The blame game in reablement implementation: Blaming frontline workers or organisational factors?

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Abstract prepared for the annual meeting at the Danish Political Science Association, November 1-2 2018, Vejle, Denmark

Public Administration Panel:" Assessing welfare rights in a world of changing governance"

*** Work-in-progress, please do not cite or circulate ***

Abstract

This paper provides an analysis of the implementation of reablement in local-level government. Reablement is one of the greatest and most recent trends in the long-term care system in Denmark as in other western countries. Introduced as a policy solution to the global concerns of aging populations and the increasing need for long-term care service and framed by the discourse of active aging, the principles of reablement promotes a paradigm shift and a transition from what has been considered as a 'passive' or 'compensatory' approach to care to an 'active' approach aimed at mobilizing the older person's potentials for independence by involving the older person in his or her own care.

In Denmark with inspiration from Sweden, reablement has been on the political agenda since 2007, with the municipality of Fredericia as first mover. Since then, reablement has diffused and been adopted by all Danish municipalities. Today, reablement is advocated as the best practice model and regarded as a cost-effective policy also being highly beneficial for older people. Furthermore, offering reablement services has become mandatory for all Danish municipalities.

In spite of the fact that reablement is now a legal principle and a policy widely adopted by Danish municipalities, implementing reablement at the frontline of home care, however, still poses a challenge. In accordance with top-down implementation literature, both the intervention theory of reablement and key actors involved in reablement emphasize that the ability and willingness of the 'frontline' (i.e. home care workers) to work intensively with reablement are essential prerequisites for implementing reablement successfully. E.g., one of the key challenges for home care workers who have moved from traditional home care provision to reablement has been the need to learn to 'step back' from helping. Thus, when reablement is considered not to have reached its full potential or when the implementation of reablement proceeds somewhat slower than expected,

frontline home care workers are often blamed and regarded as the main problem for successful implementation.

However, in this paper the main argument is that implementation of reablement is not solely dependent on the ability nor the willingness of frontline workers to work in accordance with the reablement approach. Based on a qualitative study, including 16 semi-structured interviews and focus group interviews with central stakeholders in two Danish municipalities, this paper focuses on and analyses how local organisation of reablement influences the implementation of reablement in frontline home care practice, as organisational factors and structures seem to hinder frontline home care workers providing care in accordance with an 'active' reablement approach.

Introduction

Street-level workers occupy a unique, and uniquely influential, position in the implementation process (Meyers & Vorsanger, 2003) and are often understood as de facto policymakers (Lipsky/Brodkin) being the actors responsible for making the policy work and turned into practice. Oftentimes, the ability, willingness and policy preferences of these street-level workers to implement policy are seen as primary influencing factors for implementation outcome. Consequently, these street-level workers are often blamed when the implementation of a policy lack, fails or go awry.

Looking into the theoretical and empirical literature on street-level workers concerning which implementing factors that shape the actions of street-level behavior, no definite answers are, however, provided. The findings from these studies are mixed and often contradictory (Meyers & Vorsanger, 2003). Various factors seem to direct the behavior of street-level workers when implementing public policies and, thus, affecting the implementation process and outcome. However, taken together the literature points to a variety of political, organizational and individual interacting factors expected to influence street-level behavior (Meyers & Vorsanger, 2003). According to Meyers & Vorsanger (2003) this complexity implies a need for research on street-level work to develop "models that account for multiple, oftentimes competing sources of influence on front-line worker. (…) We need to develop more fully integrated theories of how these political, organizational and individual factors channel street-level discretion into specific directions through policy design, organizational features and professional norms and culture" (Meyers & Vorsanger, 2003:251). However, as Winter & Nielsen (2010) emphasize this may seem so complex – and analytically more or less utopian – that an alternative solution is to develop and test partial theories in order to achieve a greater understanding of that complexity. In accordance with Winter & Nielsen's argument, this paper focuses its attention on the role of organization on street-level behavior in this complex of influencing factors. The purpose of this paper is to explore which and how specific organizational factors play an important and influencing role when street-level workers are to implement a policy into practice, thus, contributing to the existing street-level work literature by widening the understanding of street-level behavior and implementation processes by underpinning the importance of organizational factors in the implementation process – an understanding that will make us better able to organize a public sector that optimizes the implementation of a given policy.

This is analyzed and argued in the context of Danish home care sector, in which a new public policy on elderly care delivery – so-called reablement (Danish: Hverdagsrehabilitering) – has been introduced, diffused and adopted by all Danish municipalities within the last ten years (Bertelsen & Hansen, 2018). In Denmark, as in other western countries – especially in England, Australia, New Zealand and several northern European counties – central and local authorities have adopted a reablement paradigm and approach within the last decade. Reablement represents a new approach to home care for older people (Nørskov Bødker, 2018) or even a paradigm shift (A. M. Hansen & Kamp, 2018; Hjemmehjælpskommissionen, 2013; Kjellberg, 2011; Rostgaard, 2016) moving from a standard and 'passive' home care service delivery approach to an 'active' approach – with inspiration from active aging and social investment agendas – focusing on older persons' capacities and

motivation and encouragement of older people to become as independent as possible. The reablement approach is regarded as a viable policy solution to the global concerns of aging populations and the increasing need for long-term care service that follow from this trend. Generally, the assumption is that the introduction of reablement will enable municipalities to reduce expenditures for elderly care and at the same time improve quality of life of older people, as more people become self-reliant or increase their level of functional ability (Rostgaard, 2014). However, thus far the evidence base concerning the cost-effectiveness and short- and long-term effects on older people's health and wellbeing is inconclusive (Aspinal, Glasby, Rostgaard, Tuntland, & Westendorp, 2016; Birkeland, Tuntland, Førland, Jakobsen, & Langeland, 2017).

