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Making sense of reablement within different institutional contexts. Collaborative service ideals in Norwegian and Danish home care

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Abstract

With population ageing, many countries are setting up reablement—short-term rehabilitative eldercare interventions—aimed at helping older adults to regain independence and thereby curb their need for long-term care. Reablement is premised on a citizen-centred and collaborative service ideal intended to challenge the fragmented thinking associated with professionalism and a dispersed service delivery field. Drawing on contextualist sensemaking theory and cross-national qualitative case study data, we explore how historical and institutional conditions influence the way reablement is made sense of on the ground. In Danish settings, characterised by legal regulations and institutional arrangements rooted in previous New Public Management reforms, new service ideals were constrained by vertical levers of control. The Norwegian bureau–professional settings opened up for user involvement but also gave rise to tensions between reablement teams working to prevent ill health and agencies expected to respond to the urgent needs of the frailest elderly.

KEYWORDS

comparative case study, home care, institutions, new public governance, Nordic eldercare, reablement, sensemaking

INTRODUCTION

Governments around the world are looking for innovative ways to bridge the gap between fiscal constraints and the increasing needs of ageing populations. After several decades with New Public Management (NPM), more recent policy initiatives typically draw on the New Public Governance (NPG) paradigm, which aims to build capacity and promote public value through collaborative initiatives across sectors, agencies and disciplines and through user co-creation (Torfing et al., 2020). In Nordic eldercare, a telling instance of this trend is the rapid spread of reablement programmes—short-term home-based rehabilitative interventions aimed at optimising older adults' daily living skills and independence and thereby reducing their need for long-term care. A key element in reablement is inter-professional collaboration using the participants' own rehabilitation goals as a common interdisciplinary platform (Birkeland et al., 2017; Metzelthin et al., 2022).

The collaborative service ideals underlying the principles of reablement tend to generate positive attitudes as they bring forth notions of capacity building, user involvement and mutual learning across disciplines and agencies (Aspinal et al., 2016; Torfing et al., 2020).

Compared to NPM-related service ideals, which cast the service recipient in the role of a customer and emphasise cost-effective service production, the collaborative service ideal seemingly corresponds better to the ethos and daily struggles of professionals working in eldercare (Rostgaard & Graff, 2023). The idea of reablement has gained momentum as a promising solution for dealing with the social and economic impacts of ageing populations. Promoted by supranational organisations (e.g., European Commission, 2013; Organisation for Economic Co-operation and Development [OECD], 2020) and an international array of clinical scholars and practitioners, reablement has entered the policy agenda of an increasing number of countries (Clotworthy et al., 2021; Metzelthin et al., 2022). It is, however, an empirical question whether and how collaborative service ideals will materialise at the level of public service provision, where frontline professionals experience conflicting expectations from a mix of governance initiatives (Edelenbos, 2005; Newman, 2001; Torfing et al., 2020). So far, only a few scholars have highlighted the shaping influence of contexts and actors in relation to reablement (Clotworthy et al., 2021; Jensen & Fersch, 2019). In this paper, the role of context will be placed centre stage. Following Torfing et al., (2020, p.3), we assume that new service ideals and modes of governance tend to be layered onto existing governance initiatives somewhat like layers in a layer cake. Although the recently added top layer may be the most visible, lower layers formed by older governance paradigms may continue to provide a solid foundation. Hence, new practices will continually have to be aligned with institutionalised practices anchored in overlapping and competing governance paradigms.

Drawing on a contextualist approach (Weber & Glynn, 2006; Fuglsang & Jagd, 2015) taking into account that institutions are 'emerging' rather than 'impacting', this paper aims to critically scrutinise how the idea of reablement is made sense of by actors operating within different historical and institutional contexts. Following Weber and Glynn (2006), we argue that institutions do not simply constrain sensemaking; they also prime sensemaking by providing frames and role expectations within which individuals notice and respond to cues. Institutions also contribute to edit sensemaking as they provide the social contexts within which groups of actors negotiate the meaning of cues and actions. From this point of departure, our study seeks to make visible how divergent policies, institutional arrangements, and taken-for-granted role expectations in Denmark and Norway provide different social contexts for sensemaking.

Our analysis is based on qualitative data from a comparative case study conducted in local eldercare settings in Denmark and Norway. Cross-national comparative studies of health and social care systems tend to focus on the macro level and have been criticised for ignoring differences between similar high-income countries (Wrede et al., 2006) such as the Nordic. Against the backdrop of different national reform trajectories and political conjunctions in Denmark and Norway, we adopt a micro-level perspective to explore how reablement is socially constructed and made sense of by managers and professionals at the operational level.

Before we turn to the case study, we briefly describe some common features of the Danish and Norwegian local care systems. We then outline our theoretical and methodological approach and proceed to our case-study analysis and discussion based on the following questions: How are the different historical, institutional and political contexts of Danish and Norwegian elder care manifested in the way allocation and provision of reablement are organised and enacted? How do these contextual conditions provide constraints and opportunities for meeting the collaborative service ideals?

