Reprofessionalisation through management control: Client focus, coherence and cooperation

Niklas Wällstedt
Stockholm University School of Business

INTRODUCTION

This paper contributes to the debate regarding how management accounting and administrative techniques are adopted by public sector professionals (cf. Blomgren, 2003; Jacobs, 2005; Kurunmäki, 2004; Kurunmäki and Miller, 2006; Skaerbaek and Thorbjørnsen, 2007). Debate participants have discussed and explained, among other things, the willing adoption of these techniques by a whole profession in certain countries (Kurunmäki, 2004) and by certain groups within this profession (Jacobs, 2005), identity problems stemming from the adoption of the techniques by professionals aspiring to become managers (Skaerbaek and Thorbjørnsen, 2007), and the ordering of nursing professionals into administrative and caring expertise (Blomgren, 2003) through the introduction of new administrative routines. These papers are all interested in investigating how professionals in medicine, nursing, and the military come to use (or not use) management accounting and administrative technologies and how this might affect the profession, based on a perspective from within the profession. Such studies coincide with the view of professions as enclosures that pose a threat to effective public sector management control (Lapsley, 2008 and 2009). However, as professionalism has increasingly come to be seen as an organisational issue (Evetts, 2006), the effects of management control on professionalism and professionalisation need to be researched at the organisational level. This paper thus argues that, to further our understanding of how management accounting and administrative techniques affect the daily work of public sector
employees, the issue needs to be approached on the organisational level through a study of both the ‘manager’ and the ‘managed’.

At the organisational level, management accounting and administration techniques comprise a part of an organisation’s management control system (MCS) and their effects on organisational members have thus been more thoroughly discussed in the MCS literature. The MCS is seen to affect organisational outcomes through the behaviour of organisational members, depending on how the MCS’ subsystems are configured (Malmi and Brown, 2008). At the same time, however, an MCS is composed of not only subsystems and administrative and accounting technologies/techniques (Kurunmäki, 2004) but also rules and routines (Burns and Scapens, 2000) based on ideas and rationales regarding the ends to be achieved and means to be used (Broadbent and Laughlin, 2009; Kurunmäki et al., 2011; Rose and Miller, 1992). These MCS elements (ideas, systems, techniques/technologies, and rules and routines) form assemblages (Rose and Miller, 1992) in the organisation together with, for example, professional groups (cf. Kurunmäki, 2004; Kurunmäki and Miller, 2011) and interact with the ideas and aspirations of more or less powerful individuals (Powell and Colyvas, 2008). The MCS elements may thus not only affect organisational members in accordance with the stipulated means and ends and underlying rationales but may also be used as a common resource and language (Ahrens and Chapman, 2007; Conrad and Guven Uslu, 2011), helping the groups in the organisation cooperate (Kurunmäki and Miller, 2011; Reay and Hinings, 2009) and relate their own ideals to the means and ends of the MCS elements, revealing contradictions (Seo and Creed, 2002) and coherences (Nørreklit et al., 2010) between them.

This means that in daily practice, professionals’ values and norms meet with the social and accounting norms and facts (Nørreklit et al., 2010) of the organisation’s MCS. How these
facts are disposed and understood show the possibilities professionals have to conduct their work, either by going along with or against professional values and providing for more or less reflexive or routinised work. Hence, management accounting and administrative techniques may lead to deprofessionalisation by the routinisation of professional tasks (Abbott, 1988) or by making professional values subordinate to financial and administrative ones (Adcroft and Willis, 2005). This paper aims to examine the process of reprofessionalisation, where professional values are strengthened and work becomes more reflexive, in contrast to deprofessionalisation. Reprofessionalisation occurs alongside hybridisation (Kurunmäki, 2004), polarisation (Jacobs, 2005), and the ordering of individuals within a profession (Blomgren, 2003) and is strongly connected to these processes, as ordered and hybridised professionals cooperate. In contrast to earlier studies, however, this one was conducted in a municipal elderly care organisation, where the professions may be regarded as ‘weaker’ and more open as it is an important context in its own right, but also to discuss whether such a process may also occur in contexts where professions are ‘stronger’ and more closed. This relative openness is helpful in discovering how organisational management control affects the daily work of public sector workers from a professional perspective.

THEORETICAL FRAMEWORK

The elderly care setting researched here could best be described as one of social work, a profession that is diverse, value driven (Hugman, 1996), open, and highly respectful of experiential knowledge (Healy and Meagher, 2004). Classic professionalism would argue that social work is not historically grounded as a profession (Neal and Morgan, 2000). Moreover, its willingness to incorporate diverse occupational groups within its borders, its application in different cultures and resultant difficulty in forming a coherent body of abstract knowledge make it difficult for social workers to claim a jurisdiction (Abbott, 1988) and thus appeal to the status of ‘profession’ (Hugman, 1996; Healy and Meagher, 2004). According to Evetts
(2003, p. 397), however, ‘it no longer seems important to draw a hard definition between
professions and other occupations but, instead, to regard both as similar social forms which
share common characteristics’. One of the main reasons for this is that professions, like
occupations, are increasingly subject to the logic of the organisation (Evetts, 2006 and 2011).
Questions regarding professional learning, appropriate professional conduct, professional
autonomy, and who the professional is working for are decided in the organisations that
employ the professionals (Jonnegård, 2008). Professionalism is demanded of everyone
(Fournier, 1999) and ‘[i]n return for professionalism in client relations, some professionals are
rewarded with authority, privileged rewards, and high status’ (Evetts, 2006, p. 134). Increased
professionalisation may thus not always be rewarded with professional status.

Professionalisation may therefore be conceptualised as a change in the characteristics of the
work conducted by workers in the organisation, a change that could be described in both state
and directional terms. Professionalisation in state terms would mean that workers are
becoming more professional; reprofessionalisation would thus refer to a return to a state of
professionalism. In directional terms, reprofessionalisation refers to a redirection in workers’
tasks and a change in the centre of the professional efforts. According to Jonnegård (2008),
the client and the common good have lately been replaced by the well-being of the
organisation as the centre of professional efforts. A redirection towards the client’s well-being
would thus be interpreted as a kind of reprofessionalisation. As mentioned above,
reprofessionalisation is also contrary to deprofessionalisation, that is, the loss of professional
values (Adcroft and Willis, 2005) and the routinisation of tasks (Abbott, 1988). Therefore,
reprofessionalisation is concerned with strengthening values that may have been endangered
and increasing reflexiveness where task routinisation may seem imminent. According to
Evetts (2011, p. 415), ‘organizational techniques for controlling employees have affected the
work of practitioners in professional organizations’ in ways that may spur
deprofessionalisation. To, instead, argue a case of reprofessionalisation, this paper studies the
work conducted in the case organisation, how the organisational members reflect upon their
tasks and values, and how the organisation’s MCS affects them. Hence, this paper contributes
to literature on both professions and management control.