Research concerning reablement implementation emphasizes that this is a challenging task (e.g. Rostgaard & Graff, 2016). The introduction of reablement have required major changes in the elderly care sector; a change in focus, a cultural shift and changes in the organization of home care. These changes have had great implications - not a least for frontline home care workers who have been introduced to new practices and changes in job function, task and responsibilities – e.g. by moving away from doing tasks for frail and older people to supporting older people to do things for themselves, a need for acquiring new knowledge and skills to work in line with the reablement approach and to exceed traditional professional boundaries by increased interdisciplinary collaboration (Birkeland et al., 2017; Rostgaard & Graff, 2016). Frontline home care workers need not only to change understanding of what constitutes good elderly care. They also need to adopt new practices, i.e. to 'step back' and encourage older people to regain or re-learn the ability to do things for themselves primarily by observing and not automatically intervene when an older person is struggling to perform an activity. Compared to traditional home care, this is a new way of working that challenges existing professional identities, logics and practices (Dahl, Eskelinen, & Hansen, 2015; A. M. Hansen & Kamp, 2018). Shifting the mindset of staff from 'doing for' to 'doing with' is seen as a major challenge and the reablement approach requires time to change to a different way of thinking and acting (C Glendinning & Newbronner, 2008; Caroline Glendinning et al., 2010; Hjelle, Skutle, Førland, & Alvsvåg, 2016; Rabiee & Glendinning, 2011; Trood & Joyce, 2018; Wilde & Glendinning, 2012). Furthermore, the shift in approach requires considerable training and retraining of frontline staff. But it also requires that home care workers are motivated to work according to this new approach. If home care workers have a long history in traditional home they may find that reablement does not appeal to them or may struggle to stand back and encourage older people to 'do' for themselves. There may be feelings of guilt, watching an individual take a long time to perform a task when, with the help of another person, the task could be completed in a fraction of the time (Murphy, 2018; Rabiee & Glendinning, 2011). Resulting from this, it is then not surprising that home care workers do not always provide elderly care according to a reablement approach but instead are inclined to fall back onto conventional 'compensatory' care, thus leaving a discrepancy between policy ambitions and street-level practice when implementing reablement. As the head of an assessment office in a coastal municipality stated in an interview on the status of reablement implementation in the municipality: "Reablement has not yet reached the final sandbank…".

Published research on how the reablement paradigm and approach has been implemented within the local municipalities is sparse. Whether the implementation of reablement is a success or failure – we do not know. However, even though reablement seems simply "the right thing to do", there is a lack of evidence about reablement (Aspinal et al. 2016), and at the same time some municipalities still experience difficulties implementing reablement at the frontline of elderly care (references).

Although recognizing that several factors influence street-level behavior, in this paper, I focus my attention on the role of the organization of street-level behavior, more specifically the organization of eldercare and reablement at street-level in two Danish municipalities. The paper proceeds by reviewing the implementation literature and research on street-level behavior and factors predicted to influence street-level behavior, predominantly focusing on organizational factors. I then briefly introduce to reablement, as the policy at stake in this paper. > Method and data – findings and discussion.

Street-level behavior and influencing factors

In his seminal and now classical 1980 study of workers in schools, courts and welfare agencies, Lipsky defined street-level bureaucrats as *'public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work'* (Lipsky, 1980:3). These street-level bureaucrats include police officers, nurses, pedagogues, teachers and other public employees who produce and deliver public welfare services, control access to public programs or enforce public laws and regulations (Loyens & Maesschalck, 2010). To Lipsky, and other scholars following him, these street-level workers are pivotal players in the implementation of public policy. Street-level workers do not only execute government policies and directions but they informally construct (and reconstruct) policy in the course of everyday organizational life (Brodkin, 2011; Lipsky, 1980), because their decisions and actions become or represent the policies of the government that they work for, when providing services, allocating benefits or imposing sanctions to citizens (Lipsky, 1980). Due to wide discretion and autonomy from organizational authority, street-level workers are able to exercise their own judgement when putting policy into practice, and are in that way 'producing' public policy as citizens experiences it (Meyers & Vorsanger, 2003). However, their actions and decisions may not always match the stated policy goals and objectives which can lead street-level workers 'making policy' in unwanted or unexpected ways.

According to Lipsky, street-level workers use a repertoire of coping mechanisms as a kind of self-defence (Nielsen, 2006) due to an experienced discrepancy or conflict between the many demands for their services and the resources available in their jobs. As a result of this discrepancy, street-level workers become increasingly frustrated and feel compelled to develop patterns of practice and make use of coping behavior in their interaction with citizens and clients, such as routinization and stereotyping, trying to make their work life more manageable (Lipsky, 1980). Thus, from this perspective street-level bureaucrat behavior is seen as a product of their working conditions (Nielsen, 2006).

