Mia Vabø

13 Changing Welfare Institutions as Sites of Contestation

Nordic welfare states have been labelled as "caring states" (Leira, 1994) and "social care regimes" (Sipilä, 1997) to signify extensive provision of publicly funded care offered to and utilized by citizens from all socio-economic groups. The provision of public services is characteristically channelled through local authorities. A broad range of statutory social services are provided by municipalities, such as kindergartens, schools, primary health care and various forms of residential care and home care. In fact local governments account for approximately two-thirds of all public expenditure and employ approximately two-thirds of all employees within the public sector (Baldersheim & Ståhlberg, 2002, p. 74).

From the idea that services should be accommodated to local circumstances, considerable decision-making power has been devolved to the local level. Scholars regard the relations between the local and central levels of governance to be rather coordinated and harmonious (Baldersheim & Ståhlberg, 2002). For instance, organizing joint conferences has become a growing industry, and reform steps have to a large degree been conceived as joint central–local projects, characterized by substantial elements of mutual learning and replication across municipal borders (Baldersheim, 2003, p. 31). The Norwegian Association for Local Authorities (KS), which both takes on the role as employers' representative and as consultant in administrative reforms, plays an important role in creating consensus between the central and local levels (Hanssen et al., 2012).

During the 1990s, efforts to fine-tune the local service apparatus have increasingly taken inspiration from the global public sector reform agenda, New Public Management (NPM) (Blåka et al., 2012). Like in most Western countries, the NPM trend has attracted a lot of attention in Norway, partly because it appears as a radical "shock" suggesting that power relations should be drastically reshuffled. But partly also because the conception of NPM, as it is regarded to be a global trajectory of reform, has fuelled a range of comparative research and made researchers focus narrowly on particular practices across national borders. According to Wise (2002) this principal focus may actually have magnified its impact and distorted our view of public sector evolution. Almost all organizational changes are interpreted within a single reform paradigm, while reforms outside this paradigm go unnoticed (Wise 2002, p. 555; see also Baldersheim, 2003, p. 30).

In this chapter, the Norwegian home care institution will serve as an illuminating case to demonstrate how ideas taken from the NPM agenda intersect with other drivers of change rooted in other normative positions. The chapter demonstrates how this particular service has been overlaid by expectations from central and local governments. Some elements in this process has been legislative in character. However,

within the multi-level Nordic democracy, there are multiple channels, which allow a wide range of actors to influence the policy process (Burau & Dahl, 2013; Meagher & Szebehely, 2013). The chapter particularly illustrates the way in which NPM-related ideas have provided points of leverage not only for actors driven by the search for efficiency, but also for actors concerned to rearticulate more traditional public sector values.

Before turning to the empirical part, the chapter starts by mapping out a conceptual framework through highlighting social service institutions as contested formations, characterized by modes of governance that are not readily compatible. The framework also highlights the process of change as a discursive struggle – a process whereby various actors aim to create, maintain and disrupt institutions in accordance with their particular frames of meaning.

13.1 The Contested Character of Welfare Service Institutions

In their search for conceptual models that adapt endogenous as well as exogenous sources of change, Mahoney and Thelen object to the widespread assumption that institutions are almost inert formations. In their approach, institutions are fraught with tensions because they inevitably raise resource considerations and invariably have distributional consequences. Hence, there will always be some actors who are in favour of change, while others may defend the status quo (Mahoney & Thelen 2010, p. 8).

In the case of public social service institutions, it is widely recognized that ongoing and persistent tensions exist, for example, between fiscal goals and welfare goals, between efficiency and various probity measures, between individualized care and procedural justice (see for instance Lipsky, 1980; Gummer, 1990; Harmon & Mayer, 1986; Newman, 2001; Hogget, 2005, 2006). In order to highlight that a number of people are bargaining among themselves to decide on the best way to get things done, organizational scholars have characterized social service organization as multiple actors/multiple goals organizations – in sharp contrast to single actor/single goal models (Gummer, 1990, p. 9).

Tensions between different ideas about the best way to run services are fine-meshed. Care professionals may disagree, for instance on whether care providers should take on an enabling or supportive role, or they may disagree on how service provision can best be specialized and coordinated. Hood and Jackson (1991) argue that, even though arguments about the best way to run public administrations are numerous, these arguments seem to serve a small but stable set of administrative values. They distinguish between three families of administrative values – all of which are widely accepted, but still difficult to satisfy by the same organizing principle. The first set of values is connected with the matching of resources to defined objectives – that is, to maximize outputs. The central concern is to keep public organizations lean

and purposeful – to trim fat and avoid slack. An orthodox organizational design for realizing these values is the *rational goal model* – a typical mechanistic structure and setting of fixed and checkable goals.

The second set of values is related to rights and the adequacy of governmental process. The core values of fairness, equity and rectitude are ensured through process control rather than output control. Hence, the ideal organizational form is the *hierarchy model* characterized by transparency, due process and formal accountability flowing upwards to democratic bodies.

The third set of values includes traits such as resilience, adaptivity and reliability. Public service providers are expected to be able to operate even in worst-case conditions, to adapt rapidly in a crisis and to be able to learn from failures. Adapting to ambiguous and unstable conditions calls for an *organic organization* – based on a high degree of slack, committed staff, cooperation and constant adjustments. This third set of values has been regarded as a more "hidden" constitutional dimension of government associated with public trust (Toonen, 2007, p. 305) and the way discretionary power of public service agencies is used to create "legitimacy from below" (Rothstein, 2007, pp. 213-221). Put briefly, it may be related to the ability of institutions to avoid scandals and negative headlines in the news.

According to Hood (1991) these three sets of values are regarded as indisputable though largely in conflict within public bureaucracies. For instance, it may be argued that procedural routines are needed in order to act responsibly towards all potentially worthy cases. Nonetheless, bureaucratic procedures may simultaneously be regarded as wasteful and inefficient from the perspective of the financial controller or as excessively rigid from the perspective of front-line staff, who are required to respond to special circumstances and needs of clients. The way in which the three different sets of values are balanced is not given once and for all but is constantly negotiated between different actors and may be radically disturbed when new administrative reforms are put into practice.