Although public sector performance management and management control are usually
researched through institutional theory (Modell, 2004 and 2009), the present paper broadens
the scope by introducing the pragmatic constructivist view of Nørrekilit et al. (2010). This is
attempted, first, because of the case’s array of techniques, logics, and routines: although facts
may stem from field level logics (see, for example, the case of quality indicators stemming
from the logic of consumerism in Østergren, 2006), organisational members encounter the
facts rather than the underlying logic and must make sense of it and use it. Hence, using the
pragmatic constructivist concepts of professional values, social and accounting facts, and
possibilities may prove more fruitful than attempting to identify specific logics and their
origin and then connect them to accounting and administrative techniques. Second,
institutional theory emphasises institutional contradictions as the origin of micro-level change,
whereby such contradictions as between, for example, the professional logic of qualitative
care and indications of inefficiencies derived from a performance measurement system may
be followed by mobilising actors into collective praxis (Seo and Creed, 2002). The issue of
reprofessionalisation, on the other hand, is more closely related to coherence than to
contradiction, which makes the Nørrekilit et al. (2010) framework a more suitable analytical
base for this study, since coherence is one of the main components of their pragmatic
constructivist model. Nevertheless, if reprofessionalisation implies stable changes in
professional logic (Reay and Hinings, 2009), that is, ‘the taken-for-granted rules guiding
behaviour’ (p. 629) of the professions in the case, the pragmatic constructivist model may
shed additional light upon how praxis emerges within the institutional framework.

It would also be possible, however, to start from institutional theory and the assumption that
the origin of institutional conflicts (Seo and Creed, 2002) often begins with the revelation of
new facts such as accounting figures (Nørreklit et al., 2010) or new or contradictory rules or
routines (Burns and Scapens, 2000). For Nørreklit et al. (2010), these new facts, rules, or
routines would open up new possibilities for action within an organisation. How this action
would ensue would depend, however, on the actors’ professional and individual values.
Recalling the notion of professional knowledge (Abbott, 1988), the course of action will
depend on the possibilities, which, in turn, will depend on the observation of facts,
knowledgeable logical reasoning that connects the facts to the possibilities, and values of the
actors (Nørreklit et al., 2010). To act, an actor needs to understand what can be done
(according to the facts) and be willing to do it (according to his/her values). Different
professionals may have different understandings of what can be done pursuant to the same
facts but also have different values of what is appropriate.

Samuel et al. (2005) offer a telling example of how the construction of new facts opens up
new possibilities by which the accounting profession may advance into the medical care
industry. Thanks to engineers’ reconstruction of healthcare into products, so-called
diagnostic-related groups, these factualised products enable accountants to use their
professional skills in cost accounting. Although medical experts’ values and abstract
knowledge made it impossible to turn healthcare into a business, the construction of new facts
and accountants’ professional knowledge and values made this possible. Although
institutional changes and the emerging market economy discourse were enabling the
construction of new facts, those new facts made possible praxis changes that probably quickened institutional change. Besides the recursiveness between institutional arrangements and praxis, Samuel et al. (2005) show how the work of one profession may affect that of two others, opening up possibilities for one without closing them for the other. Medical professionals could have used these new possibilities but they were inhibited by their professional values.

Neglecting to take maximum advantage of new possibilities may not only be a matter of values but may also indicate a problem with the communication relating to the new facts. Through hybridisation (Kurunmäki, 2004), professionals such as doctors become able to use accounting techniques, which leads them to becoming proficient in using the common accounting language (cf. Hall, 2010). A hybridised professional would thus be able to understand the facts communicated through accounting and professional languages and thus spot new possibilities, whereas non-hybridised members of a polarised profession (Jacobs, 2005) would not have learned the accounting language and would thus fail to spot all the new possibilities. However, learning the accounting language seems more important to those aspiring to hold managerial positions (Jacobs, 2005; Skaerbaek and Thorbjørnsen, 2007) than to those pursuing a career closer to the core of the profession. These latter professionals may have problems visualising their work through accounting, while hybrid professionals may excel at doing so (Kurunmäki and Miller, 2006); this makes it important for non-hybridised professionals to visualise their work in other ways. Swedish nurses pursuing a career as caring experts solved this problem by extensively documenting their daily work through their own professional language rather than accounting language. This strengthened their professional position and identity by ‘putting their thoughts into words’, highlighting their professional efforts to themselves and to others (Blomgren, 2003).
These mechanisms of visualisation and communication may also be found in an organisation’s MCS. For some professionals, certain MCS elements or facts together with other facts may open up new possibilities, because these professionals are accustomed to communicating and reasoning about these facts. If the professionals also have professional and individual values that allow them to act upon the possibilities, they may do so; however, they may fail to see other types of facts and underestimate possibilities because they are not accustomed to reasoning in those terms and are inhibited by professional and personal values. However, the facts of the organisation’s MCS may enable the professionals to work according to their own knowledge and values and collaborate on certain issues while maintaining their professional standards. According to Nørreklit et al. (2010), coherence among values, facts, possibilities, and communication is paramount if action is to occur.

The empirical and analysis sections will show more in detail how such coherency is developed, how related matters occur, and the consequence wherein each studied profession is more involved in ensuring financial efficiency, although in different ways and for different reasons. The paper will also show how the possibilities found by professional actors relate to other professional actors and how coherencies among values, facts, techniques, routines, and logics are exploited and skilfully constructed by actors to employ the possibilities embedded in the MCS. This provides further evidence of changes in the public sector, which have previously been examined with a focus on the medical profession, in which doctors and nurses have started to use administrative and accounting techniques (Blomgren, 2003; Jacobs, 2005; Kurunmäki, 2004) making them, at least somewhat, administrators and/or managers. In some of these studies, professionals went from performing one task to another while continuing to perform their original tasks; other studies seem to indicate a differentiation
between those who adopted the new techniques and those who did not. In the less professionalised environment of the studied case, this mobilisation and redirection of effort from one task to another and the adoption or non-adoption of administrative and accounting techniques can be followed by studying how the actors identify new facts and possibilities and attempt to exploit them through cooperation and argumentation.

