time-limited support (maximum of four years). This situation created opportunities for new actors who emphasize values (human or religious) or alternative methods (e.g., cognitive psychology, empowerment). They are, however, also subject to central government regulations, local requirements and specifications, and – not least – local attitudes among the NAV employees (street-level bureaucrats, cf. Møller & Sannes, 2009). The result is increased efforts to include users in ordinary business on the one hand and, in qualifying new providers and projects, new actors who adapt to the standards of the traditional providers on the other.

Purchasers' Views

An interviewee from NAV in one of the municipalities argued that the increased focus on open tenders in public procurement during the last decade had brought more non-profit organizations into the field of vocational rehabilitation. This NAV representative added that the private providers were good at keeping up to date professionally, where new concepts and methods were always emerging. At the same time, the interviewee was rather sceptical, asking rhetorically, 'Is it new or just the emperor's new clothes?' The interviewee also noted limitations with the requirements specification: 'During the contract period you cannot make major changes in the contract. This hampers innovative thinking.'

The supposed uniqueness of each of the suppliers was also questioned. One interviewee commented in relation to social entrepreneurship among the civil actors:

> And to put it a little flippantly, so social entrepreneurship, it's a customisable diffused word. Also, you have very many players in our field that are relatively similar; some call themselves social entrepreneurs, some do not, but they do essentially the same. However, all have in common that they think that they are distinct then.

The interviewee also stated that, in relation to a large bidding process, 'it is very often the same tools that recur, the same methodology, and then one solves some things a little differently'. One reason for this similarity seems to be related to the movement of personnel between the different providers as they are either idealistic or commercial:

> And this is interesting, because we see that between the commercial and non-profit, depending on contracts, that to some degree one talks about the specific nature of their organisation. However, it's not unusual that we meet again [the same] operational people in another specific organisation, or a third, or a fourth. So it's sort of engagement as such one moves around and brings [ideas] with them.

All in all, the interviewees did not identify huge differences between civil and commercial actors. In response to a direct question about the possible added value of using idealistic and/or voluntary actors compared to commercial ones, one interviewee said: 'We cannot find that. No, we experience that there is a huge commitment to users from all these

suppliers, really.' The dominant view seemed to be that the tender regime to just a minor degree implies new actors with new angles on how to work with vocational rehabilitation. However, non-profit organizations have some leeway, especially when addressing the individual needs of the users and/or in cooperation with the 'ordinary' work life, establishing working opportunities for users.

Service Providers' Experiences

As we have seen, government policies have shifted from a stable supply structure to increased competition in vocational rehabilitation, leading to a more varied supply structure. Larger commercial actors operating nationwide are entering the market. To compete and survive, the non-profit organizations have not only changed their activities, but also directed their attention to how to complete applications and how to market/profile themselves differently. As one of the providers remarked about process innovation, 'it is indeed the tender processes we have had, then (a part of the) innovation is teamwork to make a good offer'.

An interviewee from a civil provider of vocational rehabilitation offered this reply to a question about the increased use of open tenders: 'I want to believe it has sharpened the sector. So, we have had to think again, we have had to develop and we have had to work smarter to be part of the competition.' Another informant reflected on this in the same manner. The increased use of tender processes was positive in the way that they really had to present good solutions. However, they added that the uncertainty was frustrating:

> There can be a lot of good development in it. The good thing about it is that we really need to reset ourselves and think about everything we do and describe why we do it and think about it. The best way to do it. So there's an improvement in it then, as I think it's quite healthy and good. Of course, it's terribly frightening, because you have 25 employees, and when you wonder if there's any work to go to, maybe just a few weeks, having families, etc. … So there is nothing funny about the uncertainty it implies.

The same interviewee insisted that, when the framework agreement with NAV was in place, there was some leeway to come up with new initiatives:

> Yes, on a daily basis, we see that NAV is very excited if we can, and in cooperation with them, be able to further develop and renew and improve the measure. We have follow-up meetings with them at least twice a year, where we keep each other informed and talk about issues and what can we do to further improve measures.