13.2 Institutions as Constituted by and Changed by Discourse

The idea that institutions are rather stable formations, incidentally punctured by exogenous shocks, directs the focus of attention to *major* changes. In contrast, scholars, such as Paul Pierson (2000) draw attention to ongoing incremental changes unfolding over time because of efforts to close the gap between an institution's intentions and outcome. Kathleen Thelen's approach moves beyond the discussion of major versus incremental change. Streeck and Thelen (2005) and Mahoney and Thelen (2010) refer to several mechanisms of institutional change, most of which imply that institutions may change even though they appear to show stability. Institutions may change abruptly as rules are replaced by new ones, but changes often occur more gradually, as is the case with the mechanisms of conversion, drift

and layering. *Conversion* occurs when institutions are redirected towards new goals, functions and purposes; *drift* takes place when rules are formally the same, but institutions adapt to shifts in external conditions. *Layering* occurs when new rules are attached to existing ones – that is, that rather than replacing existing rules, new rules tend to change the structure and status of the "old" rules (see van der Hejden, 2011 for a broad discussion).

My presentation of the historical institutional context of the Norwegian home care system will demonstrate the usefulness of these concepts of incremental change. Still they do not fully capture the direction and dynamic of change. Following Schmidt (2008, 2010), I believe that the dynamic of change is better explained if more attention is drawn to the substantive ideas of political actors and *why* they want to alter or preserve their practices. Institutions are serving both as *constraining* structures and *enabling* constructs of meaning. Institutions constitute the context within which agents think, act and speak, but they are also a result of agents' thoughts, words and actions. Sentient agents are able to think critically about their own institutions and are able to build consensus around ideas. Hence, discursive institutionalism regards norms and rules-of-the-game as dynamic, intersubjective constructs rather than static structures.

Mainstream sociological institutionalism has paid considerable attention to management ideas and the fact that these ideas are transformed as they are put into operation in different contexts. Røvik (1998), for instance, regards popular management ideas as semi-finished products and as such, required to be crafted into existing routines and practices. Discursive institutionalism takes one step further by considering the direction of change. Ideas are not free floating; they are always represented in a more overarching discourse. Any given discourse may serve to articulate not only different levels and types of ideas, but also the structure of meaning that channels policy or actions in certain directions.

"A discourse refers to a set of meanings, metaphors, representations, images, stories statements and so on that in some way together produce a particular version of events" (Burr, 1995, p. 48). As noted by Schmidt (2008, p. 310), discourse is not only about what you say, but also to whom you say it, as well as how and why. It can be seen as a historically contingent body of regularized practices of language that are condoned by a particular community (De Cock, 1998, p. 2). They play an important role in structuring power relations; institutionalized practices like medical counselling or accountancy are characterized by specialized arguments and tacit rules of communication dictating what can be talked about in which ways, and (above all) who has the right to speak.

Like institutions themselves discourses are neither monolithic nor static, but are overlapping and co-existing with competing discourses. Words and phrases are sometimes exchanged across discourses, filled with different meanings and used for different purposes. Words that are open to different ascriptions of meaning, so called "floating signifiers" (Laclau, 1990), tend to flourish in management reforms

(Czarniawska-Joerges, 1993). Hence, these reforms open up for ongoing struggles between different discourses to fix the meaning of important words – for instance, the meaning of "quality" or "user orientation" (Clarke & Newman, 1993, p. 60; Vabø, 2006).

In their studies of NPM-related changes in the UK, Clarke and Newman (1997) found that managerial roles and routines were layered on top of existing bureaucratic-professional practices and produced fields of tension rather than being simply *replaced* by new policy ideas and discourses. Newman (2001) emphasized the same points in her study of Tony Blair's Third Way policy: " New discourses had to negotiate or displace the residues of those installed under social democratic and neo-liberal governments, now deeply embedded in institutional norms, entrenched interests, cultural values and organizational or professional identities" (Newman, 2001, p. 166). According to Newman tensions between the "new" and the "old" may be resolved in various ways. New discourses may *co-opt* existing discourses into their own legitimating narrative, they may *subordinate* existing discourses through state power or they may be *appropriated* by managers, professional staff and others in their pursuit of other agendas.

In the context of social service institutions it is of vital importance to recognize the distinction between changes in political and administrative decision-making and changes at a practical level of service provision. Governments may proclaim that they "have" purchaser-provider splits, performance-related pay or Total Quality Management. Official announcements, however, rarely offer a sufficient account of what is going on "on the ground" (Pollitt, 2002). Change agents – whether they are civil servants or consultants – support their arguments with metaphors, broad abstracted labels and conventional notions which permit a flexible redefinition of steps to be taken. Vabø (2002) characterizes the managerial discourse as a language of reconciliation in which seemingly opposed values are miraculously resolved. As they open up for many possible meanings, broad abstract labels become floating signifiers that may create a context of positive expectation – such as, Who can be against quality?

Public management reform is often a multi-step, long drawn out and erratic process (Pollitt, 2002). An important part of the complexity is the multi-layered nature of administrative action. Professionals in social services organizations may, for instance, be offered new positions as "purchasers", "providers" or "strategic managers" or may be subjected to new practices through inspections and audit regimes. It is, however, important to bear in mind that they are caught up in the play of competing discourses and may therefore respond to suggested changes in ways not anticipated (see, for instance, Halford & Leonard, 1999, p. 102, Harris & Unwin, 2009). People may comply with suggested changes because there is no alternative but may not always be committed to them with enthusiasm or identification. As noted by Clarke and Newman (1997, p. 54) they may be subjected *to* a discourse but not necessarily subjected *by* it. The latter way of complying with changes typically

occurs when care staff feed data into a performance management system and thereby empower strategic managers to rationalize service provision (see below).