According to succeeding literature on street-level bureaucrat behavior inspired by Lipsky's work, street-level workers are embedded in interacting policy, organizational, professional, community and socio-economic systems, and their behavior is, thus, influenced by multiple factors. Researchers have identified a broad variety of factors, e.g. political, organizational and professional/individual, that are claimed to explain the process of frontline decision-making or the development of coping behavior (Loyens & Maesschalck, 2010; Meyers & Vorsanger, 2003). Furthermore, much empirical research has examined the actual effects of these factors assumed to have an impact on street-level discretion. However, the findings from these studies have reached mixed and sometimes contradictory conclusions (Loyens & Maesschalck, 2010; Meyers & Vorsanger, 2003).

When reviewing the literature on influencing factors, e.g. Loyens & Maesschalck (2010) distinguish between four categories of factors assumed to have an impact on street-level behavior: 1) The effect of individual decision makers' characteristics, e.g. gender, educational background, ethnicity, culture, role definitions, religious beliefs, moral values (Loyens & Maesschalck, 2010), the street-level workers' ability and willingness to implement the policy (Winter & Nielsen, 2010), individual interests, professional norms and the processes through which street-level workers construct meaning in their daily work routines (Meyers & Vorsanger, 2003), 2) Extra-organizational factors, such as the community, the media and other service providers (Loyens & Maesschalck, 2010), 3) Client attributes, for example clients' greater or lesser needs (Loyens & Maesschalck, 2010), and 4) organizational characteristics, such as the internal structure of the organization, workload pressure, routines, rules and constraints, organizational culture, and the influence of coworkers and supervisors (Loyens & Maesschalck, 2010).

Organizational factors

To be elaborated…

Setting and the policy to be implemented

In this paper, organizational factors influencing street-level behavior and implementation are analyzed in the setting of one of the largest welfare areas in Denmark – the care and services for elderly. In Denmark, as in other Western countries, the population are generally becoming more healthy and live longer than previous generations. Consequently, Danish population projections show that the number of people over 65 years will increase significantly in the next 50 years, while the number of people aged 18-64 remains status quo during this period. Due to an almost exclusively tax-financed Danish welfare system, this increasing elder population and stable working age population pose a challenge for the funding of the Danish welfare system, in which the workforce are to provide for an increasingly larger group of elderly (Ministry of Health, 2017). This has created a burning platform for several policy solutions and changes in the health and eldercare sector. Reablement is a recent but one of several attempts colosing the gap between future expanding care and limited resources. In Denmark, as I many other western countries, municipalities have adopted a reablement paradigm and approach within the last ten years (Bertelsen & Hansen, 2018) – mostly because of policy diffusion (Rogers, 2003) but since 2015 offering reablement services has been mandatory for all Danish municipalities due to national legislation. Thus, today Danish municipalities are required to assess if a person in need of home care services could benefit from a reablement scheme. Due to the initial diffusion of this policy idea and the great local autonomy of Danish municipalities, there is a widespread variation in the organization and content of reablement (Bertelsen & Hansen, 2018). However, generally reablement is often described as focused, time-limited interventions provided in people's own homes or in community settings, aiming to train and support primarily older people regain their functional skills around daily activities, psychical and social functionality and achieving better quality of life following a period of ill health, decline in function or an admission to hospital (Aspinal et al., 2016; Ministry of Health, 2017). Furthermore, reablement is often multi- and cross disciplinary in nature (Aspinal et al., 2016), where physio- and occupational therapists initially work out reablement plans for the individual and continuously co-operate closely with social- and healthcare assistants who work as home trainers with the persons in the scheme. Purportedly, reablement has the potential to increase the quality of life for older people and to make the long-term care systems more financially sustainable by reducing the need, and thus the cost, for care (Rostgaard, 2016).

Even though an activating dimension (help-to-self-help) have dominated the elderly policy in the social sector in Denmark since the 1980's, reablement, thus represents a new and innovative policy and practice initiative, and is even claimed to a represent a paradigm shift from conventional and compensatory home care service delivery. However, despite the fact that reablement is largely adopted by many countries and local governments, and now is a legal principle in Denmark, our documented knowledge of the effect of reablement - in particular with regards to individual health outcomes, quality of life and the finances of the municipalities - is very limited (Aspinal et al., 2016).

Data and Methods

The material for this paper comes from an online survey conducted among leaders and senior management in the eldercare service area in Danish municipalities but primarily from qualitative semi-structured individual interviews and focus group discussions with central actors who one way or another are involved in the local formulation or implementation of reablement in two Danish municipalities. The original research project (Bertelsen & Hansen, 2018) including both the online survey, interviews and focus group discussions aimed to explore the local organization of reablement in Danish municipalities and perceived advantages, disadvantages and challenges of reablement and its organization by key stakeholders.

The interviews and focus group discussions were conducted in two Danish municipalities with relevant and central actors: Front-line home care staff, home care team leaders, needs assessors, reablement therapists, and political and administrative executives[1]. See table 1 for an overview of the number of individual interviews and focus group discussions conducted.