Key Practitioner Message

- Reablement assume different forms depending on context but interdisciplinary collaboration, holistic thinking and person-centredness are core principles.
- Contextual factors, for example, regulations, organisation or delegation of decision-making power, influence the possibilities to enact the core principles.
- Reablement risk to be watered down into standard activating measures or contribute to the prioritisation of certain user groups or interventions above others.

Home- and community-based elder care in Denmark and Norway

Belonging to the Nordic family of universal welfare states, Norway and Denmark share many characteristics. Both countries are characterised by a comprehensive infrastructure of tax-funded health- and care services with equal access and distribution across all socio-economic groups based on needs. From the idea that services should be adapted to local conditions, the majority of health and social care services outside the hospital system are organised on the local level (Vabø et al., 2022).

Seen from a bird's eye view, the two countries have followed similar reform trajectories. At the turn of the century, health and social care services in both countries were affected by the global NPM wave and the idea of

'doing more for less' (Hood, 1991, p. 5). More recently, both countries have implemented structural reforms with the aim of delegating responsibilities from regional hospitals to the local care system. Though NPM has not lost its grip, the formation of contemporary care landscapes in Danish and Norwegian municipalities is increasingly being driven by ideas of New Public Governance (NPG) stressing the value of working across agencies and disciplinary borders and supporting the active engagement of citizens (Torfing et al., 2020; Vabø et al., 2022).

Despite similarities in policy trends and administrative reforms, the two countries are characterised by national as well as local variations, with three differences being particularly relevant for our analysis. In Denmark, the key eldercare services, 'home care' and 'home nursing care', are commonly organised in separate departments. Among the Nordic countries, Denmark has traditionally had the most generous home care provision, with a high level of service including coverage of practical care tasks such as cleaning offered free of charge (Daatland & Szebehely, 1997; Szebehely & Meagher, 2018). In Norway, 'home care' and 'home nursing care', are typically organisationally integrated and employ a higher level of registered nurses (RNs) compared to Denmark (Szebehely, 2020). Furthermore, practical household tasks have gradually been offloaded from public home care due to extensive usage of income-graded user fees that incentivise citizens to self-fund private cleaning services (Vabø & Szebehely, 2012).

Second, the national governments in the two countries used different strategies to accommodate NPM reforms. Since Denmark made a free choice of home care provider legally required in 2003 it has been mandatory for municipalities to implement a purchaser–provider split separating needs assessment from service provision. Although several larger Norwegian municipalities followed the example of Denmark and organised for free choice, Norwegian municipalities were never been legally required to adapt to these NPM ideas. Hence, many smaller municipalities preferred to maintain a traditional bureau-professional model of governance.

The third difference regards factors influencing the implementation of reablement. While the central governments in both countries have supported the subsequent spread of reablement through earmarked funding for various forms of research and development (R&D) work, training and handbooks (Parsons et al., 2023), the Danish government used regulatory measures to a much higher degree. In Denmark, where reablement was introduced by the municipality of Fredericia in 2008 as part of endeavours to reduce the need for home care, the central government introduced regulations to ensure that reablement services would be more harmonised across municipal borders and made universally available for all citizens (Hjemmehjælpskommissionen, 2013). In 2015, an amendment to the Social Service Act made it mandatory for municipalities to offer reablement to all home care applicants 'in so far [as] reablement is assumed to improve their functional ability and hence, reduce their need for home care' (authors' translation) (LOV 1524, 2014). The Danish legislation thereby contributed to the institutionalisation of an already established link between reablement and the intake and assessment service of the regular home care system.

Inspired by the Danish Fredericia model, The Norwegian Association of Occupational Therapists played a push role in drawing up guidelines and introducing reablement for Norwegian municipalities. Together with the professional associations of physiotherapists and registered nurses, their efforts were supported by the national government, which provided earmarked grants to enable a comprehensive multicenter clinical controlled trial (Langeland et al., 2019). The introduction of reablement coincided with the enactment of a comprehensive reform delegating responsibilities from hospitals to municipalities through the introduction of substantial fees for bed blocking (Norwegian Ministry of Health and Care Services [HOD], 2008). Norwegian municipalities saw reablement as a key measure in their efforts to avoid costly rehospitalisations and reablement thus spread rapidly parallel to the structural reform.

Theoretical framework: Making sense within institutions

The sensemaking lens is frequently used in the study of health and social care, for example, to explore how middle-level managers in health organisations carry out their functions and influence their colleagues (Checkland et al., 2013), how health organisations are making collective 'sense' as they work together to improve the delivery of health and care (Warwick-Giles & Checkland, 2018) and how, in a crisis like the Covid pandemic, people's sensemaking and associated biases are conditioned by surrounding institutions (Pham et al., 2022).