Still, not everyone is convinced that competition fosters new and better solutions. One interviewee, from a new actor in the field of vocational training, argued the opposite: 'I think we would have been much more creative if we had been able to try things out.' For them it was their new ideology, reflected in the name of the project, that caused problems for some of the public purchasers of services. When asked if NAV, the key supplier, included innovation as an asset in its procurements, this interviewee said:

> Absolutely not. Nothing, no, it does not sound familiar. No, it should be as it is. We have some suggestions along the way and we do things differently. … If there is something we do that they do not recognise from the contract, then we need to talk about it. It is quite detailed what to do when.

According to this interviewee, the potential for innovation was more connected to their relationship to the employers and the labour market than to NAV. Another provider highlighted the importance of the relationship to the labour market, indicating that this implied local solutions inside a quite standardized regime from NAV. The interviewee contended that this standardization was mostly a good thing that different providers had requested. However, the changes in government policies are rather novel. The following quote sums up this section:

> I wonder if the vocational rehabilitation business may be in a kind of pupa stage, where you have gone from a larva and then you become a butterfly. So, we get a very big change now in the vocational rehabilitation business, where things get very nice at the beginning, and then we will see for after a while. I do not know how long butterflies live.

Discussion

In this article we have reviewed the historical policy processes and institutional constraints in distinct welfare areas (dimension (iii) in the triangle) and, to a minor degree, the relationship between the providers and the users (i.e., dimension (i)). Still, the relationship between the government as a purchaser and the civil associations as providers of welfare services has been emphasized (i.e., dimension (ii)). The systemic level is at the core of our study, especially the shift from fixed agreement to increased use of open tenders in the procurement of welfare services. This shift has affected the providers of these services in a variety of ways. It is clear that the focus on economic criteria in the tender process in some ways feels constraining for the civil associations that offer SUD treatment and vocational rehabilitation. It influences both the way one works with tenders and the content of the tender. This resembles what DiMaggio and Powell (1983/1991) called coercive isomorphism. Still, some argue that being pushed to concentrate on efficiency and economy can be 'good and healthy' because it requires thinking in a different way and coming up with new and hopefully better solutions. In these cases, it seems that the professionalization of the administrative routines and the innovation of the measures offered go hand in hand. The drawback is the insecurity regarding a stable income that follows the increased use of open tenders. Thus, as will be argued here, there is a dual tendency in the empirical material, indicating that open tenders are valued positively or negatively partly for the same reasons.

These tendencies are influenced by the different historical traits of the two welfare areas in question. The area of SUD treatment has gone from a pluralistic field with different providers of treatment and rehabilitation to a more standardized field due to both the 'medicalisation' of SUD treatment and the increased use of open tenders. The services are professionalized and specialized and are included in the chain for the treatment for drug addiction. Specialization affects different phases in this treatment, like detoxification, outpatient treatment, ambulatory approach, and short- and long-term treatment. Furthermore, the services are diversified in relation to the patient's medical diagnosis and symptoms. The model is one of collaboration in which non-profit organizations divide the labour with public institutions (Bergsgard et al., 2010). Different providers treat users in different positions and with different needs in the treatment chain, and various organizations specialize in different tasks and target groups. To a certain

degree this can be interpreted as a specialized network organization based on each organization's capabilities and resources. Non-profit organizations act as both embedded agencies in the organizational field and institutional entrepreneurs co-creating the structure of the field (Garud et al., 2005; Garud & Karnøe, 2003). Collaborative, social innovations may be the result.

However, even if we can talk about the non-profit organizations in the field of SUD treatment as specialized organizations that partly operate in networks with other similar organizations, they also compete in many ways. They relate to the same key supplier for resources and follow the same regulations regarding tender procedures. Thus, increased specialization in a network can foster innovative solutions, yet organizations in the same field relating to the same key suppliers are exposed to isomorphism. Increased insecurity due to competition among the organizations may also lead to a mimetic process in which the organizational structure is adapted to what is perceived to be the most legitimate and successful way to organize such services. Evers (2005, p. 745) pointed to some of the same processes when he highlighted that 'the present shifts in welfare mixes and hybridization processes are not the outcome of strategic choices but, rather, of coping strategies of actors and organizations under conditions of uncertainty'. Competition creates uncertainty that is again followed by an adaption of the legitimate organizational structure. In addition, the circulation of personnel among different civil associations underscores these tendencies in what is termed normative isomorphism (DiMaggio & Powell, 1983/1991).