Table 1. Number of conducted individual interviews and focus group discussions

Type of interview	Municipality A	Municipality B	In total
Individual interview			
Chief executive of senior and health administration	1	1	2
Head of the care assessment unit	1	1	2
Head of municipal health unit	1	-	2
Head of municipal training unit	-	1	1
Home care district manager	1	1	2
Focus group discussion			
Home care front-line staff	1	1	2
Home care team leaders	1	1	2
Reablement therapists	1	1	2
Needs assessors	1	1	2
In total	8	8	16

The two municipalities in which the interviews and focus group discussions were conducted are comparable in many ways are (see Table 2); Both municipalities are medium-sized coastal municipalities, and both experience the same pressure or 'burden' of senior citizens, e.g. in the proportion of elderly 60+ years of the population and the proportion of citizens referred to home care. Furthermore, both municipalities introduced a reablement scheme in 2011 – as the majority of Danish municipalities did (in the years 2011-2014) (Bertelsen & Hansen, 2018), which after a relatively short project period became part of the daily municipal home care operations. During the project period, staffing consisted of three reablement therapists and approximately 45 home trainers in one municipality (A), and two reablement therapists and nine home trainers in the other

[1] The original research project also included interviews with citizens who participate in or had participated in reablement interventions (n=12), and representatives of local senior citizens councils (n=2) and the chairs of the local chapters of the DaneAge Association (interest and volunteer organization for older people) (n=2).

municipality (B). When collecting the data (spring 2017), reablement in both municipalities are performed by reablement therapists in collaboration with home care trainers (which are, in principle, all home care staff). The organization of reablement is 'divided' (Fürst & Høverstad, 2014): In both municipalities, the reablement therapists are organizationally anchored either in a training and rehabilitation unit together with other therapists in the municipality (municipality A) or in the assessment unit/office together with needs assessors (municipality B), while home trainers are placed organizationally in the home care unit in both municipalities.

Table 2. Municipal key figures and organization of reablement

		Municipality A	Municipality B
Municipal key figures	Population*	43,751	38,639
	Percentage of population aged 60 or over	30.2	30.2
	Percentage of population referred to home care**	2.5	2.9
Reablement start-up	Start-up of project	October 2011	December 2011
	Put in to day-to-day operations	April 2013	January 2014
	Staffing	Three reablement therapists and approx. 45 home trainers	Two reablement therapists and nine home trainers
Present organization (spring 2017)	Staffing	Reablement therapists in collaboration with home trainers***	Reablement therapists in collaboration with home trainers***
	Organization	Purchaser-provider model****	Purchaser-provider model****
		Centrally organized – in training and rehabilitation unit	Centrally organized – in assessment unit
		Divided organization (Fürst & Høverstad, 2014)	Divided organization (Fürst & Høverstad, 2014)
		Reablement therapists (6-7 therapists) placed in the training and rehabilitation unit together with other municipal therapists	Reablement therapists (5 therapists) placed in the assessment unit together with needs assessors
		Home trainers placed in home care unit	Home trainers placed in home care unit

Source: StatBank Denmark, StatisticsDenmark: ARE207, FOLK1A, AED06, and own calculations
* 2017Q4
** Percentage of recipeents referred to home care (permanent home help, total) of population (FOLK1A 2017Q4)
*** In principle, all home care staff
**** A model under which the unified management system of an organization is split into purchasers who buy goods or services and providers who supply goods or services.

The online survey was conducted from June to August 2017 among leaders and senior management in the eldercare service area in Danish municipalities. The survey was designed as a 'multiple informant survey', which collects information from respondents from different management levels and units within the same

organization[2]. Similar to the interview study, the survey focuses on the local organization of reablement and the perceived pros and cons of different ways of organizing reablement services in Danish municipalities. The questionnaire has been formulated partly on the basis of existing research on the organization of reablement, partly on the basis of the interim results from the interview study in the two municipalities, and last partly inspired by existing questionnaires regarding organization of reablement from Norway (Langeland et al., 2016) and England (Mann et al., 2016).

The respondents of the survey included 405 leaders and senior managers (level 2, 3 and 4) that are relevant for reablement in every Danish municipality, including chief executives of the senior and health administration, functional managers and line managers from the municipal health unit, municipal training and rehabilitation unit, the municipal care assessment unit, home care districts managers and/or home care team leaders. The questionnaire was pretested by selected chief executives and functional managers from the two municipalities (interview study). The questionnaire was administered electronically by means of SurveyXact (by Ramboll Management Consulting) and distributed by email informing respondents about the scientific investigation and providing them with a link to the online survey. Among the 405 respondents, 65 % (n=297) have answered the questionnaire, of which approx. 90 % are women. Thus, there is an under-representation of men in the survey, which is, however, to be expected, as most executives in this service area are women. In addition, the questionnaire respondents are primarily chief executives of the senior administration (21.8 %), heads of the assessment office (21.8 %), home care district managers (19.4 %), and heads of the municipal training and rehabilitation unit (17.5 %). The collected data from both surveys were transferred to the Statistical Software SPSS in order to carry out the data processing.

Findings

In our study, the motivation of both elderly citizens and frontline caregivers are believed to be essential prerequisites for successful implementation of reablement, which the following quote illustrates:

"Vi møder jo tit de borgere, der allerede fra start har den opfattelse; Jamen nu har de nået en hvis alder, så er det lovligt ikke at kunne tingene selv, og så har de heller ikke motivationen for at gå ind i opgaven. Og så går det nogle gange hen og bliver lidt selvforstærkende, når nu der så kommer en af de lidt ældre hjemmeplejere ud og har det helt store omsorgs- og plejegen, og tager det som en selvfølge; "jamen selvfølgelig skal du da have den hjælp". Så kan vi jo nogle gange godt... Det oplever jeg i hvert fald, at man godt kan stå i den situation, at motivationen er der ikke og hjemmeplejen er måske ikke lige den rette til at få det her op at køre. Så på den måde så tænker jeg, at der går stadig en hel del år inden, at den nye tankegang ordentlig kommer ind…" (Hverdagsrehabiliterende terapeut, Kommune B).