Sensemaking is the process through which people aim to understand issues or events that in some ways are novel, vague or confusing (Maitlis & Christianson, 2014). For instance, the social construction of a new work routine is viewed as a result of active processes of sensemaking generating 'rational accounts of the world that enable action' (Maitlis, 2005, p. 21). Processes of organisational sensemaking are social and systemic, not located inside individuals, but based on ongoing negotiations among organisational members who hold different pieces of information that can collectively construct meanings (Weick et al., 2005). An important foundation of

sensemaking is the utilisation of *perceptual cues* that evoke identities, frames and corresponding performance scripts without much deliberate thought (Weick, 1995). People make sense by elaborating cues into a plausible temporary guide for action. Professionals often have wide repertoires of cue-based associations in memory. For example, needs assessors base their assessment on cues from their professional background and their knowledge base about particular service interventions and regulation, but will, in each situation, also act on cues stemming from the political pressure to reduce costs.

Sensemaking is typically understood as a *retrospective* process whereby actors seek to make meaning of the past or the unknown based on their prior knowledge (Weick, 1995). However, some studies have argued that sensemaking may also be *prospective* in the sense that it is based on consideration of the probable future impact of certain actions (Konlechner et al., 2019; Shrivastava et al., 1996).

Although it is often implicitly assumed that sensemaking is never accomplished in a social vacuum, some scholars have criticised sensemaking studies for neglecting the role of the larger social and historical context in sensemaking processes (Maitlis & Christianson, 2014; Sandberg & Tsoukas, 2015; Weber & Glynn, 2006). According to these scholars the role of institutions is under-theorised as it is simply seen as internalised cognitive constraints narrowing 'how and what sense can be made [...] through the *preclusion* of potential alternatives' (Weber & Glynn, 2006, p. 1640). Within this cognitive perspective, deviance from the institutionalised thinking is ruled out, diminishing the room for agency and institutional change. Extending this perspective, Weber and Glynn (2006) argue that sensemaking is interwoven with institutions in additional ways. To provide a richer theory around the connection between institutions and sensemaking, they introduced three contextual mechanisms; *priming*, *editing* and *triggering*.

Institutions *prime* sensemaking by providing certain cues that 'activate identities, frames and role expectations' (2006, p.1648), which individuals notice and respond to. The substance of an institution pertains to a constellation of identities (typified actors), frames (typified situations) and actions (typified expectations of performance or conduct). Attention structures shape the lived experiences of individuals and pattern the cues, situational framings, social identities and action repertoires that they regularly access (2006). For instance, setting up a new service innovation staffed by certain groups of professionals will most likely contribute to the mobilisation of these professionals to utilise their knowledge base for sensemaking. In so far as professionals have expertise, legitimacy and social opportunity, they may also engage in processes of *sensegiving*, whereby they seek to influence the sensemaking of others through persuasive or evocative language (Maitlis & Lawrence, 2007).

Institutions *edit* sensemaking by providing the social context within which groups of individuals negotiate shared understandings of cues and meanings and whereby intersubjective meanings emerge. The institutionalisation of roles and actions means that individuals will form expectations of others' behaviour as well as of their own, which will lead to social policing of actions that, in turn, activate sensemaking processes and potentially guide and edit action formation. For instance, institutional editing may occur when new professional guidelines are subordinated to established regulations.

Institutions *trigger* sensemaking by providing occasions for sensemaking—either by providing dynamic foci that require continued attention or by providing puzzles that require sensemaking due to contradictions and ambiguities, such as when new modes of organisation and work clash with existing routines (Weber & Glynn, 2006). As reablement was being introduced as a paradigm shift in elder care (Metzelthin et al., 2022), it was arguably a distinct occasion for sensemaking. Still, in the context of public health and social care, where selecting, defining and processing clients are not based on clear technical criteria, sensemaking will be constantly triggered by actors who are grappling to bridge the gap between ideals of care and finite resources.

According to Weber and Glynn (2006), institutions are feedstock of sensemaking, just as processes of sensemaking may be the feedstock of institutionalisation. In other words, the institutional contexts in which reablement is implemented may act both as constraining and enabling constructs. The actors involved in reablement may be constrained by institutional arrangements but may also contribute to pushing strategies and practices towards new directions, for instance, by entering the role as sensegivers.

METHODS

Study design

The data used in this analysis were collected in a decentred comparative case study (Wrede et al., 2006) of local eldercare in Denmark and Norway. Four municipalities participated—one rural and one urban from each county—all of which had made initiatives to reshape their care service apparatus to match new service ideals about integrated person-centered care. The project was designed as a layered multiple case study (Patton, 2015), which implied that the four inter-organisational cases were made up by different levels and focal points that enabled cross-case comparisons of various subcases and themes. Reablement was one focal point and subtheme of the study.

The complexity of each case was captured by using a naturalistic form of inquiry, 'rapid site-switching ethnography' (Armstrong & Lowndes, 2018). Data was collected within a relatively short timeframe in the everyday world of service provision by a multi-disciplinary team of 10 Norwegian and Danish researchers. All researchers were experienced in ethnographic data collection methods and had extensive prior knowledge of health and eldercare provision in each country.