13.3 The Institutional History of Norwegian Home Care

13.3.1 1960s and 70s – An Era of Expansion

Like many other social services in Norway, home care services originated in the third sector and were absorbed into the nationally mandated programmes after the Second World War. The service expanded greatly in the 1960s and 70s thanks to generous earmarked grants from the central government to local authorities through a system whereby considerable costs for care were reimbursed. However, as an infrastructure of services was established by the end of the 1970s, the active role of the state and incentives for expansion were replaced by incentives for finding cohesive and cost effective care solutions at the local level.

13.3.2 1985-1995 – An Era of Decentralization and Democratization

In the mid-1980s the central government delegated to municipalities the responsibility for a whole range of services. The generous reimbursement system was replaced by one based on block grants. These efforts of devolving functions downwards went hand in hand with a reform strategy stressing participation and local democracy. A core argument behind the reform was to integrate citizens in the governing of public services in order to make services adapted to local conditions. Although it was never questioned whether home care services should be offered as an entitlement of citizenship, national policy documents valued partnership working with families and active co-responsible citizens (see also Sehested, 2002; Vabø, 2011b)

As subsidies from central government were capped, local authorities had to curb expenditures. Most local authorities then reduced the number of beds in institutions and transferred typical nursing tasks from institutions to the home care system. This marked the beginning of a process of change whereby the role of home care changed from a preventative role stressing practical and social care for the elderly with moderate care needs towards a more medicalized role of providing rehabilitation, medical assistance and nursing care for the frail and sick elderly and terminally ill. Seen through the lens of Mahoney and Thelen's concepts these changes may be characterized partly as a process of *conversion* – a redeployment of old institutions to new purposes. Changes have clearly also occurred through institutional *drift* as domestic and social tasks have tacitly been off-loaded from the home care system without any political decision-making or legislative changes (Vabø & Szebehely, 2012).

The decentralization reform also encouraged local governments to organize services in a cost-effective manner. Home care was typically organized in self-regulated teams, providing services for the population of a specific geographical area. Organizational arrangements reflected a belief that human service organizations are bound to deal with needs that are contextual, complex and shifting. It was argued that those closest to the individual service recipients (Olsen, 1992, p. 124) therefore should conduct needs assessments and service allocation. The team organization corresponds with Minzberg's (1983, p. 105) notion of horizontal decentralization – the transfer of responsibility from line managers into the realm of operators – that is, the frontline staff who work directly with service recipients. Viewed against Hood's classification of administrative values, the arguments behind the team organization were linked to core values of resilience and reliability.

13.3.3 1995: The Quest for Transparency and Enforceable Rights for Citizens

In the years following the decentralization reform, quality problems in the local care sector became a topic of public dispute. Public debates on eldercare peaked in 1990 during the so-called "elderly revolt" – a media protest started by a middle class senior citizen (Vabø, 2011b). The heated public debates generalized a kind of media hype portraying individuals' grievances against local services, often accompanied by comments from various actors entering the role as champions of the elderly in need of care. Unlike the ideal of active co-responsible citizens figuring in policy documents associated with the decentralization reform, the citizen of these media hypes was always a possessor of rights – a taxpayer with the right to expect top-quality service from a wealthy oil-nation.

In the 1990s, the legal security of citizens and accountability of local governments was put on the agenda by central governments. A range of measures were implemented to enhance the transparency of local service provision and to make the legal rights of citizens more enforceable. Procedural rights of citizens were strengthened as the *Social Services Act* stipulated the right of citizens to have their needs individually assessed, to make their views known, to receive written and well-founded decisions and the right to appeal. Furthermore, a new clause in the Health Services Supervision Act of 1984 was added in 1992 requiring that health and care services should implement a system of internal control (internal audit). The focus on internal control systems was endorsed by a Quality Regulation (*kvalitetsforskriften*) directed towards all agencies providing long-term care (Ministry of Health and Social Care, 1997). All these regulations called for more explicit allocation criteria and work procedures in home care. Local care agencies were encouraged to put into writing what was previously carried around in the heads of front line staff (Vabø, 2011a).

Local governments were also increasingly required to report information about finances, governance and services. A national information system, KOSTRA, was put

into practice. The system was based on consecutive data records and annual reports from local authorities and made it possible to compare resource use and broad quality indicators across municipal borders. An additional reporting system, IPLOS, was later added to the system, providing encrypted individual information about all recipients of care in Norwegian municipalities.

The quest for transparency and improved control was clearly rooted in traditional public sector values, stressing rights and the adequacy of governmental processes. However, central health authorities also encouraged municipalities to utilize data from KOSTRA-IPLOS for benchmarking and learning from "best practice" municipalities. It became highly entangled with a modernization agenda inspired by NPM.

13.4 The Role of NPM as a Driver of Change

Overlapping with the increased control from central governments in the 1990s, a range of measures associated with the global NPM agenda became a part of a general strategy of public sector modernization in Norway. A report commissioned by a right-wing government (NOU 2000) stated that *competition* is the key to quality. Accordingly, *various forms* of competition were recommended for public services such as competitive tendering, free-choice models and benchmarking (NOU 2000, p. 19). True marketization – that is, the idea to contract out services to for-profit companies – became a matter of passionate public dispute; in particular within elder care (Vabø et al., 2013). The resistance against "putting grandmother out to tender" was fronted by a large and well-organized trade union movement, The Norwegian Union of Municipal and General Employees ("Fagforbundet"). The union worked (and still works) systematically with awareness around marketization issues – working from below with trade union representatives rather than lobbying in Parliament. In addition, the unions felt the need to come up with constructive alternatives because they saw that if they were simply seen as arguing against change, they would have little impact. The most prominent result of the search for alternative development strategies is the Model Municipality Experiment, a counter strategy based on a basic view that there is a close link between working conditions and conditions for good services. The idea was that skills, knowledge and initiatives from "below" could contribute to enhancing cost-efficiency and quality – cooperation and not competition would produce better, more cost-effective services. The approach was based in the previous policy discourse stressing empowerment of staff and citizens (Vabø et al., 2013). This counter strategy succeeded in prevented the marketization discourse from fixing the meaning of quality.

