Multi-level coordination bodies of democratic governance for frail older persons in Sweden

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ABSTRACT

New policies for the frail elderly, integrating eldercare from local government and health care from regional government, rests on a complex transboundary policy challenge involving public and private service providers where different authorities must increasingly co-operate through multi-level democratic networked governance. The purpose of this paper is to study the members of such coordination bodies with questions about their representation, capacity and accountability in relation to horizontal management theory in the setting of the decentralized Nordic welfare state. Data rests on a survey sent to all members of 73 strategic multi-level coordination bodies handling frail elderly policy across Sweden. The findings show that representation is multi-level, but divided, into a coordination policy system of bodies staffed with either politicians or administrators from different levels of authority or mainly managers/professionals, with networks that are either local deliberative, regional strategic or public/private provider oriented. This horizontal policy coordination system determines the patterns of capacity and accountability, but perceived quality performance of the coordination body rests on latent differences in efficiency that are internal and external.

Keywords: Multi-level Coordination Bodies, Transboundary Policy, Networked Governance

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Introduction

Governments at all levels of governance today increasingly have to deal with the challenge of policy coordination through multi-level, multi-issue, and multi-actor coordination bodies for policy-making. Nevertheless, the concept of policy coordination is not new. It was defined already in the 1970s as "[…] the extent to which organizations attempt to ensure that their activities take into account those of other organizations" (Hall et. al 1977, p. 459). What is new, is the growing phenomena of solving such complex, transboundary policy-making issues through coordination bodies. In this new field in the study of public management reform, a theoretical framework of horizontal management for politics of policy coordination has only quite recently been suggested (Peters 2015). Empirical research has so far been limited to how countries with federal systems use multi-level coordination bodies for integrating local and regional authorities, actors and higher education issues (Jungblut & Rexe 2017).

Political systems can either be of centralized or of decentralized character, where the Nordic model (Greve, Lægreid & Rykkja 2016), of democratic networked governance, in cross-country studies comparing both unitary and federal states, most clearly represents the latter form with its pursuit of horizontal management as a basic prerequisite for implementing its politics (Szücs & Strömberg 2006:271-275). This model especially concerns central policy areas of the welfare state, such as health care and social services for the elderly (Szücs & Strömberg 2009) in which higher government levels – national, federal and supra-national, like EU – only give the legal framework, within which policy coordination can be (and is) carried out autonomously by a complex and nested, transboundary form of networked governance in local-regional multi-level, multi-actor and multi-issue networks.

Policy coordination within this model for horizontal management in Sweden both concern "hard" technical policy issues like the coordination of multi-level university-government-industry linkages for development of innovation and entrepreneurship, as well as "soft" social issues such as local-regional health care social work policy coordination of elder care.

In a study of Szücs and Zaring (2014) by the use of Swedish survey data on policy and high-tech agglomeration at the level of municipalities, it was shown that innovation governance nexuses, i.e. locations with greater industrial specialization paired with stronger local-regional (multi-level) formalization of innovation governance, theoretically follows the literature on regional advantage, but that university-industry-government linkages for policy coordination is linked to that advantage. The findings indicate that these types of policy instruments are useful by creating horizontal governance networks that channel and direct resource and knowledge flows, particularly at locations with higher education institutions.

Within the policy area of frail elderly with complex needs of health care and social services, the Swedish national government for a period of five years launched a comprehensive program entitled "Coordinated care for frail elderly" (Sammanhållen vård och omsorg om de mest sjuka äldre), with the aim to create better forms of management and coordination for this target group in connection to important EU-level policy goals. In Sweden, such strategic coordination for the frail elderly rests on a complex spontaneous local-regional geographical transboundary affiliation, sometimes determined by partnerships through local-regional government associations stretching across county borders, or residing within the borders of a single county.

In a first study by Szücs, Liljegren and Johansson (2014) of how local governments' social services organize their strategic policy coordination on frail elderly with the county council's health care, as well as other actors, it was indicated that it takes form in multi-level, multi-issue, multi-actor coordination bodies that are based on a highly decentralized, self-regulated horizontal management framework. A survey was sent to a stratified and randomized sample consisting of about one third of the Swedish municipalities, with answers from a representative sample of about 60 of these on their municipality's cooperation in multi-level bodies on these policy issues, including the names of the other members in these coordination

bodies. The results indicated that local governments' policy coordination on frail elderly either rested on a somewhat more hierarchical approach because being based on separate multi-level strategic coordination bodies of politicians with the main aim to resolve conflicts, or a horizontal management approach based more on a multi-level mix of politicians, administrators and other representatives. The motives of public management reform for transboundary policy coordination of these bodies either on rested on short-term socioeconomic calculation, or on long-term sociocultural tradition (Szücs et al. 2014).

Thus, the establishment of these strategic multi-level coordination bodies – which represent a new and growing kind of cross-border strategic network organization – can be understood as an example of the development from centralized government to decentralized, coordinated networked governance, but it raises fundamental questions about the organization of democracy, capacity leading to quality, and processes of legitimacy in the welfare state.

However, to the best of our knowledge, there is still a void in the research on the members of such policy coordination bodies, which makes it hard to answer even the most basic questions about the politics of public sector coordination, in terms of representation, capacity and accountability. Therefore, this contribution focuses on one specific case for such politics, namely policy coordination for the benefit of frail elderly in a highly decentralized political system (Sweden), in which multi-level (local, regional, national and EU), multi-issue (health care and social work) and multi-actor problems (public, private, civil society), can be seen as especially relevant for empirical theory testing, with its shift in the early 1990s towards a democratic networked governance model based on an ideology of horizontal management linked to the development of the welfare state (Szücs 1993, 1995, 1998, Wise & Szücs 1996).