Sample process

Sampling criteria for the case study included different country contexts and key distinctions of the municipalities regarding size, environment (urban/rural) and administrative style. Recruitment of individual interviewees were based on written consent to participate. Recruitment for individual and group interviews was partly made prior to the fieldwork based on the purpose of including professionals from all disciplines, partly based on snowball sampling during the field work to follow emerging themes of interest (Tong et al., 2007). Due to the flexible study design, we ended up including more participants than planned, and neither recruitment nor dropout rates posed any difficulties.

Data collection

The research team conducted intensive field studies for 5 days at each site in 2018–19, covering the full range of services for older home-dwelling adults, for example, home care, day care centres, reablement services and needs assessment departments. Prior to the fieldwork, the research team had collectively developed open-ended interview- and observational guides targeted different types of participants, sites and interventions. The guides aimed at covering both overall research questions as well as a few sub-themes of particular interest.

During the fieldwork, research team members shadowed individual care professionals during their day-shifts and conducted individual and group interviews on the municipal premises. All interviews were recorded and subsequently transcribed verbatim by research assistants. Quotes has been translated to English by both authors.

The full set of ethnographic data comprises more than 160 interviews with managers, key informants, care professionals and service users, field notes from approximately 1000 h of observations and a substantial amount of data from follow-up interviews and –seminars with representatives from the case municipalities. Furthermore, prior to fieldwork, the team collected a considerable amount of relevant statistics and written material, which comprised a rich data set on local and national care policies and service organisation in each site.

Data analysis

Team-based reflexivity and -analysis have been an integral part of the research process, including the coding procedure. The interviews were coded with 12 codes that signified the most important focal points in the study such as 'reablement', 'service allocation' 'multidisciplinary cooperation', 'professional responsibilities', and 'volunteers and relatives'. The software tool NVivo was used to conduct an initial thematic analysis of the full material as well as more detailed analysis of relevant parts of the data set.

In this analysis, we mainly concentrated on documents, interviews and field notes that directly concerned reablement, using 28 individual interviews and 13 group interviews. The interviewees held positions at different levels of the organisations—executive managers; needs assessors; frontline managers; and reablement, home care and home nursing care staff, including RNs, occupational therapists (OTs) and physiotherapists (PTs) and health and social care workers.

Based on this material, we conducted a more fine-grained analysis through the theoretical lens of sensemaking using Weber & Glynn's analytical concepts of *priming*, *editing* and *triggering* mechanisms as sensitising concepts (Patton, 2015) to analyse how managers and professionals made sense of reablement within certain institutional contexts. Aiming to bring the larger social and historical contexts into the analysis we supplemented a traditional 'compare and contrast' logic with the more process-oriented logic of tracing (Bartlett & Vavrus, 2017). This implied a reflexive iteration whereby the authors, both familiar with the institutional history of elder care in Denmark and Norway, progressively came to a common understanding of how and why reablement was interpreted and enacted differently across national settings.

Ethics

Ethical approval was obtained from the Norwegian Centre for Research Data. All participants in the study were well-informed about the purpose of the study and about their right to withdraw at any time without having to state a reason. The interviewees gave written informed

consent to participate in the study. Personal identifiable data were anonymised and audio files and interview transcripts were encrypted and password-protected and were accessible only to research team members.

RESULTS

As we were introduced to the four case municipalities, we found the rhetoric of reablement strikingly similar across sites. Whether in policy papers, public communications or the narratives of managers and professionals, reablement was described and talked about in idealised ways as a mindset that should permeate the whole social care service apparatus. In the process of interviewing and shadowing reablement staff, however, we noticed some distinctive national differences. For instance, reablement interventions in Denmark more often than in Norway included training in practical household tasks such as in vacuum cleaning, whereas reablement in Norway seemed to focus more on mobility issues and rebuilding strength and balance. As we began combining the different sources of data and made cross-case comparisons, we also became aware of how the way reablement was made sense of on a day-to-day basis was linked to divergent institutionalised patterns of governance and practices in the two countries. To use the conceptual framing by Weber and Glynn (2006), we noticed how sensemaking in each country was primed by distinct role constellations and associated cues, which again reflected that the two countries had previously made different policy choices.

Denmark: Reablement as a measure for reducing the need for home care

Within the Danish regulatory context, allocation and provision of reablement services are highly entangled with the purchaser–provider system of home care. In the two Danish municipalities, decisions regarding allocation of reablement services were formally the responsibility of the purchaser unit represented by needs assessors scripted to ensure that service allocation was consistent with relevant regulations and local political priorities. However, as reablement interventions had to continuously adjust to the shifting needs and capacities of recipients, the needs assessors regularly cooperated with health and care professionals working with reablement, especially OTs and PTs, through regular meetings. The therapists and, to a lesser degree, RNs had the responsibility of planning the reablement interventions, assisting with the assessment of functioning and needs, and acting as supervisors of vocationally trained care workers who were responsible for providing the daily interventions.