Since conducting professional tasks and the way the work is related to these tasks are at the heart of these studies, it is important to distinguish among the many tasks conducted in a public sector service organisation like elderly care. Furthermore, it is important to establish the connection between professional tasks and an organisation’s MCS. To support efficiency, the new public management-based MCS has focused on performance measurement to make work in the public sector transparent (Blomgren and Sahlin, 2007), auditable, and easy to follow up (cf. Lapsley, 2009; Power, 1997). Moreover, MCS scholars (e.g. Ferreira and Otley, 2009; Malmi and Brown, 2008; Otley, 1999) have emphasised performance targets, both financial and non-financial, and the evaluation of performance against these targets. According to Vedung (2010, p. 263), ‘the evaluation business has exploded’ in the public sector since the 1990s with an emphasis on evaluating output and on stakeholder evaluations and self-assessments. Thus, it can be argued that a rough theoretical distinction be made between the fundamental tasks of ‘conducting’ and ‘evaluating’, in terms of both service quality and financial efficiency. This is a distinction drawn from the perspective of performance measurement and management control, but there is no reason why this distinction cannot be made more generally, as professionals have their own ways of evaluating work quality (Abbott, 1988). In elderly care, not only qualitative care but also effective financial management must be conducted and evaluated; the MCS should be supportive of all these tasks. Figure 1 describes the typology of the four fundamental tasks.
Members of the organisation are employed to perform one or more of the tasks in Figure 1, depending on their professional function. Similarly, MCS elements control the performance of one or more of the tasks. Customer satisfaction measures evaluate service quality from a stakeholder perspective (Vedung, 2010), whereas a resource planning system facilitates financial management (i.e. conducting financial efficiency). The issue of reprofessionalisation is closely connected to a profession’s tasks, both directly and indirectly, as a profession’s work may be exploited by other professions. Thus, the redirection of efforts towards other fundamental tasks by a professional group needs to be discussed in relation to the interests behind the redirection and how the redirection may affect the values and routines of the professionals who are changing their daily work. The paper’s empirical section will examine three key organisational functions, whereas the analysis will attempt to relate these and the most important MCS elements to the four fundamental task areas, thereby showing how the MCS elements interact with the organisational members to reprofessionalise them in directional terms. Together with an analysis of professional changes in state terms, a complete case of reprofessionalisation will be argued.

EMPIRICAL SETTING, SAMPLE, AND METHOD

The case organisation, the city of Stockholm, is a big Swedish city with approximately 35,000 employees and a total budget of approximately 40 billion SEK. Elderly care accounts for approximately 16% of the total budget and approximately 20% of the city’s total workforce. Since it is a significant part of the financial responsibilities of a Swedish municipality and its connection to both caring and social work expertise, elderly care is a relevant object of study.
In Stockholm, elderly care is the responsibility of the district committees and is thus decentralised. The district committees may organise their administration as they wish, making each district somewhat different. They are, however, subordinate to the city council and its directions regarding governance and control. Most MCS features are thus common across all 14 districts. The districts are the organisational entities researched in this study.

The study follows the city’s MCS as it is implemented in elderly care. It also follows three key functions that employ more or less professionalised groups: the service provider units (home help-units and nursing homes), purchaser units, and controller. The analysis emphasises the individual level, although with some reference to the group and organisational levels. Only the in-house provider units are researched here: the purchaser and the providers are a part of the same district budget, as the in-house units are the district’s responsibility.

MCS elements of the city

The city council considers the city to be divided into two hierarchical levels: the city council level (central administration) and the district committee level (subordinate level). In practice, however, another organisational level exists: the unit level. The districts have to organise their elderly care into purchasers and providers; the purchaser belongs to the administration, and the provider can be either in-house units belonging to the administration or private units run by entrepreneurs or larger firms specialising in elderly care. The city council has special rules for allocating resources to the provider units to ensure that neither in-house nor private units gain a competitive advantage. This part of the MCS is important as it affects both in-house and private provider units, whereas other parts affect them somewhat distinctively. Therefore, to gain research consistency, only in-house units have been researched, and the elaboration

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1 There are also special committees on the subordinate level, concerned with more specialised issues such as education, infrastructure, and environment.
around the MCS will only be made in relation to in-house units, although private providers were inevitably an issue in interviews with purchasers.

First, however, it is important to consider how resources are allocated from the city council to the district. Each district gets its share of financial resources according to the number of elderly living in the district. For every person aged between 65 and 70 years in the district, the district receives relatively little money, as the chance that many will need care is low. The amount increases for older citizens on a price ladder. On the higher portion of the ladder, the district receives a large amount for every citizen over 95 years, as they are likely to need care. The district thus works with an annual budget.

At the same time, the allocation system within the district is different, as mentioned above. The provider units are remunerated in relation to the customers’ (i.e. the citizen entitled to care) care level, a level decided by the care assessors\(^2\) in the purchaser’s organisation. The higher the level of care assessed, the higher the remuneration. Nursing homes have three care levels with corresponding remuneration, whereas home help services have 17 care levels (see Table 1). This remuneration is the providers’ sole income by which they formulate their budget in relation to expected costs. For purchasers’ the remuneration comprises the costs that must be incurred in relation to the district’s allocated resources. This system has been operating in the home help services since eight years and in the nursing homes since three years; home help providers are therefore more used to this system.

\[\text{Insert table 1 about here}\]

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\(^2\) The care assessor is a social worker, holding an academic degree, who specialises in social work and law, especially the Social Service Act, which is the act stipulating the rights of citizens in need of social services such as elderly care.
Care assessors are required by law to assess care in accordance with citizen needs and not their budget restrictions. To maintain equality of assessments and care throughout the city, the city council has given the assessors instruments and care standards intended to maintain assessment equality regardless of the client or his/her district. When an assessor finds a citizen eligible for care (either through home help or by moving to a nursing home) and has assessed the care level required, the assessor constructs a detailed service plan for the citizen, now a ‘customer’, to which the provider must adhere. The service plan is something of an operationalisation of the care level and should cohere with the remuneration attached to the care level. The cost of executing the plan should be close to its remuneration. This will be discussed in more detail in the empirical section.