So, what kind of political animal is this emerging type of transboundary, multi-level networked coordination body in terms of its legitimacy and governance capacity according to

its members: and how is legitimacy linked to capacity and accountability? Hence, the purpose of this paper is to analyze transboundary policy bodies in a highly decentralized context of horizontal management for the politics of public sector coordination. The aim is to answer three questions on: (1) *representation*: How are these coordination bodies staffed and how do their members regard their governance roles? (2) *Capacity*: How do they perceive their activity, mission, influence and effectiveness? (3) *Accountability*: Who are held responsible?

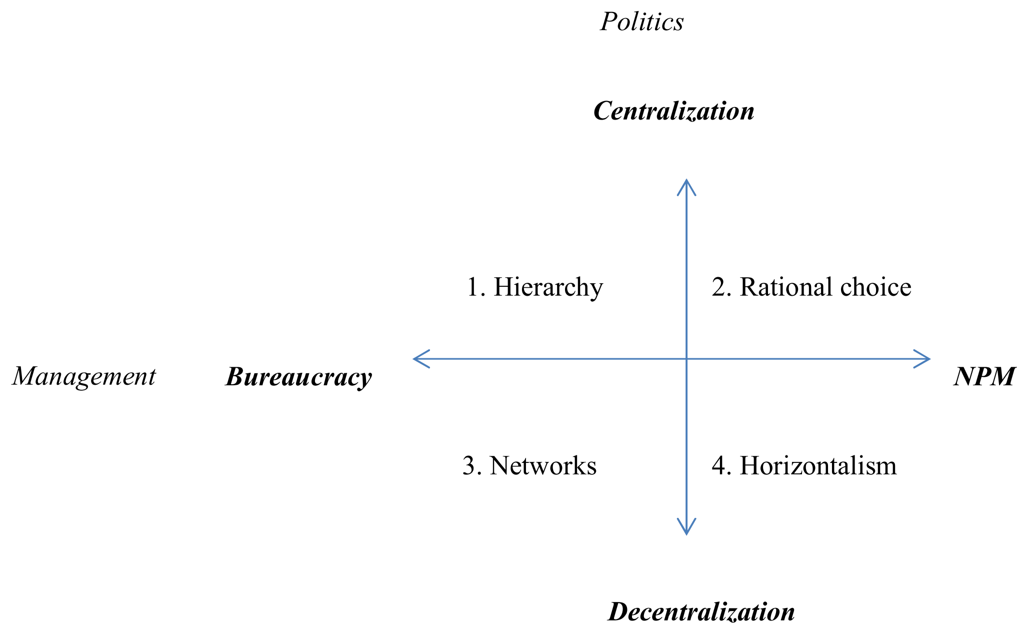
Preface to a theory on policy coordination: representation, capacity and accountability

In political theory of the state, there is still a void when it comes to public management reform in which policy needs to be coordinated because of cross-border multi-level, multi-actor and multi-issue challenges that cover all aspects from policy formulation to implementation of service delivery. Politics can either be centralized or decentralized, and the management of these policies can either be based on bureaucracy/New Weberianism or New Public Management (Figure 1). The updated model of the centralized state is dependent on *hierarchy* in order to function (Greve & Ejersbo, model 1 in Figure 1). When Weberian bureaucracy was challenged some thirty years ago, it was claimed that the state would work more effectively under the banner of New Public Management (Hood 1995), through centralized competition paired with *rational choice* strategies (model 2, Figure 1).

Nevertheless, the theoretical alternative to these in principle centralized models/strategies, facilitates a decentralized mode of policy coordination based on a communicative logic maintained through cooperation between policy actors that either rests on the *networks* of formal or informal structures that link actors that have collective goals of the state (Marsh & Rhodes 1992, Peters 2015:57), or rests coordination through horizontal values and so-called *horizontalism* (Szücs 1995:113) for horizontal management (Peters 2015, model 4 in Figure 1). Here, Jungblut & Rexe (2017) note that: “[…] strategy is related to the network approach

but is based more on the attitudes of the participants instead of their structural relationships. It highlights collaboration as a joint activity of multiple policy actors to increase the public value of their tasks through coordination." (Jungblut & Rexe 2017: 53, Peters 2015:65)

Figure 1. Politics and management and four models / strategies of policy coordination



Three prerequisites are suggested in order for such policy coordination to be democratic. First, it needs to be *representative*, that is, all policy interests ought to be formally represented in cooperation bodies including their informal network of contacts. Secondly, in order to be democratic it ought to have *capacity* to influence and perform. Third, such networked governance needs also to be *accountable,* that is, held responsible for its performance (see, for example, Christensen & Lægreid 2016). Thus, the hypothesis is that these coordination bodies are seen by its members as institutionalized parts of the policy-making process equipped by certain perceptions and values to fulfill their tasks better than what they could do separately.

Data and Methods

Information about multilevel local-regional network governance bodies for strategic elder care coordination in Sweden was gathered in two steps. First, in 2014 an initial survey directed to local government social service managers responsible for elder care was performed in a randomized stratified sample, which covered one third of the 290 Swedish local governments at municipal level (Szücs et al. 2014). From this first survey, we got information from about 60 local governments' social service/elder care managers about their representation in such bodies and its members.

Based on this information, in a second step, we selected 73 multilevel coordination bodies dealing with both health care and elder care for frail elderly in a new survey carried out in 2015, directed to all members in each sampled network organization. The empirical analysis is based on this survey performed in 2015, directed to all politicians, administrators, and other representatives in these 73 transboundary policy coordination bodies. The survey contained batteries of questions about Staffing and representation, Working modes, Missions and objectives, and Perceptions of power and democratic accountability (Szücs 2015).