Even though "true marketization" was contested, a range of softer NPM measures have been adopted, at least by urban and densely populated municipalities. Efforts to modernize the public services have been influenced by ideas such as purchaser-provider splits, autonomous budgetary units, fee-for-service reimbursement and

various forms of marketing and quality management systems (Torsteinsen, 2012; Blåka et al., 2012).

A core model associated with the NPM inspiration in home care is the purchaser-provider model – a model suggesting that responsibility for assessing and approving a contract for services should be separated from the responsibility of providing services (Vabø, 2006). The distinction between purchaser and provider roles is regarded as a necessary step towards competitive tendering and the purchase of services from private agencies. However, the Norwegian Association of Local and Regional Authorities (KS) argued that the separation and specialization of roles would also be appropriate for those who did not tender out services. KS argued that it would make in-house providers better positioned to demand quality and to control and manage quality at arm's length (Pape, 2000).

What is interesting to note here is that the purchaser-provider model was also justified as a way for local governments to deal with the legal and formal aspects of service provision. Many local authorities were already pressed to find adequate ways to adapt to the procedural rights of citizens stipulated in the Social Service Act (see further details below). Hence, in contrast to the NPM textbooks' focus on the model as "managing by contracts" (output) rather than by rules (input), local administrators argued that the model was an appropriate structure for dealing with new procedural rules decreed by law (Vabø, 2011a). They believed that specialized care assessors would be apt to take a more detached view of care needs than would the hands-on care staff (Gammelsæther, 2006; Vabø, 2007). Hence, the purchaser-provider model was reframed within the discourse of the classic rule-bound bureaucracy. This reframing obviously added legitimacy to the model and contributed to making it more acceptable and more widespread (see Blomberg, 2004 about similar trends in Sweden). The purchaser-provider model became an assumed cure-all model – a model able to enhance cost effectiveness as well as procedural justice.

13.5 Processes of Change at the Operational Level

The brief historical account suggests that the Norwegian home care institution has been characterized by a process of layering, whereby by new modes of governance stressing vertical integration – both in terms of more regulated routines for service allocation and in terms of contractual control from "above" – have been overlaid onto an organizational form characterized by horizontal decentralization. Questions then arise concerning how these new ideas of governance intersect with the norms and values justifying the "old" team organization. How did hands-on care staff understand and respond to the new imperatives suggesting that their relationship with clients should be guided by formal agreements and standards specified by specialized needs assessors?

I now turn to the practical level of the home care institutions and to the lived experiences of managers and care staff who have been the target of reform. This section draws on findings from my own published case studies conducted in several urban home care districts over the past 20 years. The first case study, conducted in the mid-1990s – the "Care Team Study"– provides insight into the team organization model which was the typical way of organizing home care the first decade after the decentralization reform (Vabø, 1998). The second study – the "Reorganization Study"– sheds light on how the efforts to restructure the home care service in line with softer NPM ideas was perceived and responded to by managers and staff. More recent studies, the "Follow-up Studies", were conducted between 2007 and 2010 and intentionally selected to illuminate how statutory accountability requirements and NPM-related measures have interacted and affected routines and service allocation. (For further details see Vabø 2011a; 2012.)

13.6 Self-regulated Care Teams Facing the Purchaser–Provider Model

My inquiries into five different home care teams in the mid-1990s confirmed that care teams were based on a collegial organization characterized by vertical communication and practitioners and staff managers (group leaders) working cooperatively. Decision-making power was delegated, not only to skilled nurses and auxiliary nurses, but also to lower-skilled home helpers who spent more time with clients and thereby acquired first-hand knowledge of the everyday life of clients. The group leaders normally made the initial contact and oral agreement with new clients either in a hospital or in the client's home. However, the initial agreement often had to be adjusted or altered because care needs were ambiguous or unstable at first. Care staff interviewees argued that at the very moment elderly people are discharged from hospital, they may need time to recover and time to experience what their body is able to manage. Care needs may also suddenly shift due to changing health conditions or changing circumstances in the standing arrangements of the family.

Both group leaders and managers regarded it a matter of course that needs assessment was a continuous process overlapping with service provision. Senior care staff who had worked in home care since the 1970s regretted that available resources had become more scant over the past years, and as a result, service staff had become preoccupied with allocating these scarce resources in a manner that would ensure that the most urgent needs were prioritized. Their core working principle was to enable people to utilize their own coping capacity. Hence, people processing work was very much about identifying needs ("real needs", "urgent needs", "no needs") and classifying people according to their willingness and ability to utilize their own coping resources.

As their work had to be carried out within the limits of scarce resources, the degree of attention devoted to individual care recipients was regularly diminished by the needs of other service recipients and by the unpredictable influx of new clients requiring the caregivers' help. In order to balance competing needs, care staff constantly had to engage in negotiations and small talk with service recipients to make the daily work run smoothly. They regarded this kind of "interactional work" (Strauss et al., 1985) as a necessary ingredient in their work although they generally experienced the juggling between competing needs an unpleasant part of home care work.

Interviews with elderly service recipients echoed the logic of justice expressed by care staff: The majority of interviewees expressed great sympathy for the busy working conditions of care staff and for other care recipients whom they believed had more urgent needs than themselves. However, a minority refused this frame of reference. In their opinion home care services was a self-evident right of citizens and therefore services should be carried out according to clear entitlement criteria and incontrovertible agreements. These arguments, from allegedly demanding care recipients, echoed the quest for transparency displayed in the heated media debates at that time (see above). Accordingly, the push for transparency was not just an idea from a policy agenda "from above"; it was also rooted in people's lived experiences within the care system.

Shortly after the "Care Team Study" was completed, the purchaser-provider model was for the first time introduced in the Norwegian care sector. The abstract principle of separating the responsibility for purchasing services from that of providing those services implicitly presumes that needs are fairly stable and unambiguous, at least for those equipped with professional skills and adequate assessment instruments. It also implicitly presumes that needs assessment should be based on more explicit criteria and predefined needs categories and not on moral judgments concerning the coping capacities of named individuals (Vabø, 2011a).