At the time of this study, DanCity organised reablement as a specialised multidisciplinary team composed of OTs, PTs, RNs and care workers located within a home care department. In DanVillage, a similar team model had proved impossible to implement in practice, partly because the nurses often had to prioritise acute nursing tasks over reablement. Instead, reablement was organised as a cross-boundary team, with the reablement therapists (OTs and PTs) co-located with the needs assessors in the purchaser unit and the care workers located in the home care service department providing both regular home care and reablement.

In the Danish sites, sensemaking was primed by a role constellation whereby needs assessors, therapists and regular home care staff each played an active role at different stages of the reablement trajectory. Needs assessors, acting in a formal gate-keeping role, were scripted to be attentive to cues extracted from the legislation and associated standards and to sensegiving efforts from the local political administrative system. Regarding the latter, the aim of making people less dependent on regular home care clearly dominated the official way of making sense of reablement:

> *Reablement is our main focus. And it's about how well you can manage on your own in your home. It is not so much a question of whether you also may have the potential strength to participate in some activity in the community or in a social club. We are still there, I must say, that 'becoming less dependent on home care' is what dominates our work.* (Manager, Physical Rehabilitation Team, DanVillage)

The Needs Assessment Department exemplifies an institutional setting in which sensemaking is continuously triggered. Needs assessors constantly deal with complex questions related to the process of interpreting, classifying and responding to individuals' needs. The Danish needs assessors, who were primarily RNs or OTs, had the formal responsibility of allocating services according to the Social Service Act. Hence, they were expected to ensure that the services assigned to individual applicants would contribute to making the person as self-sufficient as possible. The needs assessors made it clear that some professional discretion was necessary to determine if there was a potential for reablement. The way they enacted the decision was also based, however, on cues from the political–administrative system:

> *The 'service catalogue' is very indicative; you might call it our standard—it is the levels for service delivery passed by the local government. Then we also have the Social Services Act to consider. This suggests that we have some baselines to consider even prior to the assessment. Being bound by service standards and legislation can be quite limiting sometimes*. (Needs assessor, RN, DanVillage)

She explained how she would have the latitude to deviate from the local standards if she drew up a professional justification for her decision. However, as the quote below indicates, the local standards were perceived to be too restrictive for reablement.

> *For some users, the service catalogue, the fixed level of service and the public finances set some limitations. The rehabilitative services we can offer may not be the ones they really need. That could be something like 're-learning to walk to the bus again' or 'training to stand by the stove to prepare a meal'. We don't have the latitude to offer these kinds of services—not the way things are now*. (Needs assessor, OT, DanVillage)

That reablement was linked to the tasks predefined in the service catalogue meant that the opportunities of professionals to collaborate with service recipients around their preferences and needs were constrained. Hence, the limitations caused by the service catalogue came into tension with the essential rehabilitation principles that interventions should be fit to individuals' goals and preferences. The needs assessor contrasted what she called '*a truly rehabilitative'* approach with a more prevalent '*activating'* care approach. The truly rehabilitative approach would be based on the active involvement of the reablement recipients in goal setting, whereas the activating care approach simply entailed the performance of predefined care tasks in an activating manner. From the professional point of view of the needs assessor, reablement ought to be based on the rehabilitative approach, but in practice, she found that the activating care approach was by far the most common in the organisation. Therapists, who were expected to work out a reablement plan for home care staff to follow, experienced that these standards made them deviate from their own taken-for-granted assumption about a rehabilitative work approach. However, from the perspective of the home care workers, reablement was perceived and enacted as a certain kind of activating, 'hands-off' practice, much like what the needs assessor argued about. The care workers explained how they would typically support the older person to regain the ability to perform given activities in the home, such as vacuuming the floor, preparing lunch or showering. They took for granted that reablement was about practical chores and personal care tasks.

The use of quantified outcome measures provided additional cues and indirectly influenced the way reablement was made sense of in practice. Managers from the administration explained that they regularly monitored services and measured success in terms of the percentage of home care applicants being granted reablement, the duration of the interventions and the amount of care services needed afterwards. Although needs assessors and reablement staff were not individually controlled or felt incentivised by the outcome measures, they were highly aware of the managerial focus, which was visibly supported by managerial sensegiving efforts that continually emphasised the goal of reducing care needs:

> *We have in a way developed a culture of thinking that 'we are successful when we manage to end interventions* [without offering home care subsequently]. *It is hard not to feel that way—it is our way of talking: 'How far have you reached? Are you about to end it?'* (Needs assessor, DanCity)

The Danish cases exemplified how several efforts to directly link reablement to home care provision acted as mechanisms for editing, contributing to a practice that deviated from the therapists' institutionalised idea of reablement as an approach instigated by the desires and goals of individual clients. Hence, reablement turned out to be primarily training in performing predefined household tasks rather than in activities perceived to be meaningful by the client.