In the area of vocational rehabilitation, the increased use of tenders has implied a standardization, albeit with the result that a relatively closed sector has opened up. Government policies have shifted from a stable supply structure to increased competition, which has led to a varied supply structure. The government introduced a tender regime with substantial changes in policy objectives and demands. Municipally owned and rather independent organizations and some non-profit organizations previously operated in this area, but now larger commercial actors operating nationwide are entering the market. To compete and survive, non-profit providers not only change their activity offers, but also direct their attention to how to make applications and how to market/profile themselves differently. In contrast to the field of SUD treatment, where the specificity of the users, the variation, and uncertainty regarding the condition for the substance user requires *trust and collaboration*, which serves as the platform for innovation, we find that the field of vocational rehabilitation has *structured tender regime and competition* that sometimes foster innovation (see Bradach & Eccles, 1989; Williamson, 1985)

To understand sectoral differences, economic organization theories as discussed in our theoretical section give partial explanations, as shown in Table 1.

Coercive (linked to policy changes and tender regime), mimetic (linked to the uncertainty due to open tenders and the tendency to mimic the legitimate organizational structure and form), and normative (linked to competences of the employees) isomorphic forces come into play. There seems to be an imbalance for the benefit of standardization and professionalization at the expense of the uniqueness of CAs in the two fields in question.

That being said, some innovation does take place. Increased regulations and efficiency criteria sometimes imply the need for other and new solutions – solutions that can be presented as innovations. In addition, organizations with idiosyncratic resources like

Table 1. Different institutional conditions for various outcomes in two welfare areas.

	Coordination/ control mechanisms and the role of civil sector	Increased professionalization	Pressure for standardization	Basis for innovation
SUD treatment	Part of network organization and a collaborative patient care pathway based on trust.	Based on increased use of tendering regimes and medicalization	Based on professionalization, resource dependency, and competition	Based on trust, collaboration, new organizational structures, and capabilities in organization
Vocational rehabilitation	Market structure ruled by price mechanism.	Based on actions for enhanced delivery effectiveness and efficiency	Based on extensive public procurement with strict regulated tenders and large commercial actors as ideal	Towards innovative solutions caused by price pressure and policy change

user closeness and knowledge at the street level can be the basis of inventions and new activities. These resources are complementary to public sector resources. Still, none of the purchasers we interviewed indicated that they had found genuinely new and revolutionary innovative solutions among the civil sector providers.

Changes happen, and new ways of doing things do appear, but the paths leading to these outcomes are various and differ between the two selected areas. Complementarity between the public and civil sectors, and among providers within the civil sector, often results in a kind of treatment chain. Local knowledge, incremental changes, and collaboration resemble what Garud and Karnøe (2003) termed the bricolage innovative processes. This seems especially the case in the area of SUD treatment.

Conclusion

How should we conclude this discussion in relation to our research questions? The vague and unsatisfactory answer to the first question is that the increased use of public procurement has both professionalized and standardized non-profit organizations while also providing room for innovations, according to our informants. Thus, one important finding in our material is a kind of dual process, where organizations become more alike in structure, administration and to some degree in treatment, while also becoming more specialized and in some cases arriving at new and innovative solutions regarding content. However, these new solutions are – at least in the eyes of the purchasers – not revolutionary innovations in treatment and rehabilitation. In this sense, they may be called 'minor incremental social innovations' addressing unmet welfare needs via smaller changes in organising the activity, introducing new and knowledge-based methods, and establishing a few new measures in combination with the larger package of treatment and rehabilitation measures.

Increased professionalization and standardization are often seen as positive, especially in the area of SUD treatment that was earlier hallmarked by a large variety of different treatment and rehabilitation regimes relying more on religious or normative convictions than evidence-based practices. Furthermore, it is fair to say that innovativeness is more dependent on the resource capabilities of the providers, collaboration and embedded structures in the area of SUD treatment, and the content and regulations of the public tendering regime in the area of vocational rehabilitation.

Lastly, we have seen that the balance between government regulations and market competition, and the distinctiveness and uniqueness of CAs, has tipped in favour of professionalization and standardization. Still, CAs as welfare providers acts not just as supplement to the government's welfare services, but are also complementary plugging some of the holes of these services.

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