On the provider side, the citizen becomes the customer of a certain unit by choice (which will be discussed subsequently), bringing a remuneration in accordance with the assessed level and requirements in the form of a detailed service plan. The provider must execute the plan, but for a cost lower than the remuneration to maintain financial efficiency. To convince the purchaser that everything has been conducted according to plan, the provider needs to document its activities in a database open to both the purchaser and provider and to the customer’s relatives.

The provider also has to adhere to elements not specified in the service plans. The city council provides overall city objectives every year and operational objectives both general and focused on certain areas, such as elderly care. Some of the objectives are quantified, including indicators relating to the operational objectives. The objectives and indicators constitute targets for the city; however, districts and units have to break them down to their own levels. For the provider units, many of the objectives and targets are reconstructed to make up the
unit’s quality commitments (the quality stipulated by the unit to meet customers’ and their relatives’ expectations). For the city, the units document these commitments in a web-based system, together with a plan for accomplishing them and developing the quality of their quality commitments. Similarly, the units need to specify target levels for the quantified indicators in the web-based systems. In their year-end report, units report to the district administrations on how their targets have been met, which is, in turn, reported to city council.

The accomplishment of quality commitments is reported back to the district committee, as they are based on their objectives and targets; however, this is not considered the only or most important way of internally evaluating quality. Instead, the city conducts an annual customer satisfaction survey to shed light on how well the provider units have succeeded in their quest for quality service. The results are published on the city’s web page, specifying the levels of satisfaction acquired by each unit-level providers by service areas. The publication of the customer satisfaction survey results, together with the quality commitments that each unit has to formulate for their customers, is intended to form the decision base for customers and their relatives when selecting a service provider. When asked for advice regarding the choice of provider, assessors may refer only to the survey results and quality commitments, as they are supposed to be impartial.

_Actors and their involvements_

In addition to the above-mentioned elements, a number of actors have been identified. On the purchaser side, the assessor manager and the care assessor have been identified as important organisational members. On the provider side, the unit manager, coordinator, and care giver (home help in the home help service or assistant nurse in a nursing home) are the key members. As the units studied here are in-house, they formally belong to the district
administration; therefore, the administration’s manager of elderly care is also ultimately responsible for the provider units. Some elderly care managers were interviewed; however, they were considered less important to this study and were thus left out of the account. Most of the studied districts placed financial governance onto the same controller for both the purchasers’ and providers’ budgets. Other important actors comprise the elderly citizens/customers and their relatives.

The role of the care assessor on the purchaser side has been described. The purchaser side usually has an assessor manager (although this is not obliged) responsible for the purchaser budget and care assessors to conduct their function according to the stipulated standards. On the provider side, the unit manager, often a former nurse or social worker, is responsible for service quality and financial management, and care givers provide care. Coordinators link the unit managers to the care givers and often also work in practical care or occasionally even financial management. In terms of financial management, the controller assists both the assessor and provider unit managers. Each month, the controller (and sometimes the elderly care manager) conducts budget meetings with each unit manager to discuss the budgets and financial management.

Elderly citizens eligible for care are regarded as customers. They are important actors, as they embody the commitment of both purchasers and providers; without them, elderly care would not exist. As mentioned, they are free to choose their provider, and the chosen provider is obliged to provide the care stipulated in the service plan. The only exception is if a nursing home is full; in this case, the customer must wait for a vacancy or choose another home. The district, however, will have to provide the assessed care in the long term, irrespective of how full their nursing homes may be. Many customers have problems choosing and looking after
themselves, making relatives important actors, as they often have significant power in deciding and holding providers accountable for not adhering to their quality commitments.

**Sample and method**

The data were collected by studying budget documents of all 14 district councils/administrations in the city and the quality commitments of 55 units, and through 27 interviews with organisational members in five of these districts and key officials responsible for the city budget, including the organisational members described above (except customers and relatives). In many of the interviews, the researcher had the opportunity to examine the administrative system that the respondent was working with while the respondent explained how he/she used to work with it. In other interviews, operational documents were studied with the respondent. Meetings between provider and controller and provider-unit meetings between provider manager and care givers were attended. The researcher also attended a care assessor conference to gain insight into the underlying principles of care assessment.

The interview questions began generally, with question such as ‘What are you working with?’ ‘How are you working with it?’ and ‘Why are you working with it? or Why are you working with it as you do?’, followed by the same type of questions regarding communication (what they communicate, how they do it, and why). The first two questions (‘what’ and ‘how’) aimed to present a clear picture of their daily work and the ‘why’ questions aimed to produce information on the respondents’ reflexiveness and values. The general questions were supplemented with more specific questions regarding issues such as objectives, indicators, and commitments, thus forming a kind of triangulation among the formal documents stipulating what the actors should do, the actors’ own statements about what they do and how
and why they do it, and observations of their use of their systems and the meetings. This should lend sufficient validity to the paper.

The study follows the organisation’s key functions and their relation to recently introduced MCS elements. The interviews were conducted within a rather narrow time window, allowing respondents to answer questions about how they used to do things before the MCS element was introduced. The study should not be seen, however, as a before-and-after study; it instead attends to the present situation with tentative reference to how the situation was previously.

EMPIRICAL DATA

This section presents the empirical data in functional order, meaning that the three key functions are presented in the order that they are encountered by the customer. The exception is the controller, who never meets the customer; the controller will thus be accounted for last.

The purchaser side, the care assessors

The care assessor’s commission is regulated by the Social Service Act, which mandates the maintenance of a reasonable quality of life by stipulating that everyone in need of social services has the right to get them according to their need. Their need should be assessed objectively and without any consideration given to financial budget. Ideally, an individual should be equally assessed regardless of where he or she applies for care. According to the Act, the assessment starts with an application from an individual, which indicates the care required by him/her. The care assessor then maps the needs, assesses the kinds of services that the individual is eligible to receive, and finally decides the care that he/she will receive. The individual then becomes the responsibility of a service provider; however, the care assessor is obliged to follow up after a certain period.
The care assessor function has remained unchanged since approximately 20 years, beginning with the introduction of the purchaser/provider structure in the Swedish municipal sector. This function strives to balance the individual statements of care needs with the validated findings of scientific research in fields such as social work and geriatrics to support the maintenance of a reasonable quality of life. Every individual is entitled to receiving necessary care and/or help. This balance inevitably involves the systematic classification of individuals into specific groups as one of the key features of the profession. Care assessors learn during their academic training what to look for. One should note that the commission for the care assessors is to match care with needs, making the classifications a tool for matching a class of needs with a class of care. Mapping instruments have been developed and validated for this purpose through scientific research.