The introduction of the questionnaire contained questions about the respondent: "According to information we received from a previous survey of strategic collaboration about elderly people with complex health and social care needs, you are (or have been) a member of a body for strategic coordination dealing with such issues. We would like to ask some questions about this coordination body and your work with this target group. Below, we would like to have some information about you, who is responding to this questionnaire: Affiliation (municipality, county etc.); Your position /job title; How long have you been in the current position/job title; Gender; Age; The coordination body your answers of this questionnaire refer to; How long have you been a member/representative of this organizational body? (If the respondent is/was a member of more than one such body, he/she got one questionnaire for each body). These categories are also used as explanatory variables in the findings section,

looking for the explanatory power of role-, sector-, gender- and age differences of the members in the multi-level coordination bodies."

The sample of relevant representatives from these bodies in the survey came to include 870 persons, with a response rate of 63 percent (n=545), with participation from all 73 sampled coordination bodies for frail elderly people. In total, 56 percent (309) of the respondents represent local government authorities of 163 municipalities, and 39 percent (215) represent regional government authorities from 17 counties, while 2 percent (12) represents both local and regional government through the local-regional associations of government, and 3 percent (13) represent private health and care establishments for frail elderly.

The sample of respondents within these 73 multi-level organizational bodies contains 31 percent men and 69 percent women. Two percent are under age 35, 11 percent are between 35-45 years, 29 percent are between 46-55 years, 52 percent are between 56-65 years, and 7 percent are 66 years of age or older. They have in average held current position in their local government/municipality, regional government/county, or other organizations for organization for in average 6 years, and he or she has been involved in a policy coordination body for in average 4 years, i.e. approximately from the 2010 elections and onwards.

Among the sample of respondents, 23 percent (127) are politicians, 65 percent (355) are administrators (mostly civil servants but also from the private sector), and 12 percent (62) are health and care professionals. Among the politicians 56 percent (71) are local government politicians, and 44 percent (56) are regional, county level politicians. Among the managers/ administrators, 54 percent (193) come from local government, 41 percent represent (146) regional government, while 2 percent (6) work in local-regional government associations, and 3 percent (10) come from private health and care business. Among professionals, 68 percent (42) work in local government elder care services, 27 percent in (17) in regional government

health care services, and 5 percent (3) in private health and care services for elderly people. All findings are based on non-weighted frequency and factor analysis performed in SPSS.

Results

On representation: How the coordination bodies are staffed and what they do

The most frequently mentioned group of ordinary members of the surveyed coordination bodies are Top local social welfare administrators; 87 percent of the members of such bodies answering the questionnaire say that their body includes this category. Other quite frequently mentioned categories of ordinary members include Local county level health care administrators and Other local government administrators (80 percent), Regional/County specialist health care administrators (77 percent) and Top Regional/County administrators (75) are also often seen categories of representation. Thus, a first finding is that the surveyed policy coordination bodies can in fact be labelled multi-level, and that they are to a great extent populated by administrators from different local and regional authorities.

Secondly, at the other end of the spectrum, surprisingly few of the members in the coordination boards mention civic organizational representation. Only 2 percent mention that Pensioner / nonprofit organizations are represented in these boards. Political representation is also less frequently observed. Only 28 percent of the members mention that the leading local level politicians are ordinary members of their board (Top local government politicians, of the council and executive board). Instead, the political representation seems to be taken care of by Local government board members and Regional/county level government board members, most clearly connected to the policy field of elder care and health care (mentioned by half of the respondents).

A third interesting finding in answering the question of how these kind of boards are staffed, is that as many as 43 percent mention that *Private health care providers* are ordinary members in their boards. This high figure can be explained by the fact that quite many of the Swedish local and regional governments have introduced competition between service providers in accordance with a centralized incentive model, introduced in 2008 by the Law on Public Choice System (Lagen om valfrihetssystem, SFS 2008:962). Thus, since 2008 gradually an increasing proportion of sub-national governments have decided to introduce a system of public, but individual choice system for health care and social services to elderly.

The answer to the question of how coordination bodies are staffed, thus, seems to be that they contain at least three latent multi-level categories. This assumption is confirmed by performing factor analysis. In Table 1, it is shown that the boards consist of three latent types of multi-level representation: political, administrative and managerial/professional. While some of the members of the policy coordination bodies are surrounded by politicians from various levels of government, other body members are surrounded by administrators representing different levels of government authority. A third dimension of coordination body staff representation share that they are managerial/professional service providers.

The strongest dimension is that of transboundary policy coordination bodies with mainly political representation, with its high level of variance explained, and with all correlation coefficients far above rule of thumb 0.30, and Crombach's alpha measure well above 0.70 (rule of thumb). However, it must be noted that the category Pensioner/non-profit organizations do not fit any of these properly because of the low representation mentioned above (resulting in too low factor coefficient estimates, correlation and Crombach's alpha).

Table 1. Types of member domination in cooperation bodies (Orthogonal Rotation, Varimax)

	Types of representation in respondents body		
Ordinary member of coordination body			*Managerial/*

	Political	*Administrative*	*professional*
Regional/County government politicians	**0.91**	-0.07	-0.20
Local government board members (for example social welfare board)	**0.90**	-0.03	-0.19
Top local government politicians (Council and Executive board)	**0.76**	-0.07	-0.10
Top Regional/County administrators	0.09	**0.77**	-0.27
Top local social welfare administrators	-0.18	**0.76**	0.18
Regional/County specialist health care administrators	-0.07	**0.68**	0.45
Other local government administrators	-0.04	0.13	**0.74**
Private health care providers	-0.21	0.02	**0.72**
Local County level health care administrators	-0.17	0.52	**0.64**
Variance explained (%)	*36*	*19*	*13*

Comment: Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.72. Variance explained=68 percent. Equal to or above .60 in bold type. (Binary variable: 1=Yes (ordinary member in the multi-level coordination body, 0=No.) Crombach's Alpha: 0.86 (Political), 0.64 (Administrative), 0.64 (Managerial/professional).