[2] 96 out of 98 municipalities are represented in the survey. In each of the 96 participating municipalities, between one and seven respondents have answered the questionnaire with an average of three respondents in each municipality (Bertelsen & Hansen, 2018).

Citizens' motivation

In accordance with the institutionalized intervention theory of reablement, the motivation of the elderly citizen is perceived key to the success of reablement, as one home care worker observed:

"[J]eg tænker, at meget af det der er afgørende for om det [hverdagsrehabilitering] er en succes eller ej, det er borgerens motivation." (Medarbejder i hjemmeplejen, Kommune B) (See Newton, 2012).

That elderly citizens are motivated to become independent are, thus, perceived as an essential prerequisite for reablement to succeed. Thus, it is a challenge when some citizens are not motivated. If elderly citizens are not motivated and interested in becoming independent from the help of the municipality or they do not want to exercise etc., it is difficult for home care workers to practice reablement. There is little benefit providing a reablement service if the older person in question does not understand the difference between traditional home care and reablement or is not motivated do to do thing for themselves (Greenwood, Ebrahimi, & Keeler, 2018).

According to the home care workers, assessments officers and reablement therapists that we interviewed, the vast majority of the elderly citizens do, however, want to be self-reliant and independent of help from their municipality in daily activities, and are, thus, positively accepting the reablement services that they are offered from their municipality. Only a minority of citizens are not particularly interested in becoming independent – which is more common for practical assistance (e.g. help with cleaning) than for personal care (e.g. personal hygiene, toilet visits, etc.)[3].

Home care workers' skills and willingness

As the introductory quote by a reablement therapist illustrates, emphasis is also placed on the importance of home care workers being motivated and skilled to work with a reablement approach (e.g. having to 'stand back' rather than 'doing for'). However, in both municipalities this is perceived as a key challenge. There is a consensus among interviewed assessment officers, reablement therapists, and home care group leaders that some home care workers seem more motivated and skilled doing reablement than others. Thus, it has become common practice for these central actors to select the more motivated home care workers to work with reablement service tasks:

"Vi har jo vores favoritter. Vi ved godt, at den hjælper dér, så skal det nok lykkes, hvis vi sender hende ud. Vi ved godt, hvem de gode piger eller mænd er. Dem, der kan løfte opgaven." (Visitator, Kommune A).

Hjemmeplejeleder: "Det handler også noget om, hvilke hjælpere vi vælger. Det gør det. (…) Altså jeg ved godt, hvem jeg skal vælge i min gruppe, hvis jeg har nogen, hvor jeg tænker 'det her, det er en stor opgave'. Så hvis vi får startet godt, så ender vi et andet sted, end hvis vi bare starter. Jeg ved godt, hvem jeg skal

[3] See Hansen (E. B. Hansen, 2015).

vælge, når det er nogle krævende ting og hvor jeg lige som kan sige 'prøv at høre her, her skal vi sådan og sådan'."

Interviewer: "Og hvad er det der sådan gør, den person…?"

Hjemmeplejeleder: "Det er hjælperens motivation, og at hjælperen kan se et formål med tingene. Så lyser det ud af hende 'nu skal du bare se i dag'. Altså de er mere positive og har en bedre tilgang til tingene, hvor nogen der skal ligesom bare have tingene gjort. Eller dem, som har det store omsorgsgen, hvor jeg tænker 'arh… det er også synd'. "Så er der kaffe, så kan vi lige sidde og snakke." (…) Men dem der sådan er lidt vedholdende med at sige 'ej, du skal altså op, og du er nødt til at skal gå fra A til B'. De når også resultaterne. 'Og nu lægger vi lidt på, og i dag kan du det og i morgen så kan det være, at det er lidt tilbage', men man giver ikke op og så siger 'nah men så må vi jo så blive her på det niveau. Vi forsætter igen næste dag. Vi prøver lige og se, om vi kan komme et niveau højere'. Der er der forskel! Det er der helt klart! (Hjemmeplejeleder, Kommune B).

"Jo, selvfølgelig har vi fået nogle af medarbejderne med. Vi har rigtig mange medarbejdere i Jammerbugt Kommune, der er skide dygtige, det har vi. Men vi har også rigtig mange af dem, som nok bare ikke har en interesse for det her. "(Hverdagsrehabiliterende terapeut, Kommune B).

In addition to motivated staff, the delivery of reablement depends on suitably trained care workers. Ongoing refresher training or shadowing of experienced workers is vital to sustain the reablement approach (Francis, Fisher, & Rutter, 2011), and care workers require specific training in reablement. However, in both municipalities only a few home care workers were initially trained in reablement when starting up reablement as pilot projects, thus becoming so-called 'home trainers' with special skills in reablement. When the reablement scheme went from pilot projects into day-to-day operations, it was then expected that the reablement approach would disseminate from trained home trainers to other home care workers by employee-to-employee training. Today, there are only a few of these home trainers left. Paradoxically, it is nevertheless expected that all home care workers do work with reablement in their everyday practice. If home care workers are not motivated nor have the abilities to deliver care according to a reablement approach, the actual implementation of the reablement policy initiative is doomed to failure. Thus, the perception is that the success of reablement implementation requires both motivated elderly citizens and employees and suitable trained home care workers.