Stockholm’s care assessors are required to quantify their classifications, however, because of the city’s remuneration levels. Before these were introduced, care assessors merely needed to write down their assessment in care plans, which stipulated for the providers what services the customer required. The current routine is described in Figure 2. It is slightly different if the customer applies for home help or an apartment in a nursing home. If the application is for home help, the care assessor visits the customer’s home and allows him/her to describe what help is required; this is the mapping sequence of the routine in Figure 2, where the customer’s needs are the focus. The care assessor then returns to the office and assesses the services that are reasonable to be granted to the customer to enable him/her to maintain a reasonable quality of life. For example, a customer may need help getting out of bed every morning, showering twice a week, or shopping once a week. The city has developed a database with a standardised timing for each event (e.g. how long it takes to perform a standard procedure for
getting out of bed, showering, or shopping) with the help of statistical experts and occupational therapists. The database is connected to an Excel spreadsheet into which the assessor enters every event. The sheet then calculates all the events and summates the exact amount of hours of service per month. This calculation indicates a financial remuneration level from 1 to 17 (see Table 1). The care assessor then communicates the decision to the provider in a care plan, specifying all the things that the customer needs help with, and the remuneration level.

*Insert figure 2 about here*

If the customer applies for an apartment in a nursing home, the mapping is more complicated, as the customer is often in very poor health. The care assessor often needs help from a nurse to map some of the genuine medical needs. Moreover, for mapping of cognitive abilities, the care assessor requires help from someone in daily contact with the customer, for example, the provider’s assistant nurse or the former home help. The care assessor may map behaviour and daily life activities independently. Assessment is then performed through a set of validated instruments connected to a scale on which the customer receives points on issues regarding daily life activities, cognitive abilities, behaviour, and medical needs, on a scale between 1 and 24. The higher the score, the more the care that is needed. If the score is between 1 and 8, the provider receives remuneration according to remuneration level 1. If the score is between 9 and 16, the remuneration level is 2; if the score is between 17 and 24, the remuneration level is 3. Every application, assessment (including remuneration levels), and length of decision (most decisions need to be reassessed once a year) is inserted into the umbrella system forming the database and administrative system for the elderly care function. The care plans are also communicated to the provider through this system.
The interviewed care assessors and care assessor managers indicated a problem with the mapping and assessments. Each assessor attends to an average of 140 customers. Every routine takes approximately 3 hours, but only approximately 45 minutes is spent with the customer, as the rest of the time is required to assess, calculate, and write plans. Owing to the obligation to follow up on the assessment, this procedure is repeated about once a year for every customer. The care assessors however find the administration important, as it is the only way to show the connection between the individual assessment routine and the stipulations of the Social Service Act. In addition, much haggling with the providers occurs, especially when a nursing home receives a customer with remuneration level 1. The providers believe this level has been wrongly calculated and represents a financial loss for the unit. The assessors in such cases try to avoid a financial discussion and focus on their professional function, leading them to demand evidence of a greater need for care through extensive documentation. One care assessor discusses this as follows:

‘Naturally, there are quite tough negotiations sometimes because they [the providers] want the level to go up. I think there is a pressure, because as provider manager you want the staff to contribute to raise the levels. And sometimes the truthfulness [in the documentation] is difficult to relate to as they [the providers] learn, more and more, how the system works and what to say and, above all, what to write’.

Some of the interviewed care assessors have individual budgets, whereas others have ‘group’ budgets. The choice depends upon how the districts wish to proceed, but they all go through the budgets each month with the district controller either individually or in groups. The care
assessors thus know how much they have left to ‘spend’ on a customer. This should not affect their assessments, but one care assessor ironically remarked:

‘It is interesting how the level of “reasonable quality of life” drops when the district has a financial deficit and raises when it has a surplus’.

According to the assessor, the issue related above is implicit in the organisation, something of a pressure more felt than discussed, although it might sometimes be discussed in the unit meetings.

Statistics inserted in the umbrella system, where assessments from the past several years could be compared across all the districts, revealed that problems have emerged concerning the equality of assessments throughout the city. This was partially caused by the differences in the financial stress levels across the districts and the differences among the districts’ cultures. This led to an investigation and a project to develop a new mapping and assessment instrument to make assessments more equal throughout the city; the project was supported by a majority of the political parties on the city council. The former instrument was considered incompatible with the intentions of the Social Service Act, as it was used rigidly to force customers into predetermined service categories. According to the project leader in charge of developing the new instrument, the instrument is supposed to support the mapping of the individual needs of the customer and not in relation to predetermined service categories or financial restraints. The assessment part of the instrument is also supposed to enhance the professional freedom of the care assessors, enabling them to make decisions more in accordance with individual needs than existing categories. Paradoxically, however, the care assessors find the assessment part of the instrument constraining and routinising, while
finding the mapping part of the instrument a positive contribution to their work, permitting them to use more of their professional skills.

The assessors have no problem with their new requirement to quantify their assessments. For the nursing home assessment, they use virtually the same assessment tools as they would without quantification. The home help assessment is also quite similar. The Excel sheet used to calculate remuneration levels requires little extra work. In any case, the care plan should specify, for example, how many showers a week and shopping trips the providers need to provide. The biggest problems with the remuneration levels, the care assessors and assessor managers explain, is the constant haggling with providers trying to raise the remuneration levels for their customers. This and the administration is very time consuming; one assessor even doubts that the assessment process is socially beneficial, as it is very expensive.