Thus, with the help of the factor analysis of Table 1, we also get a first glimpse of what these multi-level policy coordination bodies do: while some of these consist mainly of politicians and presumably deal with politics, and thereby conflict resolution (Szücs et al. 2014), other coordination bodies are mainly dealing with administrative planning tasks, being populated by administrators, and yet another group are being found in cooperation bodies dealing mainly with strategic professional issues of elder health and care service provider management. These findings correspond to previous research on Swedish local governments' cooperation in policy coordination of elder care and health care (Szücs et al. 2014), and make it theoretically relevant to focus on comparisons between politicians, administrators and professionals.

Governance roles: What they are really doing (to be representative).

Among the politicians, as shown in Table 2, the most common feature is to exchange information – that is, the most polite way to articulate conflict resolution. Almost half of them mention this task, compared to the administrators and the professionals (40-41 percent). The administrators on the other hand score the highest on problem identification and solving (27 percent), compared to the politicians (23 percent), and the professionals (25 percent). The role of the professional in these coordination bodies is most clearly to develop elder care activities (32 percent), compared to the administrator (30 percent) and the politician (28 percent). Although these differences are small, they indicate role differences in accordance with what could be assumed of these three categories. This finding is further supported by looking at the time spent on frail elderly, where the manager/professional (being closest to the elderly) scores the highest, followed by the categories of the administrator and the politician. Thus, while the politician in these coordination bodies most clearly can be labelled the diplomat, the administrator has to work out what problems need most urgently to be solved, and the manager/professional's task is to figure out how to solve such an urgent strategic policy issue.

Table 2. Time spent on different tasks in general and frail elderly in particular (means)

Leader/-Professional role	Exchange of information	Problem identification and solving	Develop-ment of activities	Other	Total	Time spent on frail elderly
Politician	45	23	28	4	100 (115-123)	47
Administrator	40	27	30	3	100 (349-334)	58
Professional	41	25	32	2	100 (60-58)	71
Total	41	26	30	3	100 (532-507)	56

Comment: These differences are statistically significant in time spent on frail elderly issues (Eta=.24, Eta2=.06, Significant at 99 percent level, .0001). However, there are no significant differences between level/sector, or gender and age of the respondent.

The question about what they do in the coordination body also naturally concerns meeting participation. The largest and statistically significant differences are found between multiple levels of government and actors (Table 3). The average number of meetings per year is six, and members representing an association of local government (which often have the task to coordinate the activities between levels and groups) participated the most in average, followed by members either representing the municipality or the regional county level. Representatives of private service providers and civic organizations attend only four meetings in average. The only statistically significant differences exist between levels/sectors that think that there are "somewhat too many meetings" and "somewhat too few meetings," respectively. That there are too many meetings are above all mentioned by the private/civic sector representatives (mean value .38), while the opinion that there are too few meetings is held mostly by members representing local government association representatives (mean value 0.42). Thus, this group of "coordinators between local governments" attends most coordination body meetings per year, but still thinks there are too few meetings, while the private/civic organization representatives have the opposite strategy, wanting to "bail out" the most.

Table 3. Frequency of meetings/participation per year and opinion about the amount (means)

Level of local government and sector	Number of meetings per year	Number of times last year participated	"Somewhat too many meetings"	"Somewhat too few meetings"
Municipality	5.8	4.6	0.07	0.24
Regional/County	5.8	4.6	0.04	0.36
Association	5.9	6.3	0.00	0.42
Private/Civic	5.3	4.1	0.38	0.23
Total	5.8	4.6	0.06	0.30

Comment: Range in the two columns to the right is between 0 and 1 (affirmative answer).

Because of the very nature of these coordination bodies is to form democratic networked governance for frail elderly, a central question in connection of what its members do to be representative, besides going to the meetings, is about their network contacts with other coordination body members.

Our findings in Table 4 are based on the following survey question: "In your work/ mission, how often do you have contact with key actors/players in the following organizations regarding the care of older people with complex needs (e.g. via telephone, personal meetings, emails, etc.)?" Almost half of the members in the coordination bodies are in weekly contact with the Municipality Social Services, who thus seems to be the top spider of the web in the politics of coordination frail elderly policy. One fifth of the members have weekly contact with Local government board members (for example social welfare board) and Local County level health care administrators. Thus, the core Troika of these boards in terms of weekly contact is based on the administrative and political heads of the local government social service boards and the regional county level administrators. At the other end of the spectrum, we find Private health care providers and Private social service providers together with Pensioner/non-profit organizations, whose representatives have such contacts less frequently or never.

Who is contacting who then: are there any latent patterns in this democratic networked governance for frail elderly? This can be analyzed by factor analysis. In Table 4, it is displayed that there are three different latent types of network; a local deliberative, a public/private provider, and a regional strategic one. Those respondents that more frequently contact Local government board members (for example the Social welfare board), also share more frequent contacts with Top local government politicians (Council and Executive board), Municipal social services, and Pensioner/non-profit organizations, making this type of network quite deliberative by its nature of local public service providers and decision-makers in clinch with its local civic organizations. This deliberative democracy networked factor explains 27 percent of the variance. The public/private provider network is defined by the fact that those who more frequently contact the Local County level health care administrators, also more frequently is in contact with both other public providers, like Regional/County specialist health care administrators, as well as Private health care providers and Private social service providers. The variance explained of this provider network is 24 percent.