In the "Reorganizing Study" conducted at the turn of the century (Vabø, 2002) I got a taste of the first reactions among manager and staff who had recently modernized their work organization in line with the purchaser-provider model. As mentioned above, the new structural arrangement was justified as a way to strengthen the legal rights of care applicants. Care managers and staff had been told that specialized care assessors would relieve them from paper work and make sure that citizens were well informed and equipped with a proper letter of assignment.

Even though these arguments were widely accepted as legitimate, care staff still regarded it as a matter of fact that specifying needs prior to the service provision is often next to impossible. Even the needs assessors themselves, who had previously worked as group leaders of home care teams, recognized that care needs are inherently ambiguous, unstable and shifting. They experienced the new assessment routines as cumbersome. In addition to attending to the frail elderly person in their charge, they had to be attending to procedures and form filling. When confronted with weak

patients who had just been discharged from hospital, they sometimes felt rude in "bombarding" their patients with questions and written information. They knew from previous care work experience that many frail elderly need some time to be aware of their post-discharge condition before they are willing to admit they need help. Care staff made ironic comments about new legal protection talk and gave narrative examples of how written information provided for legal protection sometimes gave rise to anxiety among frail elderly people because they did not have the energy to read them through. Nonetheless, they found it improper to make their voice heard. "*Who can be against legal protection of vulnerable old people?*"

Soon after the new structural arrangement was settled, provider staff had experienced that the separation and distance between needs assessors and hands-on staff was problematic – particularly when facing sudden shifts in care needs or facing care needs that had not been fully recognized by the needs assessor. New routines required a formal reassessment procedure. If the amount of service offered was inadequate, they had to state a reason for their judgment, make a phone call to the needs assessors and request a reassessment. The new procedure was awkward, laborious and sometimes unworkable because of time constraints.

Problems relating to inflexible and time consuming assessment routines cleared the way for a softer division of work between the needs assessors and care providers. Shortly after the model was implemented routines were renegotiated among local managers. Agreements were made to adopt a "wait-and-see" approach, which meant that care assignment letters and more fixed care routines were not settled prior to service provision, but after two weeks – after the opinion of care staff had been heard. Additionally, as unstable and unpredictable needs continued to occur, the terms of the contracts were regularly ignored. In certain situations it appeared inhumane and it would obviously result in blatant disregard of the wants and needs of the care recipients not to give a hand with small tasks, whether it be the laundry, feeding the wild birds outside the window or getting some extra groceries from the shop. The contractual logic of the purchaser-provider model was softened in order for care staff to attend to "real needs", "urgent needs" and "unstable needs". They regarded their own adjustments in the day-to-day practice as "rescue operations" when confronted with frail elderly who were dependent on help. Ironically, their rescue operation may also be seen as a way to hide unfortunate consequences of the purchaser-provider model and thereby an indirect way to sustain the prevailing discourse and direction of reform (Vabø, 2006). Or, to use Newman's concept, their rescue operation may have served to co-opt the professional discourse and practices into the legitimizing narratives of NPM.

While both purchaser and provider staff interpreted the new roles and routines in a heuristic manner, officials of the city district administration were highly committed to the aim of modernizing the service apparatus. Two change agents (called "internal quality consultants") were working full time to flesh out the bones of the new purchaser provision structure. Their reform plans and projects were highly influenced by the NPM agenda and were to a large degree guided by the support

services of a private consultancy company engaged by the town council. The two agents were enthused by the new world of management ideas coming from outside the municipal administration. They were involved in a process of implementing a quality management system, a regular user survey and citizen charters. They certainly realized that they had some teething troubles at the start of the project. However, according to what they had learned from private consultants as well as from a speaker from an innovative Swedish municipality, changes could take a longer time than expected, and there could be some setbacks along the way. They maintained that if more investments were made in training purchasing skills, if assessment officers were given more casework time, more training and sophisticated assessment tools, contractual control would be accomplished.

13.7 The Purchaser-Provider Organization as a Tool for Taylorization

The home care district described above was also included in the Follow-up Study in 2009 – 10 years after the Reorganization study. Over time, as new work procedures and performance measures were developed, the purchaser-provider organization matured in two ways. Firstly, both staff and managers regarded collaboration across the purchaser-provider divide as inescapable. Care staff reported that they were expected to be co-responsible for making sure that reassessments were made and files updated. Officials generally expressed a more pragmatic view of the purchaser-provider split than did the devoted change agents 10 years earlier. Together with well-functioning computer systems, this had eased off some of the friction between needs assessors and care staff providing hands on care(Vabø, 2011a; Vabø, 2012).

Secondly, services had become more strictly predefined by the purchaser, both in terms of tasks and time use. Standards and citizen charters provided information not only about entitlements; they also provided information about services that people were *not* entitled to expect. Hence, the new purchaser function contributed to the earlier mentioned process of drift whereby service elements were tacitly off-loaded from publicly funded home care, most likely onto families and commercial service providers (Vabø & Szebehely, 2012). The trend towards standardization also contributed to change the role of professionals. Whereas the previous working principle suggested that the raison d'être of home care was to enable elderly people to promote their own self-care, home care was now more narrowly linked to the task of providing safe and sound care. Care staff appeared as responsible "doers" rather than creative "enablers" (Vabø, 2012).

Furthermore, care staff had been subjected to a range of performance controls. They spent considerable time in front of computers, reporting on what they had done/not done, on how much time they had been spent on various tasks and so forth. In addition, they had to register and report IPLOS statistics (see above) and

respond to various forms of audits and surveys related to quality assessments at regular intervals. The information reported by provider units was fed back up to the local administration. As strategic managers had been empowered with quantified information updating them on the performance of different service providers in the city, they constantly used data as tools to enact remedial actions. For instance, efforts had recently been made to improve the utilization of staff resources through a new division of tasks, which meant that neighbourhoods were shared differently between provider groups. According to care staff the reorganization actually undermined the efficiency of day-to-day routines as they now had to start all over again building new trust relations with new clients.

The story may illuminate how the existing professional discourse, stressing flexible adaption to the coping capacity of individuals, was *subordinated* to a rationalistic discourse that stressed how predefined services should be delivered. Care staff adopted the new behaviours of the performance management system, but retain their self-image, values and knowledge rooted in the professional discourse. Hence, rather than melting into a new hybrid, the purchaser-provider model created tensions.