*The providers*

Several opinions were aired during the interviews and meetings about which administrative elements of the MCS were important for conducting high quality services. One provider unit coordinator referred to the service plans as the main document for conducting the services, whereas one unit manager assigned the greatest importance to the city’s quality objectives and the way the unit uses them to formulate their quality commitments. It is sometimes felt that the control signals come from two directions, the care assessors and the politicians; perhaps this is why some care givers are more interested in talking about the unit’s value system than their commitments or service plans. One assistant nurse said:

‘The value system and the commitments affect each other all the time. You can’t say that one or the other is more important. They go along pretty well. One of our key words in the value
system is “time” [with the elderly] and by that I don’t think it works out very well with the commitments. We don’t have the staff that we should have. We are good on values like security, but our “time” is not very good’.

The clash between formal commitments like taking the elderly on a walk everyday (a quantified commitment derived from the committee objectives) and more soft values like spending quality time in the kitchen with the elderly was debated in several units. Many commitments demand significant effort but are given low priority by the caregivers. For the unit managers, however, the commitments and their relation to the city’s objectives are among the most important MCS elements. As discussed in the case setting section, the units have to address all relevant council and committee objectives, confirm their own commitments to the objectives, and report on how these were achieved. These commitments then constitute the quality commitments of the units. One nursing home unit manager said:

‘This [the quality commitments/committee objectives] is an incredibly important document for the relatives. Relatives of today have really done their homework about the matters of quality. They look at around-the-clock manning, formal competence, activities, and service plans. How we commit to it … We have the commitments on official boards where relatives can see them together with plans for the week, etcetera’.

Another nursing home unit manager said:

‘Some objectives and indicators are not relevant for us. But we use those that are and formulate quality commitments. We try to be as specific as possible, but not too much. We
cannot write that we commit ourselves to giving every customer a shower five times a week. Because then someone will come and say “what about today?”.

The quotations above indicate how unit managers reason about the manner in which they will use the objectives from the city council and construct own quality commitments. They also highlight quality commitments and service plans as important in evaluating service quality. For the providers, the customers and, above all, their relatives are the most important evaluators of service quality, and they use the quality commitments and service plans to do this.

Very few respondents regard the documentation system as important in delivering services. Only a few unit managers considered documentation important for carrying information between shifts, making it easier to conduct high quality service. However, documentation is an ambiguous term in the organisation. The IT system for documentation has met with resistance, as only a few care givers feel that they are competent computer users. Instead, the organisational members talked about routines and changes in routines for carrying the documentation of important local information between shifts. The new IT system for documentation was thus not primarily regarded as a tool for conducting services. The system, called ‘paraSoL’, is a sub-system of the umbrella-system. It is through paraSoL that the care assessors communicate their care plans, to which the providers have to respond within a certain time with a corresponding individualised plan for the customer. Some care givers think this feature of the system is important for conducting the right care to the customers; however, others are more critical and believe that it diverts too much from their work time with the customers.
Documentation is also an important issue concerning service quality evaluation, especially in relation to service plans. One home help unit manager said:

‘I really hope that everyone understands why we must document. I use to say that we need both suspenders and belt. Documentation exists so that we can cover our backs. If someone falls and we go there to pull the lady up from the floor, and something happens to her, and we didn’t write anything, then we’re going down’.

The manager draws attention to a special case; however, some coordinators talked about cases where a customer refuses a service he/she is entitled to according to the service plan, such as taking a shower or a walk; in such case, it is crucial to document why the service has not been provided. Documentation is also used for other purposes, as one home help unit coordinator explains:

‘[Financial] resources come from the care assessors. Through good documentation we can raise the level of a customer. I hope they [the care givers] understand that connection, because we have discussed that a lot. We bring it up every time we talk about budget’.

This is an issue that a number of care givers raised during the interviews, especially those working with home help services. As mentioned above, they believe that they lose time with their customers because they have to spend significant time on documentation. Much of the discussion during interviews on the provider side, with managers, coordinators, and care givers, concerned routinisation, which made it difficult to change things, for example, making the care givers provide more documentation. Difficulties were also encountered in changing things that were more directly associated with qualitative care; a nursing home manager even
compared the assistant nurses’ way of working with the elderly to working in ‘a factory in the 1950s’. When asked about the resistance to changes in routine and their unwillingness to change, one care giver in a nursing home said:

‘I don’t know why we don’t. I guess we go on in old routines. Why? You tell me … You don’t ask yourself why, you just go on. As I said, we make small changes but nothing big or drastic. In the elderly care business, I guess you go on in old tracks’.

One home help unit manager said that she has been compelled to release an hour per day of each care giver’s time with customers to enable them to utilise this time for documentation; she hopes that this will make them document as thoroughly as they should. A nursing home unit manager, together with the unit coordinator, employs another strategy. They try to relate the documenting issue very closely to the care giver’s commitment to the customers to make them understand that they can conduct better care to the customer if they can obtain more resources. This was also observed during a meeting in a nursing home between assistant nurses and the unit manager, when the assistant nurses’ scepticism gradually seemed to fade after the implementation of this strategy. Another home help unit manager emphasised this by saying:

‘The most important tool for affecting the co-workers is to get peace and quiet and talk about it [what has to change]. You have to explain why they need to do things. I try to explain as well as I can and give examples. We have had planning sessions and meetings and talked, I have tried to give example and explain. It is very mixed; some think that everything is obvious while others don’t understand anything. Then I usually bring it down to the individual level and go through it one more time. Concretise and compare with something else
… You have to go down as far as possible and give other examples, then people usually understand “that was not strange.” Everyone cares about the elderly, so the trick is to show how things matter to the elderly’.

As mentioned, many care givers seem to have lessened their scepticism towards documenting, especially in units where the quality of care is emphasised and managers can show that they work with care issues just as hard as they do with documenting issues. Moreover, it appears that the responsibility the care givers attain when they become contact persons for ‘their own’ customers, functioning as the connections between them and their relatives, hospital, and care assessors, is positively related to the use of documentation as a tool for improving quality. One home helper said:

‘The contact person is the one that follow up and has contact with medical nurse, etc. We document everything, and I am trying to learn this now. The documentation is, as I understand it, that relatives can go in and look. It is for the elderly’s whole network. Documentation is good, but I have to practice more …I think we are developing and working better. Maybe it is the relationship between the customer and the one helping that is developing. Then quality should get better’.