Table 4. Types of network contacts in multi-level bodies mentioned by the respondent (Orthogonal Rotation, SPSS Varimax)

	Coordination body representatives' networks		
Network contacts	*Local Deliberative*	*Public/private provider*	*Regional strategic*
Local government board members (for example social welfare board)	**0.88**	-0.20	0.07
Top local government politicians (Council and Executive board)	**0.81**	-0.25	0.28
Pensioner / non-profit organizations	**0.76**	0.07	0.16
Municipal social services	**0.67**	0.11	-0.43
Local County level health care administrators	-0.15	**0.82**	0.23
Private health care providers	-0.03	**0.78**	-0.03
Regional/County specialist health care administrators	-0.14	**0.77**	0.33
Private social service providers	0.40	**0.50**	-0.24
Regional/County government politicians	0.21	0.02	**0.88**
Top Regional/County administrators	0.04	0.39	**0.76**
Variance explained (%)	*27*	*24*	*19*

Comment: Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.71. Variance explained=70 percent. Equal to or above .50 in bold type. Crombach's Alpha: 0.81 (Local deliberative), 0.72 (Public/private provider), 0.75 (Regional strategic).

To conclude, it seems that the horizontal management model of networked governance guided by horizontalism (Szücs 1995, Figure 1) in a highly decentralized welfare state like Sweden, really provides for what can be defined as *policy coordination system*, built on multi-level representation in boards for 1) politicians' exchange of information as diplomats representing the interests of the different levels, but in deliberate contact with its own municipal public service provider as well as civil society organizations; 2) administrators from different levels handling the question of *what* issues should be strategically dealt with in contact with other providers of elder care providers and health care; and 3) managers / professionals from the different levels in clinch on *how* these most strategic issues should be solved.

On Capacity: How they regard their mission, influence, contribution and effectiveness

Local and regional public sector reform during the last decades rest mainly on two logics of governance for capacity: competition and cooperation (Szücs 2010, 2011, 2013). In line with this, from our previous research, it is suggested that there can mainly be two ways to coordinate capacity *within a system* of networked democratic governance: by policy coordination through conflict resolution and by policy coordination trough a defined set of common rules. Further, it seems also to be two main *structural reasons* for such policy coordination, emerging because of community or efficiency reasons (Szücs et al. 2014). Therefore, questions in the questionnaire about the respondent's perceptions/attitudes on why they participate in the coordination body on elderly peoples' complex need of medical health and social care include: (1) to resolve conflicts between organizations involved; (2) to create clear rules for organizations involved; (3) to create community, consensus and shared learning among participants; and (4) to achieve greater cost efficiency including the use of quality assurance systems (several items could be checked).

How its members regard their mission: why they participate.

The findings show that the largest proportion of respondents agree in that the reason to participate in the coordination body is "to create community, consensus and shared learning among participants" (64 percent totally agree), followed by the reason "to create clear rules for organizations involved" (42 percent totally agree) and "in order to achieve greater cost efficiency including the use of quality assurance systems" (29 percent totally agree). Only 2 percent of the respondents totally agree in that the reason is merely to "to resolve conflicts between organizations involved". Thus, the transboundary challenges according to a large degree is shown by the members in these bodies wanting above all to maintain this policy coordination system, by horizontal community and learning based governance.

Perceptions of multi-level influence.

When the respondents are asked to estimate how much influence different groups of members have in their coordination body in matters relating to older people with complex needs, it is shown that members who represent Municipal social services are perceived as having most influence: 30 percent of the respondents estimate that this group has “great influence” or “some influence” (50 percent) in their own coordination board. The second most influential group is the Local County level health care administrators: 20 percent of the respondents estimate that this group has “great influence” or “some influence” (45 percent) in their own coordination board. The third most influential groups of members in the coordination bodies are Regional/County specialist health care administrators: 21 percent of the respondents estimate that this group has “great influence” or “some influence” (34 percent) in their own coordination board. Thus, the three most influential groups are indeed the ones closest to the frail elderly in need of a complex, personalized mix health care and social work. This finding further support the identification of the horizontal management approach of the Scandinavian welfare state.

At the same time, important strategic leaders at the hierarchical top are vied as somewhat less influential in different matters relating to older people with complex needs. On fourth place in the list of the most influential comes Regional Top Regional/County administrators: 21 percent of the respondents estimate that this group has “great influence” or “some influence” (34 percent) in their own coordination board. Regional/County government politicians comes at fifth place: 15 percent of the respondents estimate that this group has “great influence” or “some influence” (29 percent) in their own coordination board, followed by Local government board members (for example social welfare board) and Top local government politicians: 11 percent “great influence” and 19 percent “Some influence. In fact, at the same time, Pensioner/non-profit organizations are seen as least influential on frail elderly issues, being even less influential than private health care and social service providers. Thus, the horizontal management model has not changed that much since the early 1990s after the shift in values that paved the way for non-profit and for-organizations to carry out public services based on the preferences of the individual (Szücs 1995).

In accordance with these findings, the factor analysis reveals three latent forms of influence: Private-Civic, Administrative and Political (Table 5). The most clearly verified factor here (variance explained is 34 percent), shows strong coefficients linking Private social service and health care providers to Pensioner / non-profit organizations. This means that these groups form strong influence in only some of the coordination bodies studied, and presumable foremost in those areas where local governments have introduced the so-called the Law on LOV (Lagen om valfrihetssystem), where the local government have decided to introduce a voucher system based on national incentives to implement a model for competition between public and private providers for the elderly to choose from.

Administrative influence is shown by the strong coefficients of multi-level capacity, based on the influence from Local County level health care combined with influence from Regional/County specialist health care administration, Regional/County administration, and Municipal social services.