According to the survey results, by contrast, the majority of respondents find that home care workers are both motivated for and have the necessary skills to work with a reablement approach; 81.7 % of the survey respondents either strongly disagree, disagree or partially disagree with the statement that home care workers are not motivated for delivering care according to a reablement approach. Additionally, almost 60 % of the executives either strongly disagree, disagree or partially disagree in the claim that home care workers do not

have the necessary skills working with a reablement approach. Furthermore, qualitative answers of the respondents illustrate the perception of the surveyed executives:

"It is widely believed that most of the employees are motivated and competent, and reablement makes sense [for them]. However, the problem might be that it is difficult for employees to unlearn habits, learn new routines and procedures – at the same time as structures around their work makes it difficult to work sufficiently with reablement. E.g. [it] requires some education/ supplementary training to work with reablement while structures in and the organization of elderly care (e.g. the purchaser-provider model) make it difficult for employees adapting to reablement as a new working method."

This illustrative example from one respondent is further supported by the fact that the survey item "The organizing and planning of day-to-day home care work makes it difficult to work with reablement for employees" is one of the highest ranked statements regarding disadvantages and challenges of reablement. Almost 50 % of the respondents strongly agree, agree or partially agree with the statement that existing structures and the organization of reablement (e.g. lack of carer continuity, a heavy workload, and scarcity of resources) hinders home care workers from working sufficiently with a reablement approach.

Organizational challenges/barriers *(to be elaborated)*

Characterized as street-level workers, home care workers are responsible and pivotal players for making the policy work – and the ability and willingness of the street-level workers to work intensively and continuously with reablement are – in accordance with street-level bureaucracy literature – unquestionably essential prerequisites for implementing reablement successfully. However, as indicated above our study also show that some organizational factors seem to influence the possibilities for home care workers to actually deliver reablement services as expected. From the study in the two municipalities, we find especially two main organizational barriers for optimal implementation of reablement in frontline home care practice: 1) Problems in the day-to-day organizing of reablement work and 2) a lack of supporting structures and incentives for interdisciplinary exchange of knowledge and experience – the latter as a key feature in reablement and as an important driver for interdisciplinary collaboration.

Day-to-day organizing of home care work

As suggested by the findings from the survey, the day-to-day organizing of home care work seems to hinder home care workers to work adequately with reablement. This is supported by the perception of needs assessors, reablement therapists and home care workers from the two municipalities. All stress for one thing that reablement processes lack continuity of care workers, for another that there is not enough time for home care workers to carry out their work within a reablement approach.

Lack of carer continuity

Needs assessors, home care workers and reablement therapists, whom we interviewed, emphasize that a lack of continuity of care worker is a challenge for reablement work – and that carer continuity is equally important

for both citizens, the home care workers and the possibility for interdisciplinary collaboration. E.g. as a group of home care workers stresses:

Medarbejder:" (…) Alle skal, men det var rigtig godt til start, hvor vi blev sat på en borger og kom der kontinuerligt, som det kunne lade sig gøre, ikke også. Der er det gået lidt fløjten, at vi kommer så mange. Fordi den tryghed ved at det er Rosa der kommer eller en anden, ikke også. Det har så utroligt meget at sige."

Medarbejder: "Men vi får jo også bygget noget op. Hvis det er den samme, der kommer. (…) Det gør vi jo ikke med syv."

Medarbejder: "De får også meget tillid til os når vi kommer fast. Og det er svært kan jeg høre. Det er rigtigt svært." (Medarbejdere i hjemmeplejen, Kommune A).

Continuity of carer, i.e. that service is given by one or few persons and not by several different persons, is highly valued in elderly care in general (ref.). However, according to interviewed home care workers continuity of carer is especially important when providing reablement. Home care workers are the occupational group who most frequently visit the elderly in their own homes, thus often having more knowledge about the elderly citizens in their everyday lives than other occupational groups, they know the citizens and their personality and know how to present the reablement approach to be well received. However, to know the individual elderly citizen it is necessary that the home care worker continuously visit the elderly citizen. To home care workers, the lack of carer continuity could result in a lack of overview and lack of knowledge of the progress in the individual reablement process, as well as a lack of motivation and lack of ownership of the individual reablement processes. When many and varying home care workers visit the individual citizen, taking ownership and responsibility for the individual reablement process does not come naturally. As an example, a needs assessor portrays this challenge:

"Men det er også meget med, når der kommer syv forskellige [medarbejdere], så føler ingen et ejerskab for det. Hvis der er tre hjælpere, der får lov til at være omkring en borger, så skal det nok også rykke, for så føler de et ejerskab. De begynder at føle, at det her skal de være med til for at det lykkes. Men er du der én gang hver anden måneden, så kan man næsten ikke forvente, at du skal føle et ejerskab for det. (…) Alle vil sikkert gøre det så godt som de kan, men har heller ikke altid de bedste odds at arbejde på." (Visitator, Kommune A)

Furthermore, due to a lack of continuity of carer it is difficult for home care workers to monitor and keep track of the individual's functional ability and motivation over time, thus not knowing what to demand supporting citizens in their training of daily activities, not knowing how the process has progressed and whether and how an improvement or deterioration in the citizen's situation and functional ability has happened. The following excerpts are again from a focus group discussion with needs assessors from Municipality A.

Visitator: "Men jeg synes simpelthen, at det er et kæmpe problem. Ville man virkelig lave god hverdagsrehabilitering og virkelig udvikle, så skal man have noget kontinuitet i dem, der kommer. For så ved de, hvad der skete i går og dagen før."