13.8 How Responsible Purchasing Paved the Way for Professional Power

In general, my studies have revealed that the efforts of local governments to fine-tune their purchaser-provider model have not been linear (Vabø, 2006, 2009). The process of change has been oscillating back and forth between "tightening steps" (i.e., towards more formalized procedures and harder control) and "softening steps" taken in order to respond promptly to shifting needs. What is important to note is that, although the purchaser-provider model definitively has worked to intensify care work and disempower the voice of professionals, constant discursive negotiations about how to run this organization efficiently may open up new opportunities for professional discourses to influence the way in which the purchaser-provider organization is enacted. My last example will illuminate how this can happen.

The topical case – the home care service in a medium-large Norwegian city – was chosen on purpose in the 2007 study to explore how a system based on "responsible purchasing" was put into practice. The decision to implement a purchaser-provider model was advertised by the local authority as a reform to secure the legal protection of citizens – not as a way to tender out services. In response to resistance from trade union representatives, the committee working to design the purchaser-provider organization came up with the term "responsible purchasing" – a term coined to emphasize that budget responsibility was transferred to the purchaser unit. This condition called for a fee-a-for-service reimbursement system – a system where the purchaser would assess individual needs and pay according to a contract specifying both the type of service offered and the amount of care staff time provided. Taking into

consideration the lesson from other municipalities, flexible reassessment routines were built into the model. In a case of increasing or decreasing care needs, it was decided that home care staff would have to make a "Need Change Report" (NC report) to the purchaser. The care assessor would then reassess care needs and possibly change the initial contract.

Care staff gradually learnt how to manoeuvre within the new system and became aware how making visible their own time use would secure remuneration that was more adequate. Staff interviewees reported unanimously that compared to the "old" team organization the new purchaser-provider arrangement caused a great deal of extra computer work mainly due to requirements to make NC reports for every minor change in care needs. For example, if the doctor prescribes for the patient to take eye drops three times a day instead of two times a day, a NC report is needed; if the prescription goes back to a two-times a day programme, another NC report is needed and so on. Even though the number of needs assessors had been doubled since the new organization model was introduced, it was impossible for them to respond to all the NC reports. They simply did not have the capacity to make all the reassessments required (see also Blomberg, 2008). Care staff, who were pressed to respond promptly to shifting needs, had to be persistent and had to spend time phoning the purchaser officers – just to get things moving. In practice this meant that reassessments to a large degree were delegated to care staff. Hence, the division of responsibility between purchaser and provider was blurred.

Care staff interviewees described the system as cumbersome and time consuming. Nevertheless, the fee-for-service system relieved them of the unpleasant burden of juggling between competing needs. They did not want to return to the "old" system. They still had a memory of the unpleasant part of home care work in the previous team organization where they continually had to give less priority to some people in order to meet the most urgent needs of others. Within the new purchaser-provider organization, when new and urgent care needs occurred, they could write NC reports and allocate more resources to meet the new care needs. Hence, the new organizational arrangement had in their view solved a problem of the team organization.

However, the flexibility built into the responsible purchaser-provider model certainly created a new problem for executives in the local administration as they now perceived that cost control had become very difficult. A consultancy firm, hired to investigate why costs in home care had risen sharply, pointed to several possible reasons for the problem, among which the excessive use of NC reports was one. As the consultancy firm is one of the most eager promoters of the purchaser-provider split, no critical comments were made concerning the adequacy of the purchaser-provider model in home care. The consultancy report attributed the problem of blurred lines of responsibility in terms of the skills and behaviour of employees – both of assessment officers and care staff. Officers in the purchaser unit had allegedly not managed to take the objective stance needed for their position. Their relationships with care staff had become too cosy. On their hand, care staff were accused of lacking "purchasing skills"

and of having a one-track mindset on "care rationality" without any perspectives on cost control. The consultants recommended the local authority to make an effort to improve purchaser control and to restrict the number of NC reports. In particular, care providers should be made more accountable in terms of economic issues.

In the wake of the consultancy investigation several suggestions were made on how to reduce the number of NC reports. One possible starting point was to make quantitative comparisons between provider units to explore whether some units were more inclined than others to write NC reports. The call for performance control indicates that the flexibility and trust characteristic of the "responsible-purchasing" model was problematized and would most likely be constrained by new control efforts in the near future.

13.9 The Dynamic of Change in Social Service Institutions

In this chapter, attention has been paid to processes of change within the Norwegian home care institution. Being embedded in a nationally mandated programme on "ageing in place", home care expanded greatly in the 1960s and 70s. The core aim of the service was to prevent and postpone institutionalization among older people. After a major decentralization reform in the mid-1980s, as the service became a part of an overall local health and social care apparatus, many local governments reduced the number of beds in institutions and thereby transferred new tasks to the home care service. Hence, the role of home care gradually changed, from a preventative role stressing practical and social care for elderly with moderate care needs towards a more medicalized role providing personal care and nursing care around-the-clock for the most frail, disabled and chronically ill (both old and young) (Daatland, 1998). Through the lens of Thelen's concepts of incremental change, change in the service profile of home care may partly be seen as a process of *conversion* – a "redeployment of old institutions to new purposes" (Streeck & Thelen, 2005). Changes also appear as a process of institutional *drift* due to pressure stemming from processes of rationalization in other parts of the health care system – for example, in the institutional care sector as well as in the hospital sector. Domestic and social tasks have tacitly been off-loaded from the home care system without any political decision-making or legislative changes (Vabø & Szebehely, 2012).

In conjunction with changes in service profile, the home care institution has been marked by various administrative reform efforts – including efforts associated with the global wave of New Public Management (NPM). As mentioned at the outset, scholars often regard NPM as a major driver of change. And it is often presumed that changes occur in a regular and unidirectional manner. However, following Mahoney and Thelen (2010) the history of the Norwegian home care system displays how measures picked from the NPM reform agenda have been grafted on to several layers of existing governance arrangements rooted in competing normative frameworks. In order to

understand more deeply the direction and dynamic of change in these processes of layering, I argued that is useful to bring in some insight from discursive institutionalism (Schmidt, 2008, 2010). Like the theory of layering, discursive institutionalism suggests that endogenous sources of change will never enter a world of tabula rasa, but a social world already infused with meaning and its own vocabulary.