Table 5. Forms of influence in the coordination body (Orthogonal Rotation, SPSS Varimax)

	Coordination body influence		
Different groups of members influence	*Private-Civic*	*Administrative*	*Political*
Private social service providers	**0.93**	0.09	0.06
Private health care providers	**0.93**	0.12	-0.03
Pensioner / non-profit organizations	**0.56**	0.18	0.46
Local County level health care administration	0.35	**0.78**	-0.02
Regional/County specialist health care administration	0.23	**0.73**	0.05
Municipal social services	-0.02	**0.70**	0.24
Regional/County administration	-0.06	**0.62**	0.29
Regional/County government politicians	-0.06	0.15	**0.88**
Top local government politicians (Council and Executive board)	0.11	0.03	**0.73**
Local government board members (for example social welfare board)	0.08	0.28	**0.68**
Variance explained (%)	*34*	*18*	*13*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.70. Variance explained=65 percent. Equal to or above .50 in bold type. Crombach's Alpha: 0.81 (Private/Civic), 0.80 (Administrative), 0.77 (Political).

The political sphere of influence includes multi-level influence from Regional/County government politicians, Top local government politicians and Local government board members.

In fact, this pattern of multi-level political, administrative, and provider focused influence is parallel with how the boards are mainly staffed into representative multi-level political and administrative coordination bodies, as well as managerial/professional service provider boards (Table 1). Hence, while political coordination bodies carry multi-level political influence, administrative coordination bodies are driven by multi-level administrative influence, and managerial/professional domination in coordination bodies are driven by private/civic forms of influence, and presumably so most clearly in locations where the system of LOV has been implemented according to Table 6. Thus, multi-level representation in coordination bodies to a great deal explain the level and nature of influence for transboundary policy coordination.

How the members of these bodies regard their roles in providing good service quality.

The factors of multi-level political, administrative and managerial/professional influence, shaped by either multi-level political, administrative, or and managerial/professional service provider representation, is also shown in the degree to which actors in the coordination body contribute to high quality elder care and health care for frail elderly with complex needs.

The group of members that most respondents think contributes to high quality elder and health care for frail elderly with complex needs among the present actors in their own coordination body are Top local social welfare administrators: 35 percent "To a very high degree" and 48 percent "Somewhat high degree". The second most commonly mentioned group contribution to services is Top Regional/County administrators: 28 percent "To a very high degree" and 42 percent "Somewhat high degree," followed by Regional/County government politicians: 26 percent "To a very high degree" and 44 percent "Somewhat high

degree," Local County level health care administrators: 25 percent "To a very high degree" and 44 percent "Somewhat high degree", and Other local government administrators: 23 percent "To a very high degree" and 39 percent "Somewhat high degree." What these groups of large contributors to frail elderly services have in common is that they are administrators at multiple levels and actors of government authority. However, here we must also have in mind that the largest proportion of members in these coordination bodies are in fact administrators, as described in the beginning of the presentation of the findings. Thus, just as in the case of the question of influence over frail elderly policies, the fact that administrators score highest in the question of which actors who contribute the most to frail elderly services, is probably explained by the larger proportion of administrators in the staffing of these coordination bodies.

Among the multiple levels of politicians, those closest to the actual services – that is Local government board members – are perceived as contributing the most to frail elderly services among politicians: 17 percent "To a very high degree" and 33 percent "Somewhat high degree," followed by Regional/County government politicians: 14 percent "To a very high degree" and 34 percent "Somewhat high degree," and Top local government politicians: 9 percent "To a very high degree" and 19 percent "Somewhat high degree."

Nevertheless, in fact private health care providers score somewhat higher compared to the top local politicians, at: 9 percent "To a very high degree" and 24 percent "Somewhat high degree." However, the perceived contribution from pensioner/non-profit organizations was quite low: 2 percent "To a very high degree" and 7 percent "Somewhat high degree." Thus, again it seems that a very low proportion of pensioner/non-profit organization in the staffing of these bodies, seem to reflect that few see an actual contribution to coordinated frail elderly policies.

What then are the latent patterns of contribution? According to Table 6, it is quite clear that latent types of health care-social services contribution are multi-level political, administrative or operational in nature, and again reflect multi-level the representation as shown in Table 1. Thus, multi-level representation in coordination bodies to a great deal also explain the level and nature of the contribution to the service quality emanating from this multi-level policy coordination. A main difference here is that Pensioner/non-profit organizations are more clearly included in the political dimension, that is: the more the respondent thinks multiple levels of political representatives contribute to coordinate the quality of health and social care, the more he or she also includes user organization representatives in this equation.

Table 6. Types of forces contributing to elder care and health care quality according to member in multilevel coordination body (Orthogonal Rotation, Varimax)

Ordinary member of network body	*Political*	*Administrative*	*Operational*
Regional/County government politicians	**0.88**	0.13	-0.20
Local government board members (for example social welfare board)	**0.87**	0.23	-0.12
Top local government politicians (Council and Executive board)	**0.85**	-0.03	-0.02
Pensioner / non-profit organizations	**0.65**	-0.03	0.53
Regional/County specialist health care administrators	-0.03	**0.84**	0.14
Top local social welfare administrators	0.18	**0.78**	0.08
Local County level health care administrators	-0.17	**0.74**	0.35
Top Regional/County administrators	-0.31	**0.67**	-0.04
Private health care providers	-0.10	0.12	**0.77**
Other local government administrators	-0.07	0.19	**0.73**
Variance explained (%)	*32*	*25*	*12*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.68. Variance explained=69 percent. Above .60 in bold type. Crombach's Alpha: 0.84 (Political), 0.83 (Administrative), 0.59 (Operational).

How the members of these bodies regard effectiveness: external and internal performance.

Although multi-level representation of coordination strongly shape the level and form of influence and contribution of the coordination bodies, when it comes to the perception of coordination body effectiveness, a completely different pattern emerges, in which indicators the indicators form into two types of performance measures (Table 7). The variance explained is equally high for both factors. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) is 0.86, which as well as the reliability measures well above the rule of thumb.