According to studies by Falk et al. (2001), this kind of responsibilisation of care givers as contact persons is one way of strengthening them in their occupational role and of making them more autonomous and reflective of customer needs.
The controllers

The controllers are responsible for going through all financial data, evaluating financial performance, and making forecasts. They are a support function for the district and the in-house provider units. The managers are responsible for the financial management of and everything else that concerns the units. One controller said:

‘All [provider] units, really, function as business units; they get their income through performance ... Budgets need to be balanced, usually we say that it has to have some surplus, so that you have a little buffer. But the objective is that you have a balanced budget. And that you achieve all targets and qualities’.

The city has some financial targets, the most important and obvious being a ‘balanced budget’. The second most important is the accuracy of the forecasts, a target that applies most strongly to the controllers, as forecasting is their responsibility. Forecasting is supposed to help managers take action if there is a danger of a unit deficit. When asked what is done when there is a forecasted deficit, one controller said:

‘They [the unit managers] usually look over the working schedule. Then they go through their revenues. Often it has helped that they really scrutinised their revenues ... The years I’ve been working, the unit managers has become better and better at going through their revenues and care levels. To check if they have customers in need of higher care levels, and then they’ve also become better at applying for higher level from the care assessors. Then they have to document a lot ... because you have to prove that the customer needs a higher level. Usually, it works’.
This quotation exemplifies the new focus on revenues. Formerly, the unit managers focused on costs, but the new system, with its remuneration levels, has prompted new strategies. The controllers interviewed took some pride in being the ones who introduced the unit managers to the concept of income. The controllers see themselves as pedagogues responsible for educating the staff. Efforts have been made to educate not only managers but also co-workers like care givers. As the quotation highlights, the controller believes that she was successful in her pedagogic quest. She said:

‘When it comes to the financial issues, I have tried to make things a little bit more fun for the [provider]managers, and not only make it into a “must do”. I remember a manager at one unit that used to think that this was really stressing. But after a while when we had been working with this she said, “Oh, how fun it is with financial issues”, and that is fun for me. If they think it is fun with the financial issues, they get the energy to work with it’.

The latter quotation expresses the pedagogical role the controllers feel they have, although not all talked about it in terms of ‘fun’. This role is, however, just one of the important issues for the controllers. They usually attend to more traditional controller work, such as the systematic use of the databases to ascertain that the accounting is being properly maintained and to refine the forecasts. The resource planning and umbrella systems compose a powerful database when connected. The umbrella system enables the retrieval of all data on care levels covering a number of years, making it possible to follow assessment trends and prepare forecasts on the basis of these trends and the current situation. The controller also makes routine transaction checks to ensure that all costs and incomes are accounted for in accordance with the decided remuneration levels.
This is also used in the pedagogical role, as the controllers hold monthly meetings with the unit managers, where the controller goes through all the unit’s accounts, finding deviations between the actual and forecasted costs, and discussing new forecasts. The controller has all the numerical data, but the manager knows how the unit and the staff work. For example, the unit managers hire and lay off staff, so they know how expenses will fluctuate. During the meetings, the controllers present their interpretations of the accounts and other data, while the unit managers contribute their own information. Together, they brainstorm concerning the reasons for deviations, risks of making the wrong forecasts, and ways of fixing deficiencies. Most discussions are held in a kind of situated accounting language, with many references to ‘level ones’, ‘umbrella system’, and ‘quality commitments’; one example is the discussion during one of these meetings, wherein a deficit was explained by the nursing home unit manager as having been caused because they had a ‘level one’ and not enough ‘level three’s’; they needed at least seven level three’s and no level one to be financially efficient. This presented a dilemma for the unit manager, as he could not make any cutbacks and was afraid that the care quality would suffer; he saw little chance of persuading the care assessors to raise the care level on the ‘level one’. The solution was to take this up later with the elderly care manager of the district and perhaps be permitted to cover the upcoming deficit with surpluses from previous years.

ANALYSIS

All of the case actors are exposed to the traditional institutional contradiction (Seo and Creed, 2002) of public sector work, that is, the contradiction between the two fundamental tasks of maintaining finances and maintaining good service quality. However, how the exposure looks and how it is interpreted differ. For the controllers, financial management is central; care quality can also concern them but only peripherally. Care givers have difficulty accepting
their resource restrictions, feel that they have too little time to maintain quality care, and feel subordinate to these restrictions. Care assessors try to decouple quality from finance but feel this is difficult. The provider manager, apparently the most hybridised (Kurunmäki, 2004) actor in this case, being a former nurse or social worker with financial responsibility, is the actor for whom the contradiction is most central. These premises are hardly new, but, from the perspective of Seo and Creed (2002), this basic contradiction should be one of the most important reasons for change whenever an agent in the organisation becomes aware of it and is able to mobilise change.

As organisational members were already all too aware of this contradiction, its identification is not a big issue in this case; rather, identifying possibilities for change (Nørreklit et al., 2010) is most important. In this case, the introduction of new accounting facts in the form of care levels coupled with remuneration and quality indicators in turn coupled with quality commitments opened up new possibilities; the configuration of the MCS (Malmi and Brown, 2008) is the basic premise for further interaction among the actors. Here, the non-problematic stance concerning the care assessors’ quantification of needs is key. This quantification is crucial for the new system to work, for the controller to be able to make better forecasts, and for the provider manager to start working with income maximisation. The care assessors’ professional logic and values appear coherent with the new facts to whose construction they contribute. Quantification in this sense differs little in value from the already adopted logic and values concerning the classification of needs and care that has comprised care assessors’ working procedure for over 20 years. Care assessors’ expertise is used, as was the engineers’ expertise in the case of Samuel et al. (2005), to construct the accounting facts that form the possibilities that other professionals may act upon. On the other hand, efforts to decouple their work from financial issues, which seem to be sanctioned by the politicians on the city council,
could be interpreted as active resistance to hybridisation. It seems obvious, however, that the care assessors have become what Kurunmäki and Miller (2006) would term ‘calculating selves’, as they are fully aware of how their assessments are connected to the providers’ financial management. The care assessors’ active resistance to hybridisation, following their professional values, diminishes the power of the language of accounting, however, and increases the power of the communication occurring through the words of the caring profession.

Parallel to the remuneration system, other parts of the MCS operate in the organisation, opening up further possibilities. The system of quality commitments connected to the quality indicators of the governance system, together with the individual care plans, contributes to ‘factualising’ and visualising the responsibilities of the provider unit staffs. Customers and relatives can refer to these formal responsibilities and hold managers and care givers accountable for deviations from the commitments and plans. This opening of possibilities for one stakeholder creates problems for another, which needs to be combated. As such, this new social fact about daily work makes it important for the provider managers to take action in a way that makes sense, and the most sensible approach would be to combat the customers and relatives using thorough documentation.