Visitator: ”Og de ved hvor dårlig borgeren var i sidste uge, og nu kan de så se et kæmpe fremskridt.”

Visitator: ”Det er også noget, der motiverer borgeren. Når man kan se i sidste uge, at der var syv andre, der var der.”

Visitator: ”Ja, så er der ingen der føler ansvar for det. Det er et problem.”

Visitator: ”Hvis man er inde og kigge på en borger, som har haft besøg i én uge - der har måske været seks forskellige. Det er klart at den, der kommer om fredagen ikke ved, hvordan tingene så ud i mandags. Så hvis man spørger: "Hvordan går det? Kører tingene planmæssigt? Er der sket en forbedring ift. Strømpepåtagning eller ift. bad?" Så hører man ikke ret tit noget, fordi ingen ved det. Så siger hjemmeplejen, at det er første gang de er der: "Jeg var der i mandags, men det var ikke til bad." eller "Jeg har aldrig været ved hende før, så jeg ved ikke hvad jeg skal sammenligne med." Det kan man jo godt forstå. Det er helt fair.” (Visitatorer, Kommune A).

Lacking the possibility to monitor and keep track of developments of citizens' functional ability and motivation over time, could possibly cause that home care workers rarely report back to reablement therapists and needs assessors if and when they find an improvement or worsening of the functional ability of the citizen. Accordingly, lack of carer continuity also seem to affect interdisciplinary collaboration and communication among occupational groups involved in reablement. At the same time and due to lack of carer continuity, it can be difficult for home care workers to insist on a reablement approach with a citizen, who express that other home care workers coming in the home do not work towards or make demands regarding self-reliance. A home care worker explains:

”Jeg synes, at det er nemmest hvis man er den, der kommer mest ved borgeren. Jeg var ved en borger i dag som det måske er to måneder siden jeg var ved sidst. Og jeg beder ham om at barbere sig "Amen det plejer I godt nok at gøre", siger han ”Ja! men hvis du barberer dig først, så kan jeg se…”. Men det kan godt være lidt svært, hvis nu jeg så fornemmer, at hende som plejer at være der, at hun barberer ham. Og så kan han da heller ikke forstå. Så virker jeg bare doven. I hans øjne. Og det kan godt være lidt svært at stå og insistere på synes jeg!” (Medarbejder i hjemmeplejen, Kommune B).

Lack of time

The perception that home care workers do not consistently provide elderly care according to a reablement approach but instead are inclined to fall back onto conventional compensatory care, thus may be ascribable to the day-to-day organizing of home care work do not seem to support continuity of carer in reablement. However, time may also be an important factor. Pressure of work is also considered to have an impact on home care workers' motivation and ability to work within a reablement approach. Both reablement therapists, home care workers, home care team leaders and district managers in home care highlight that a lack of time to do their job and a need to hurry can have an impact on whether home care workers are able to let the elderly citizens participate or not. In their busy schedules, it can be difficult to provide elderly care according

to a reablement approach. Reablement means that more time is spend on the individual citizen. But if you as a home care worker experience time constraints, often it is faster to do it yourself, i.e. to provide compensatory help and care, which the five following interview excerpts illustrate:

”Fordi man har lyst til at hjælpe, hvis en [borger] lige har lidt svært ved at få den [en trøje] af og på så *swish* vi er jo lynende hurtige. Vi er jo vant til at skulle være lynenes hurtige. Man skal være god til at sige, så må det tage den tid det tager. Det tager jo længere tid.” (Medarbejder i hjemmeplejen, Kommune A).

”(…) Og det kan tage flere minutter for en borger selv at få lært at få knappet de der knapper i en skjorte, hvor man som medarbejder tænker, at jeg skal være det næste sted og så går man hen: Jeg knapper lige. Så der kan jo også godt være en overgang fra, hvor man er her til man når herhen til, hvor vi gerne vil, så er der faktisk også en periode, hvor det hedder mere tid. Og så når man står derude og så føler sig presset, så kan det være svært at have hænderne på ryggen. Og så tænker man lige: ”Det ordner jeg lige!””. (Gruppeleder i hjemmeplejen, Kommune A).

”Men det er klart, at hvis man har rigtigt travlt så - og det kan jeg sagtens forstå, vi har jo daglige handleplaner, hvor der står meget indgående om, hvordan man plejer der. Og der er beskrevet, at så gør borgeren selv. Det er ret minutiøst også for, at vores afløsere kan gå ind og gøre det. Der er sikkert nogen, der har skrevet det til os, men der er beskrevet, at borgeren vasker sig selv for oven og børster selv tænder og hår, og så får de hjælp til nedre regioner. Og det håber jeg da, at uanset hvor travl man er, at så er det udgangspunktet. Men, hvis man selv er rigtigt presset, hvis man godt ved, at fru. Jensen hun sidder og tripper, at så er det der nemt lige at sige " jeg reder lige dit hår mens du børster tænder"”. (Områdeleder i hjemmeplejen, Kommune A).