External performance ranges between those coordination body members who either do not think, or think that “The body has a clear purpose for cooperation”; that “The body has a well-defined target group for cooperation”; that “There is a good consensus in the body how the work with elderly people with complex needs should be performed”; that “Work in the body is characterized by good communication; and that “I can trust that the decisions and agreements of the body are implemented.” Indeed, the clearer the purpose and well-defined target group for cooperation of the body, the better the communication and leadership is regarded in the body, and the stronger the trust is of decisions actually being implemented.

On the contrary, internal performance ranges between those coordination body members who either do not think, or think that “Lack of knowledge about each other's activities pose a problem to work in the cooperation body”; “Lack of experience of cooperation is a problem for the work in the body”; “There is an uneven distribution of power between the actors in the body”; and that “Leadership is too hierarchical in the body.” Thus, the less the knowledge about other body members’ activities and experience with cooperation, the more uneven and hierarchical is the distribution of power and leadership. To conclude, above all it seems that poor internal performance of the coordination body – and the detected transboundary policy coordination system – really is associated with hierarchical leadership and uneven power distribution, which also gives yet more general support for the horizontalism model of the decentralized welfare state.

Table 7. Perceptions of coordination effectiveness (Orthogonal Rotation, SPSS Varimax)

	Performance Effectiveness	
Indicators of performance effectiveness perception	*External*	*Internal*
The body has a clear purpose for cooperation	**0.82**	-0.03
The body has a well-defined target group for cooperation	**0.79**	-0.02
There is a good consensus in the body how the work with elderly people with complex needs should be performed	**0.66**	-0.39
Work in the body is characterized by good communication	**0.66**	-0.40
Leadership of the cooperation body is well adapted to the task	**0.64**	-0.16
I can trust that the decisions and agreements of the body are implemented	**0.60**	-0.35
Lack of knowledge about each other's activities pose a problem to work in the cooperation body	-0.08	**0.80**
Lack of experience of cooperation is a problem for the work in the body	-0.12	**0.73**
There is an uneven distribution of power between the actors in the body	-0.16	**0.69**
Leadership is too hierarchical in the body	-0.30	**0.64**
Variance explained (%)	*30*	*25*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.86. Variance explained=54 percent. Equal to or above .50 in bold type. Crombach's Alpha: 0.83 (External), 0.73 (Internal).

The findings in Table 7 correspond to other research in Sweden on measuring performance among local government managers (Szücs et al. 2014, Björk et al 2014), however here it gets more complex because of the transboundary policy challenges that multi-level coordination body members find themselves in. There are coordination body members that systematically think that their body is not performing effectively, either internally or externally, which is why we now finally also turn to the measure of what the members of multi-level, multi-actor and multi-issue policy coordination bodies think about the accountability of their bodies.

On Accountability: Perceptions of how members are being held accountable

Two main competing concepts of democratic accountability are often defined in the literature: internal and external check (Friedrich 1940, Finer 1941). However, when it comes to multi-level, multi-actor and multi-issue policy coordination bodies it gets more complex, as there is in fact no internal check, but rather at best a coordinated check of policy performance effectiveness (for a separate study on democratic accountability based on the very same data, see Johansson et al. 2017). Therefore, the assumption is that the responsibility is multi-level and again divided into separate spheres of coordinated administrative and political accountability and responsibility. The following question was used in the questionnaire: "To what degree do the following operators monitor and review work in the collaboration body?" The group that the largest proportion of the respondents says working "To a very high degree" with accountability are Top local social welfare administration (27 percent), followed by Regional/County administration (13 percent), Local government board members (for example social welfare board), Local County level health care administration (10 percent) and Regional/County government politicians (8 percent).

However, the factor analysis reveals a more simplified pattern. That is, accountability is either performed externally by media, relatives, revision, inspection authorities and Pensioner/non-profit organizations, or performed internally but multi-level by politicians and administrators separately. Thus, also democratic accountability is formed in multi-level dimensions of representation for politicians and administrators (Table 1).

To conclude, accountability is democratic by its clearly divided accountability roles in checks and balances of multi-level political and administrative responsibility. Again, the variance explained by these factors is high, with well above the rule of thumb for measures of sampling adequacy and reliability, as seen in Table 8.

Table 8. Forms of democratic accountability in respondent's multilevel body (Orthogonal Rotation, SPSS Varimax)

	Coordination body representatives' accountability		
Accountability actors	*External*	*Administrative*	*Political*
Relatives	**0.89**	0.18	0.14
Inspection authorities	**0.85**	0.08	0.19
Media	**0.83**	0.06	0.08
Revision	**0.82**	0.07	0.26
Pensioner / non-profit organisations	**0.71**	0.18	0.32
Local County level health care administration	0.20	**0.83**	-0.04
Top local social welfare administration	0.03	**0.83**	0.25
Regional/County specialist health care administration	0.14	**0.83**	0.10
Regional/County administration	0.06	**0.64**	0.41
Regional/County government politicians	0.21	0.20	**0.88**
Local government board members (for example social welfare board)	0.22	0.27	**0.84**
Top local government politicians (Council and Executive board)	0.30	0.04	**0.78**
Variance explained (%)	*45*	*18*	*12*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.82. Variance explained=74 percent Equal to or above .50 in bold type. Crombach's Alpha: 0.91 (External), 0.84 (Administrative), 0.88 (Political).

Responsibility for lack of quality.

But what happens if lack of quality is found, who do the respondents claim to be primarily responsible? The question in the questionnaire was "Who do you perceive as responsible for any lack of quality that can be linked to cooperation /collaboration around elderly people with complex needs?" Thus, who will be seen as transboundary responsible if "shit happens"?