Norway: Reablement to prevent hospitalisation

At the time of this study, none of the two Norwegian sites was organised within a purchaser–provider model. NorVillage had rejected the purchaser–provider model since the 1990s on the grounds that the local market was too small for a free choice model. NorCity had recently dismantled its purchaser–provider model as part of a local policy initiative aiming to challenge the rigorous control regime of NPM through the introduction of self-managed care teams. Hence, in the Norwegian sites, both needs assessment and service allocation were delegated to the operational level in a bureau-professional organisational model. In both sites, reablement teams were organised as

autonomous units separated from regular home care services and working only with reablement. The rationale behind organising reablement separately from regular home care was to accommodate early and proactive interventions and to avoid being absorbed in the more acute nursing care tasks in the home care services.

The NorCity team was co-located and cooperated closely with a hospital discharge team to determine who should be offered reablement. The team worked exclusively with people who were not enrolled in the regular home care service. The NorVillage team was intended to assume the role of a 'spearheader' and to work proactively with a range of service providers to enable them to refer potential reablement candidates in an early stage of their functional decline. Like elsewhere in Norway, the reablement teams comprised a combination of therapists (OTs and PTs), nurses and care workers. As nurses have traditionally been regarded as the principal occupational group in the Norwegian eldercare sector, they were taken for granted as members of the reablement teams in contrast to Denmark. Their role was seen as critical in helping people recover after a functional decline.

Both Norwegian reablement teams had been set up as key elements of policy strategies to avoid (re) hospitalisation through more preventative and rehabilitative approaches. Reablement was seen as a measure to break a negative circle of being insecure, made passive and increasingly homebound after a functional decline. In fact, local policy making extracted cues from the professional discourse of occupational therapy educational institutions and associations. Hence, rather than being constrained by administrative regulations like their Danish counterparts, the professionals who were working in reablement teams became sensegivers in the wider strategy for service development in the wake of the structural reform. For instance, the NorVillage team functioned as an educational site for home care staff members who were encouraged to adopt a reablement mindset in their daily way of working.

Although the Norwegian therapists had the latitude to decide on how to determine who would benefit from reablement, they were committed to making assessments based on well-recognised assessment tools. These tools were supposed to help them screen who among the candidates had the willpower and the physical capacity to go through a goal-oriented reablement trajectory. In deciding whether a person should be classified as ready for reablement, they would especially take note of signs of 'motivation'. As in the Danish teams, the ideal reablement recipient was an older adult who had an active lifestyle prior to a recent functional decline. Initially, when reablement services were set up, certain categories of clients, for example, those with dementia or psychiatric diagnoses, were excluded as they were expected to find it difficult to manage goal-oriented training. However, both Norwegian teams had relaxed these standards after a while as they experienced that people in these categories could also benefit from reablement. Based on their experiences, it made sense to expand the target group and to not be too rigid about for whom or for how many weeks the interventions should be provided.

Based on our observations, interviews and local statistics, we found that the Norwegian reablement interventions were largely centred on self-care and mobility issues. Typical interventions were assisting people to safely manage their shower, get dressed, and prepare breakfast. Additionally, and unlike the observed interventions in the Danish sites, the Norwegian therapists seemingly spent more of their time on helping people with their physical fitness and balance. We observed older adults being supported in doing physical exercises on the living room floor, climbing stairs and walking outdoors. Moreover, we noticed that the Norwegian teams worked more intensively, that is, with shorter intervention periods but with longer and more frequent visits. In NorCity, a report that described the previous reablement trial in the city referred to clinical evidence indicating that intensive physical training over a few weeks would be more effective than less intensive interventions over a longer period. Adding to this argument, the therapists argued that the physical training should be targeted the individual service user's preferences and needs, whether boarding a fishing boat, riding a bus or walking to the café:

> *If it is difficult for them to climb stairs, then we do stair exercises. If it is difficult to climb the stairs and continue to the laundry room, then we combine stair exercises with walking to the laundry room. If they have difficulties going to the grocery shop, we walk with them to the shop; and gradually, we will call them and ask them to meet us by the shop. In this way, we push them gently*. (Reablement therapist, NorVillage)

Reducing the need for care services was also a part of the reablement agenda in Norway. However, the link between practical household tasks and the cost of care was less direct because these tasks were charged a user fee. Hence, helping a person to become self-reliant in household tasks was not a cue for sensemaking in the same way that it was in Denmark. While observing a needs assessment meeting in NorVillage, one of the Danish researchers was struck by the therapist's response to the client's request for help with practical household

chores. Rather than assessing whether the client would be able to manage housework on her own, as would typically be the case in Denmark, the therapist recommended that the client pay for cleaning services from a private company rather than apply for public home care. The reason given was that a private service company would be more flexible, whereas the public home care service would only offer 'strictly necessary cleaning' and would charge the client 'almost the same'.

The overall aim of getting people on their feet after a functional decline was underpinned by the professionals' measurement of the progress of the reablement service being provided. Although both the Danish and the Norwegian teams registered and compared the average number of care hours before and after the intervention, s, the use of professional outcome measures that focused on the progress of the individual service recipient were more prominent in Norway. The teams used standardised measurement tools for physical performance and a client-centred outcome measure designed to help individuals to identify problem areas in their occupational performance. The success of the NorCity reablement service was summarised through measures of averages—for example, the reablement recipients' own perceptions of performance increased from 3.4 to 6 and their physical fitness from 5 to 6. In NorVillage, the reablement team argued that outcome measures were of high importance in case the politicians investing in the resource-intensive service would question whether it fulfilled its intentions.