My empirical examples from the home care sector give a taste of how processes of change have been driven by tensions between competing discourses and logics of governance, creating both intended and unintended consequences. For instance, I have demonstrated how the idea of competitive tendering entailed a discursive struggle around the concept of quality. The idea that competition will enhance quality may have mobilized some actors to tender out services, but it also provoked and enforced an alternative modernization agenda rooted in the normative drivers of previous reforms – stressing democracy, user-participation and a bottom-up approach to quality development. Other elements of NPM, like the purchaser-provider model, were not politically contested in the same way. Rather, as the purchaser-provider model was justified as a way to strengthen the legal rights of citizens; it operated in conjunction with government efforts to respond to people's demand for transparency and enforced citizen rights. Hence, the core structure of NPM was "sheltered" by the classical bureaucratic discourse stressing the value of due process, transparency and predictability.

My inquiries into the operational level of home care demonstrate that the purchaser-provider model subjected care workers to more rules and procedures (process control) as well as more performance control. Both these modes of governance challenged the autonomous role of care professionals and their ability to respond to the shifting care needs of individual care recipients. The way in which these tensions were resolved varied across organizational borders as well as over time. Snapshots from my case studies suggest that the contractual logic of the model is sometimes implemented in a "heuristic manner". Care professionals collaborate across the purchaser-provider divide in order to respond to the unstable and shifting needs of individuals. In some cases the co-responsibility of care professionals appeared as hidden rescue operations taking place alongside the efforts of local governments to make service provision more streamlined and standardized. However, my case studies also demonstrate how democratic forms of decision-making at the local level incidentally allow the professional discourse to fix the meaning of buzzwords surrounding restructuring processes.

The story about the Norwegian home care system exemplifies how efforts to reshape this service institution in line with ideas taken from the NPM agenda have derailed, as they have been infused with arguments and ideas linked to other reform drivers. Hence, in order to create legitimacy both from "above" and from "below", efforts to restructure service organizations tend to have unintended consequences which in turn prompt further reform efforts. This dynamic of change suggests that the home care system has become an unstable institution, characterized by a constant striving to rebalance conflicting modes of governance.

References

Baldersheim H. (2003). Local government reform in the Nordic countries. Bringing politics back in? In N. Kersting & A. Vetter (Eds.), *Reforming local government in Europe. Closing the gap between democracy and efficiency. Urban Research International, vol. 4*, (pp. 29-39). Leske + Budrich, Opladen.

Baldersheim, H., & Ståhlberg, K. (2002). From guided democracy to multi-level governance: Trends in central-local relations in the Nordic countries. *Local Government Studies*, *28*(3), 74-90.

Blomberg, S. (2008). The specialisation of needs-assessment in Swedish municipal care for older people: The diffusion of a new organisational model. *European Journal of Social Work*, *11*(4), 415-429.

Blåka, S., Tjerbo, T., & Zeiner, H. (2012). *Kommunal organisering 2012. Redegjørelse for kommunal og regionaldepartementets organisasjonsdatabase*, [On Municipal organization 2012. Descriptions based on the organization database of the Ministry of Local Government and Regional Development] NIBR Rapport 2012:21.

Burau, V., & Dahl, H. M. (2013). Trajectories of change in Danish long term care policies – reproduction by adaption through top down and bottom up reforms. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in europe* (pp. 79-95). New York: Springer + Business Media.

Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.

Clarke, J., & Newman, J. (1993). Managing to survive: dilemmas of changing organisational forms in the public sector. In R. Page & N. Deakin (Eds.), *The cost of welfare* (pp. 46–64). Aldershot: Avebury.

Clarke, J., & Newman, J. (1997). *The managerial state, power politics and ideology in the remaking of social welfare.* London: Sage.

Czarniawska-Joerges, B. (1993). *The three dimensional organization. A constructionist view*. Lund: Studentlitteratur, Chartwell Bratt.

Daatland, S. O. (1997) *Social protection for the elderly in Norway*. Text Series, 4. NOVA, Oslo.

De Cock, C. (1998). Organizational change and discourse: Hegemony, resistance and reconstructions, *M@n@gement*, *1*(1), 1-22.

Gammelsæther, P. (2006). *Forvaltningsreformer i pleie og omsorgstjenesten – en kartlegging av kommuner og bydeler med bestiller-utførermodell*. Stjørdal: Ressurssenter for omstilling i kommunene (RO).

Gummer, B. (1990). *The politics of social administration. Managing organisational politics in social agencies*. Englewood Cliffs: Prentice Hall.

Halford, S., & Leonard, P. (1999). New identities? Professionalism, managerialism and the construction of self. In M. Exworthy & S. Halford (Eds.), *Professionals and the new managerialism in the public sector* (pp. 83-102). Buckingham: Open University Press

Hanssen, G. S., Saglie, J., & Smith, E. (2012). KS i det norske flernivådemokratiet. In M. Reitan, J. Saglie & E. Smith (Eds.), *Det norske flernivådemokratiet* (pp.311-341). Oslo: Abstract forlag.

Harris J., & Unwin P. (2009). Performance management in modernised social work. In J. Harris & V. White (Eds.), *Modernising social work. Critical considerations* (pp. 9-31). Bristol: The Policy Press.

Harmon, M. M., & Mayer, R. T. (1986). *Organization theory for public administration*. Burke: Chatelaine Press.

Hogget, P. (2005). A Service to the public: The containment of ethical and moral conflicts by public bureaucracies. In P. Du Gay (Ed.), *Values of bureaucracy* (pp. 165-191). Oxford: Oxford University Press.

Hogget, P. (2006). Conflict, ambivalence, and the contested purpose of public organization. *Human Relations*, *59*(2),175-194.