In the case of any lack of quality in the policy coordinated by the body, most the members of these bodies say that the Top social welfare administration will be “To a very high degree” responsible” (42 percent), followed by different actors of the regional county level responsible for the health care of the frail elderly (34-36 percent). At third place comes Local government board members such as the social welfare board (who is in fact are responsible according to the Law). However, the factor analysis again provides a more distinct multi-level pattern based on representative roles in responsibility being either multi-level administrative (with pensioner/non-profit organizations included) or operational (Table 9).

Table 9. Forms of accountability responsibility of respondent’s multilevel body (Orthogonal Rotation, SPSS Varimax)

	Coordination body representatives' accountability responsibility		
Accountability responsibility actors	*Administrative*	*Operational*	*Political*
Regional/County specialist health care administration	**0.88**	0.22	0.15
Local County level primary health care administration/order-performer unit	**0.83**	0.24	0.17
Regional/County central administration	**0.75**	0.02	0.39
Top local social welfare administration	**0.69**	0.27	0.29
Pensioner / non-profit organisations	**0.71**	0.18	0.32
Operational level local primary health care personnel	0.18	**0.94**	0.03
Operational level elder care personnel	0.15	**0.92**	0.05
Operational level hospital / specialist care personnel	0.23	**0.92**	0.01
Top local government politicians (Council and Executive board)	0.13	0.01	**0.87**
Local government board members (for example social welfare board)	0.27	0.11	**0.82**
Regional/County government politicians	0.33	-0.23	**0.81**
Variance explained (%)	*47*	*23*	*10*

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO): 0.80. Variance explained=80 percent. Equal to or above .50 in bold type. Crombach’s Alpha: 0.87 (Administrative), 0.94 (Operational), 0.84 (Political).

The strongest dimension is the multi-level administrative, with almost half of the variance explained, followed by the operational multi-actor dimension. Again, the variance explained by these factors is quite high, with well above the rule of thumb for measures of sampling adequacy and reliability, as seen in Table 9. However, the weakest of these dimensions are the political, with only ten percent variance explained. Thus, this finding seems to be an *Achilles heel for democratic accountability*, because while these politicians are bound both by law and by the electorates of the local and regional government levels, they are as a multi-level group of actors the least seen as a main source of responsibility if any lack of quality occur in the social and health care coordinated policies for frail elderly people in their constituencies.

Conclusion and discussion

The decentralized Nordic welfare state is since its detected shift in the early 1990s of turning into a horizontal management model, an interesting and relevant testing site for studying politics of policy coordination to solve transboundary multi-level, multi-actor and multi-issue public sector dilemmas. In particular, because it allows us to analyze how and why such horizontal policy coordination can be viewed as a successful form of democratic networked governance when performed in coordination bodies dealing with such transboundary policy challenges. Data in order to test this comes mainly from a survey of the members in 73 such policy coordination bodies from all of Sweden dealing with frail elderly policy through the provision of social care from the local government level and health care from the regional government level, and services delivered by both public and private service providers that also may involve non-profit and interest / pensioner organizations.

The theoretical assumption advanced in this paper is that such transboundary multi-actor and multi-issue policy coordination problems within a new policy area, such as frail elderly

policy, can be solved better within a context of networked democratic governance characterized by values and strategies of horizontalism and horizontal management for greater capacity and accountability based on multi-level representation (mostly local and regional), that incorporates supra-national (for example, EU) and national legislative frameworks. That is, strategies founded on the participants' values of those networks and transboundary policy coordination bodies and their joint activity to increase the public value, rather than the structural relationships between these organizations.

First of all, the findings show that horizontal management model of networked governance, guided by horizontalism, in a highly decentralized welfare state like Sweden, really provides for what can be preliminary defined as *policy coordination system*, built on multi-level representation in boards for 1) politicians' exchange of information as diplomats representing the interests of the different levels, but in deliberate contact with its own municipal public service provider as well as civil society organizations; 2) administrators from different levels handling the question of what issues should be strategically dealt with in contact with other providers of elder care providers and health care; and 3) managers / professionals from the different levels in clinch on how these most strategic issues should be solved.

Secondly, this transboundary multi-level representation to a great extent determines their inherent capacity, in terms of multi-level but separated political and administrative influence (and contribution), while operational level influence shows a strong interaction between private service providers and civic organizations (most presumably this is a strong way to influence in municipalities where the local government has decided to introduce a market like system for elder care). Performance however, is mainly divided into internal and external factors of more or less well-performing coordination bodies according to its members.

Third, this multi-level division of representation between the political, administrative and operational level finally as well determines the ways to be accountable and responsible for its performance. Although external check constitutes a strong dimension for testing the accountability of the coordination body, internal check is mainly divided into the multi-level the political and administrative domains, while responsibility in case of misconduct also includes the operational level to a great extent, while the weakest of these dimensions is the political. Hence, this last finding is labelled the *Achilles heel for democratic accountability* within this transboundary policy coordination system, because while these politicians are bound both by law and by the electorates of the local and regional government levels, they are as a multi-level group of actors the least seen as having primary responsibility in the case of any lack of quality will occur in the social and health care coordinated policies for frail elderly people in their constituencies.

These findings open up for a continuing discussion on the relationship between organization and processes and the quality of transboundary, nested welfare services such as social services and health care to frail elderly. In short, the big question seems to be: Why do some coordination bodies within the decentralized, horizontally managed welfare state succeed to function internally and deliver and implement externally while others fail? According to its members, some coordination bodies perform worse or better internally (good communication, experience, equal representation, non-hierarchical) and/or produce worse or better in terms external efficiency and quality (clearer purpose, well-defined target group, better leadership, consensus and trust in the implementation of decisions): why is that, given the findings in this paper? Thus, transboundary policy challenges of public management reform analyzed in this paper opens up a whole new political dimension for the late modern welfare state, not the least in terms of efforts in linking quality to processes and the organization of democracy.

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