Although these quantified measures contributed to the legitimisation of reablement as an effective intervention, the validity of these measures were not on the agenda in the two case municipalities. Neither was the question on whether the balance between preventative reablement and long-term care provision was cost-effective. Asking a therapist from the NorVillage team whether some reablement recipients would possibly have managed to regain functional capacity by their own efforts, she replied: '*It is hard to say. You will never know. That's the way it is—that's a condition when it comes to early intervention-work and people are in a grey zone between self-reliant and dependent.*' Despite uncertainties regarding the costs and benefits of investing in early or rehabilitative interventions, both the reablement staff and officials were convinced that reablement would make sense in the long run. They generally based their faith on cues stemming from the sensible logic of reablement and from information from the quantifiable outcome measures of the therapeutic disciplines. On the other hand, for the health and care professionals not working directly with reablement, the choice of target groups did not necessarily make sense. For instance, we encountered examples of professionals wondering why 'the fittest' older adults would get the most intensive therapeutic service while people with heavy care needs would get 'only' a standard home care package with less access to therapists. One therapist employed in a regular home care unit thus argued that the reablement teams 'cherry-picked' their clients based on their potential to become fully self-sufficient again: '*The way the allocation system works right now then [is that] many of the most fit older adults get reablement. The reablement team picks out those who can be discharged from the service after four weeks*' (PT, Home Care Team, NorCity).

The Norwegian case exemplified how the rationale behind reablement—to avoid or postpone expensive health and social care provision through intensive short-term training interventions—provided a cue for forward-looking prospective sensemaking (Konlechner et al., 2019). It made sense to offer reablement as a preventive measure for an extensive target group, not only to avoid the substantial bed blocking fees, which managers and staff were greatly concerned about, but also to reduce the economic burden of care in the years to come.

DISCUSSION

Reablement exemplifies a policy idea on the move (Clarke et al., 2015), an idea supported and spread by supranational policy makers calling for cross-national lesson learning (European Commission, 2013; OECD, 2020). In this analysis, we moved beyond the conventional notion of copyable policies and instead focused on the ways in which the idea of reablement has been subject to different interpretations and implementations due to its malleability (Jensen & Fersch, 2019). By investigating how reablement is made sense of on the ground within different national and local contexts, our study contributes to the understanding of the way loosely defined policy measures intersect with the political–institutional context in which they are embedded.

Using the analytical framework of Weber and Glynn (2006), we highlighted the role of contextual mechanisms in sensemaking: that historical and institutional contexts are neither backdrops of actions existing 'out there', nor solely internalised cognitive constraints of individual actors. Instead, they are also constitutive of action as they provide frames and role expectations within which people interact and act in response to cues (Weber & Glynn, 2006; Weick et al., 2005). The significance of the contextual mechanisms of sensemaking was underlined by a decentred comparative research design (Wrede et al., 2006), which allowed us to explore how different configurations of roles, power relations and action formation shape the way reablement is put into practice on the micro-level of service provision.

Exploring how reablement is enacted in different national and local settings, we have demonstrated how collaborative service ideals of reablement unfold differently as they are layered on top of governance arrangements and constellations of actors shaped by broader institutional environments. Although therapists in both countries agreed that a person-centred approach was a key principle in reablement, they experienced having different latitudes for involving older adults in goal setting. Danish therapists, working within the purchaser–provider arrangements of the home care system, had to negotiate this service ideal with needs assessors, home care managers and care staff—all scripted to stick to legislation and standards defining the scope of responsibility for the home care services. Hence, the idea of supporting people's self-identified goals was toned down and replaced by a reductive conception of reablement that confined its goal orientation to activities corresponding to predefined home care tasks. The Danish cases exemplified how the institutional context may contribute to making the management of daily activities a goal in itself while constraining attention to needs or goals that are not directly related to this. The Norwegian therapists, operating within settings that leave more discretionary power to professionals, were freer to make sense of reablement by extracting cues from their own professional knowledge base. Accordingly, they had set up formal assessment routines whereby clients were invited to collaborate around goal setting to ensure that they would find the reablement program meaningful. However, because reablement was implemented as part of a strategy to avoid costly hospitalisation, the interventions were largely centred on restoring physical functioning.

The way reablement was made sense of as an interdisciplinary approach was similarly primed by the different political and institutional contexts in the two countries. Danish reablement therapists, positioned in an intermediate role between purchaser-unit and home care services, were formally bound to collaborate on assessments and allocation decisions with needs assessors and were expected to delegate the daily responsibility for the reablement intervention to care workers. Hence, the contribution of their therapeutic skills were often confined to their role as therapy planners and instructors. Within the autonomous teams in the Norwegian sites, reablement therapists, in collaboration with RNs, used their professional skills to decide on who should be enrolled in the reablement program and how interventions should be enacted on a daily basis.