However, there is another incentive for the provider manager to advocate more documentation: the new concept of income into which the controllers have given the provider managers insight. The relationship between the professional work of the care assessors in classifying and quantifying and the logical connection between care levels and financial remuneration open up very specific possibilities, which emerge only through the cooperation of two sets of professional knowledge, one that knows how the care assessment process works
and one who can address the new concept of income. In this case, the hybrid manager lacks sufficient knowledge about how accounting facts are related; expert knowledge is thus needed to use the possibilities embedded in the configuration of the MCS. Since controllers’ view themselves as supportive actors devoted to their pedagogical mission of making financial issues ‘fun’ for the provider managers, the two sets of knowledge may be joined. Together, they unfold how income could be increased through thorough documentation.

The emphasis on documentation is, however, something that goes against the routinised daily work of the care givers. They value all the quality time they can get with their customers and are resistant to use this time for documentation. The care givers’ values and the new documentation routines lack coherence, which is not inevitable, as the case shows. The provider managers have skilfully started constructing coherence between the values of the care givers and the new routines by showing how documentation relates to increased time with the elderly and the care givers’ own well-being. By using the language of care givers, and thus translating the possibilities embedded in the MCS and aligning them with the values and worries of the care givers, the managers help care givers slowly embrace the idea of documenting—perhaps not joyfully but at least less reluctantly. Care givers then seem to become increasingly aware of how documentation helps them in their role as connecting persons between the elderly and their relatives and other important actors in the elderly’s network, such as health care actors. As such, this kind of redirection of effort towards documentation could be seen as an exploitation of the care givers’ values, enabling the manager maintain good financial management. On the other hand, this makes financial management more reliant on those values and on care givers’ ability to communicate professionally. This strengthens the care givers’ professional values, and, through the documentation of the professional conduct of care, care givers’ work is visualised and
underscored, which, according to Blomgren (2003), could help strengthen the profession. In terms of task performance, as depicted in Figure 1, financial management occurs through the language of professional care. The distrust in the providers shown by the care assessors when receiving requests for raising care levels puts even more pressure on the care givers to communicate convincingly and professionally. Following Jonnegård (2008), it could also be argued that the care givers’ focus on the well-being of the client is redirected towards the well-being of the provider organisation. Simultaneously, however, the new efforts to document enhance the possibilities of making more informed reflections on behalf of the client’s whole network, thereby focusing efforts even more on the client.

Thus, rather than deprive elderly care professionals of their values, the process described in this paper makes financial management dependent upon them. More focus is put on the well-being of the organisation; however, paradoxically, by making the client central. Although care assessors experience more task routinisation due to the lack of time, they also experience more professional freedom thanks to the new, politically sanctioned mapping tool that supports their role as professional care assessors rather than mere resource allocators. The care givers’ routinised work environment is, in a sense, maintained through a new documentation routine but simultaneously made more reflexive, as the quality commitments of the MCS, customer and relative demands, and the relations between care levels and remuneration problematise their work and show how their routines affect the elderly and their entire network. Thus, neither the deprofessionalisation (a loss of professional values) described by Adcroft and Willis (2005) nor the deprofessionalisation (a routinisation of professional tasks) described by Abbott (1988) would occur here. Instead, we have witnessed an ambiguous process wherein a kind of routinisation may occur but in which professional values and ways of communicating become more important. Where conflicts and
contradictions arise over resource allocation, coherence and cooperation seem to evolve with the well-being of the client in the centre. This may not only occur in an open professional environment, even within more closed professional environments and despite competing logics, ‘physicians and RHA managers beg[in] to work together; largely because there [is] no other way to provide services for patients’ (Reay and Hinings, 2009, p. 639). As long as politicians and managers continue to devise management control systems with a client focus, professionals will be able to maintain and even strengthen their professionalism. However, this process may take time and significant effort.

CONCLUSION

This paper has studied the relationships between the accounting and administrative techniques of organisational MCS in the public sector and their relationship with the managers and the managed in less professionalised work environments. Through this, a process of reprofessionalisation becomes apparent, wherein the MCS configuration and related accounting and administrative techniques cause all the organisational members, care professionals, social workers, unit managers, and controllers to work more with financial management while also strengthening the care professionals in their professional role. It has been argued that reprofessionalisation is an ambiguous process by which the professional values of elderly care employees are exploited to redirect their efforts towards tasks that promote successful financial management. As the professional values, judgment, and, ultimately, communication become important for both financial management and qualitative service provision, the elderly care workers become stronger professionally and in their professional values. What may seem a process of deprofessionalisation in its change to more routinised tasks relating to financial management could thus actually be a
reprofessionalisation wherein professional values regarding and attitudes to qualitative service provision are retained and even strengthened.

As less professionalised environments are common throughout the public sector, these findings are immediately important. However, it is not inconceivable that similar processes also occur in environments where professions are stronger. Reprofessionalisation may occur wherever the client is in focus, accountants are supportive, hybridisation is embraced by professionals to varying degrees, and task performance occurs through relationships of interdependence. In such environments, new facts may be discovered and translated, opening up new possibilities for a wider range of professions; these possibilities may be used for professional purposes and in turn strengthen the professionals. Wherever deprofessionalisation seems to occur, it should be considered that, in the long run, reprofessionalisation may occur as well.


Figure 1: Typology of four fundamental tasks of the municipal elderly care

Figure 2. The care assessment routine in the city of Stockholm.
<table>
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<tr>
<th>Level</th>
<th>Hours per month</th>
<th>SEK per month</th>
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<tr>
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<tr>
<td>1</td>
<td>0 - 1.4</td>
<td>290</td>
</tr>
<tr>
<td>2</td>
<td>1.5 - 2.4</td>
<td>578</td>
</tr>
<tr>
<td>3</td>
<td>2.5 - 3.4</td>
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</tr>
<tr>
<td>4</td>
<td>3.5 - 4.4</td>
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<td>5</td>
<td>4.5 - 5.7</td>
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<td>7</td>
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Table 1: Remuneration levels in elderly care in the city of Stockholm