Hood, C. (1991). A public management for all seasons. *Public Administration, 69*, 3-19.

Hood, C., & Jackson, M. (1991). *Administrative argument*. Aldershot: Dartmouth

Laclau, E. (1990). *New Reflections on the revolution of our time*. London: Verso.

Leira, A. (1994). Concepts of caring: Loving, thinking and doing. *Social Services Review*, *68*(2), 185–201.

Lipsky, M. (1980). *Street-level bureaucracy. The dilemmas of the individual in public services*. New York: Russell Sage Foundation.

Mahoney, J., & Thelen, K. (2010). *Explaining institutional change. Ambiguity, agency and power.* Cambridge: Cambridge University Press

Meagher, G., & Szebehely, M. (2013). Long-term care in Sweden: Trends, Actors and consequences. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe* (pp. 55-78). New York: Springer + Business Media.

Minzberg, H. (1983). *Structure in fives: Designing effective organisations*. Englewood Cliffs: Prentice-Hall.

Ministry of Health and Social Care (1997) *Rundskriv om kvalitet i pleie- og omsorgsstjenestene,* I-13/97. Oslo. [Directive on quality of care]

Newman, J. (2001). Modernizing governance. New labour, policy and society. London: Sage.

NOU (2000). Bør offentlig sektor eksponeres for konkurranse? [Should the public sector be exposed to competition?] Oslo: Arbeids- og administrasjonsdepartementet.

Olsen, B. (1992). Hjemmehjelpstjenesten i endring. In S. O. Daatland & P. E. Solheim. *Og du skal leve lenge i landet. Dilemmaer og veivalg i eldrepolitikken* (pp. 120-138). Oslo: Universitetsforlaget.

Pape, S. (2000). *Bestiller-utførermodellen og kontraktsstyring av tjenesteproduksjonen. En veileder fra KS*, [Purchaser-provider models and contractual management] Kommunenes sentralforbund.

Pollitt, C. (2002). Clarifying convergence. Striking similarities and durable differences in public management reform. *Public Management Review*, *4*(1), 471-492.

Pierson, Paul (2000). Increasing Returns, Path Dependence, and the Study of Politics. *The American Political Science Review* 94(2): 251-267

Rothstein, B. (2007). Political legitimacy of public administration. In G. Peters & J. Pierre. *The handbook of public administration*. London: Sage.

Røvik, K. A. (1998): *Moderne organisasjoner. Trender i organisasjonstenkningen ved tusenårsskiftet.* Bergen: Fagbokforlaget

Schmidt, V. (2008). Discursive institutionalism: The explanatory power of ideas and discourse. *Annual Review of Political Science, 11*, 303–326.

Schmidt, V. (2010). Taking ideas and discourse seriously: Explaining change through discursive institutionalism as the fourth "new institutionalism". *European Political Science Review*, *2*(1), 1-25.

Sehested, K. (2002). How new public management reforms challenge the roles of professionals. *International Journal of Public Administration*, *25*(12), 1533–1537.

Sipilä. J. (Ed.) (1997). *Social care services: The key to the Scandinavian welfare model.* Aldershot: Avebury

Social Service Act (1991). Act 1991-12-13-81.Oslo.

Strauss, A., Fagerhaugh, S., Suczeck, B., & Wiener, C. (1985): *Social Organization of Medical Work*. Chigago: The University of Chicago Press

Streeck, W., & Thelen, K. (Eds.) (2005). Beyond Continuity. *Institutional Change in Advanced Political Economies*. Oxford: Oxford University Press

Toonen, T. A. J. (2007). Administrative reform: Analytics. In G. Peters & J. Pierre. *The handbook of public administration* (pp. 301-311). London: Sage.

Torsteinsen, H. (2012). Bakgrunn, diagnose, inspirasjon. In *Resultatkommunen. Reformer og resultater*, Oslo: Universitetsforlaget.

Vabø, M. (1998). *Hva er nok? Om behovsfortolkninger i hjemmetjenesten*. Where to draw the line. Oslo: NOVA-rapport 8/98.

Vabø, M. (2002). *Kvalitetsstyring og kvalitetsstrev. Omstillingsarbeid i hjemmetjenesten*, NOVA-rapport 18/02.

Vabø, M. (2006). Caring for people or caring for proxy consumers? *European Societies, 8*(3), 403-422.

Vabø, M. (2007). *Organisering for velferd. Hjemmetjenesten i en styringsideologisk brytningstid* [Organizing for welfare. Home care in an era of competing modes of governance]. Oslo: Unipub.

Vabø M. (2009). Home care in transition: The complex dynamic of competing drivers of change in Norway. *Journal of Health Organisation and Management*, *23*(3), 346-359.

Vabø M. (2011a). Changing governance, changing needs interpretations. Implications for universalism. *International Journal of Sociology and Social Policy*, *31*(4/5), 197-208.

Vabø M. (2011b). Active citizenship in Norwegian elderly care – from activation to consumer activism. In J. Newman & E. Tonkens (Eds.), *Active citizenship and the modernisation of social welfare* (pp. 87- 187). Amsterdam: Amsterdam University Press.

Vabø, M. (2012). Norwegian home care in transition – heading for accountability, off-loading responsibilities. *Health & Social Care in the Community*, *20*(3), 225-327.

Vabø, M., Christensen, K., Jacobsen, F. F., & Trætteberg, H. D. (2013). Marketisation in Norwegian eldercare: preconditions, trends and resistance. In G. Meagher & M. Szebeheley (Eds.), *Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences* (pp. 163-203). Stockholm: Stockholm Studies in Social Work 30. Stockholm University.

Vabø, M., & Szebehely, M. (2012). A caring state for all people? In A. Anttonen, L. Häikiö & K. Stefánsson (Eds.), *Welfare state, universalism and diversity* (pp.121-144). Cheltenham: Edward Elgar.

Van der Hejden, J. (2011). Institutional layering: A review of the use of the concept. *Politics, 31*(1), 9-18.

Wise, L. R. (2002). Public management reform: Competing drivers of change. *Public Administration Review*, *62*(5), 555-568.