The overriding aim of reablement is to contribute to systemic improvements beyond boosting the independence of the individual service recipients. In policy texts (e.g., European Commission, 2013; Hjemmehjælpskommissionen, 2013; OECD, 2020), the raison d'etre of reablement is twofold: to support the self-reliance of older adults and thereby reduce the demand for costly healthcare and long-term care. Our comparative analysis suggested that the way in which cost savings is operationalised and measured is also contingent on the broader political and institutional contexts. In the two Danish municipalities, cost savings were measured by the number of hours allocated to home care and were consequently aligned with the long-standing policy aim of lowering the demand for practical home care. In the two Norwegian municipalities where reablement was implemented as one measure to avoid hospitalisation, cost-saving measurements were largely based on therapeutic outcome measures such as strength, balance and performance of daily activities. Although favourable values of these measurements may indicate a preventive potential, they are nonetheless weak and indirect indicators of hospitalisation. Furthermore, as suggested by critical interviewees, the cost-saving measurements add to the risk that reablement teams will cherry-pick the clients who are most likely to regain independence, whereas those incapable of regaining independence would remain the responsibility of the hard-pressured and less specialised home care services. The kind of power asymmetries and conflicting interests pointed out by the interviewees are well known to occur within the contexts of collaborative governance (O'Flynn, 2008).

In line with scholars such as Newman (2001) and Torfing et al. (2020), our study suggested that managers and professionals experience conflicting expectations from a mix of governance initiatives. The introduction of reablement and its person-centred and collaborative service ideals did not mean that old governance paradigms disappeared. The way actors made sense of reablement was largely framed by values and expectations rooted in established governance paradigms. For instance, the Danish legislation on reablement strongly reflect the bureaucratic value of equal treatment, whereas the organisation and expectations of needs assessors to follow quality standards echo the service ideals of NPM. In the Norwegian settings, the trust in professionals to find the best solutions to problems dominated. Although the professional discourse that surrounded reablement had strong overtones of interdisciplinary collaboration, the therapists (both OTs and PTs) seemed to occupy a privileged position in the care systems. They were regarded as the principal actors in reablement, and the influence from the therapeutic professions was evident in all aspects of the reablement programs.

Our fieldwork was carried out in a given politico-temporal setting and does not represent the end of the story about reablement. We know that now, after our

fieldwork had ended, the cost-effectiveness of health and social care is still constantly being discussed and reconsidered. For instance, DanVillage continued to reassess how they could possibly bring in the expertise of RNs to their reablement interventions and strengthen interdisciplinary collaboration in general. In NorCity, the brewing scepticism among professionals hinting that reablement was based on cherry picking had gradually reached the managers who considered a reorganisation to better ensure a balance between preventative reablement and care for the frailest. Contemporary debates among clinical scholars also indicate emerging concern about the prospects of reablement after an initial period of trials and great optimism. Both Danish (Kehlet, 2022) and Norwegian scholars (Tuntland & Ness, 2021) have argued that reablement principles are seemingly being watered down, as services are increasingly being assessed in light of short-term cost savings rather than the long-term cost savings of making people more independent. Our analysis corroborates the perspective of Torfing et al. (2020) that the emergence of problems associated with new modes of governance tends to trigger the search for new solutions after a while. Correspondingly, our cases also exemplified how signs of success may create new opportunities for actors to extend and even innovate the collaborative mode of working. One example is NorVillage, where signs of reduced hospitalisation had triggered politicians to further invest in the reablement team by accepting the team's suggestion to strengthen their psychosocial expertise to enable them to better deal with the social and emotional problems of clients.

CONCLUSION

Reablement is a service innovation that is proliferating rapidly in many countries due to its potential to reduce the cost of long-term care. By exploring how reablement is made sense of at the everyday level in two countries hailed as leading the way in reablement, we have shown how the enactment of the core principles of reablement can be constrained or catalysed by contextual factors as they are subsumed under institutionalised governance structures. We found that the enactment of person-centredness, interdisciplinary collaboration and holistic thinking may be constrained by vertical modes of governance associated with the rules and guidelines of the legal bureaucracy or the marketised relations of established NPM arrangements. Hence, there is a danger that reablement might be distorted into a standard activating measure. Within bureau-professional contexts where decision-making power is delegated to professionals, the potential for the establishment of collaborative relations is greater. However, within these unbounded and trust-based environments, there is the risk that some professionals and service agencies will gain a more privileged position than others and contribute to the prioritisation of certain kinds of interventions or user groups above others.

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CONFLICT OF INTEREST

The authors declare that there are no conflict of interest.

DATA AVAILABILITY STATEMENT

Restrictions apply to the availability of the data that supports the findings of this study. The data from interviews and observational studies are not publicly available due to privacy and ethical restrictions but available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethical approval was obtained from the Norwegian Centre for Research Data (NSD), ref. no. 128713 and the study confirms to recognised ethical standards.

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