” (…) Når vi gør det her [hverdagsrehabilitering], så tager det længere tid. Hvis du er bagefter i forvejen, hvad gør et alment menneske så? "Skal jeg blive her længere tid? Hvis jeg bliver her længere tid, så kan jeg ikke nå det, som jeg skal over hos den næste. Jeg ved alle de andre også er presset på tid." Det er en konstant udfordring i deres hverdag. Det er der hver eneste dag. Hvis jeg så lige gør det, så er vi hurtigere færdige og så går det ikke ud over den næste borger. Fordi hvis jeg hele tiden taber tre minutter ved hver borger, hvad kan jeg så nå hos de sidste to? Så kommer jeg for sent ind og overarbejder. Hvad sker der så? Lige pludselig bliver jeg skidt, fordi jeg arbejder for hårdt. Så jo, det er en konstant udfordring. Tidsfaktoren… Især hvis den ældre ikke helt kan det, som de kunne i går, og der er to af dem i stræk, så bliver vi presset. Hvad gør man så? Jeg håber... Når jeg siger håber, så bliver de jo også nødt til at tage vare på sig selv og passe på sig selv. Hvad gør de så? Skal man være over dem over det? Jeg synes også, at man skal være ordentlige ved dem. Jeg håber bare at de store hjerters klub… Jeg kan godt se, at det ikke altid er bedst for borgeren [at gøre tingene for borgeren], men nogle gange kan jeg godt føle med dem, når man bliver presset på tid. Så gør man det måske lidt mere smidig - kan man sige det sådan?” (Områdeleder i hjemmeplejen, Kommune B).

”Jeg oplever i hvert fald mange gange, at der også er en vis mængde frustration ude i hjemmeplejen. Bare det at vi er med [ude på besøg], så føler de "ej nu ryger tiden" og de får travlt. Og de tænker, at de har slet ikke tid til at være så lang tid hos den borger, fordi nu skal vi sætte en masse ting i gang og de skal videre og

står og bliver utålmodige. Så er det lidt svært at komme videre, og så mister de også motivationen, og de har ikke den der tanke på, at hvis vi sætter det i verden nu, vi bruger den tid nu, så sparer vi faktisk tid fremadrettet. (Hverdagsrehabiliterende terapeut, Kommune B).

As the quotes above indicate, a perception of time constraints when doing reablement can affect home care workers' ability and motivation to provide elderly care in a reablement approach. Because reablement often takes up a lot of time, and if the perception among home care workers is that there is not allocated enough time to reablement, doing compensatory care is often seen as the best alternative. However, in municipality B more time is allocated to reablement compared to other more compensatory services. In addition, in municipality A home care workers do have the possibility of applying needs assessors for more allocated time if needed. Thus, in principle a lack of time should not be an issue when providing reablement. However, the application of extra time must be in writing and supported by substantive arguments – and this can be a challenge: Due to a lack of carer continuity (see above), home care workers are not regularly at the same citizen thus lacking knowledge of the citizen's functional developments, home care workers are often unfamiliar with how to motivate and formulate an application, or doing a written application is de-emphasized in a busy workday.

Lack of supporting organizational structures and incentives for interdisciplinary collaboration

Interdisciplinary collaboration is a key feature in reablement (Birkeland et al., 2017). Despite the fact, that many different occupational groups, in principle, are pivotal players involved in reablement, reablement therapists are, however, a central occupational group in reablement. The philosophy of reablement embodies the core elements of the training of therapists (Murphy, 2018). Additionally, reablement therapists act as a catalyst for reablement (Kjellberg & Kjellberg, 2011) often initiating reablement processes and are responsible for ongoing supervising and coaching of home care workers when doing reablement (Flensborg Jensen, 2016). The exchange of knowledge and experience between these occupational groups is an important driver for interdisciplinary collaboration. Furthermore, an enhanced collaboration between especially home care workers and reablement therapists is seen as a viable solution in supporting a paradigm shift in home care work.

However, interviewed home care workers expressed a lack of interdisciplinary sparring and exchange of experience in order to strengthen the reablement approach in home care particularly. In addition, a lack of supporting organizational structures and incentives for interdisciplinary collaboration is experienced. According to all interviewed occupational groups, one way to strengthen interdisciplinary collaboration and consequently the reablement approach in home care through close contact and interdisciplinary sparring with reablement therapists is by having regular interdisciplinary meetings providing an opportunity to discuss particular citizens with the involvement of different relevant occupational groups, e.g. nurses, home care workers, reablement therapists (occupational and physiotherapists), needs assessors, dietician etc. At the time we did our interviews in the two municipalities, both reablement therapists, needs assessors, and workers and team leaders in home care strongly wanted interdisciplinary meetings. However, both municipalities have previously had a form of

interdisciplinary meetings between reablement therapists and home care workers. In municipality A they previously have had interdisciplinary meetings, in which home care workers regularly met with reablement therapists. However, in the course of time these meetings have been giving a lower priority. When doing the data collection, a reablement therapist only showed up at home care team meetings once a month, and in another home care team, these interdisciplinary group meetings had been cut for some time, as the chief executive of senior and health administration in municipality A expressed it:

"På et tidspunkt var der et meget stort merforbrug i hjemmeplejen, hvor der virkelig blev strammet op på meget, og der ved jeg, at der var nogle af de møder, som simpelthen blev fjernet, fordi det var vigtigere, at folk var ude at køre..." (Sundheds- og ældrechef, Kommune A)

In the startup phase in municipality B, they have had similar regular interdisciplinary meetings between home care workers, reablement therapists, needs assessors. At these meetings reablement therapists and needs assessor showed up regularly in home care groups. Three days prior to the meeting, reablement therapists sent a note informing home care workers about time, location and agenda for the meeting, and then home care workers relevant for the specific citizens on the agenda were attending the meeting. A needs assessor, however, recalls these meetings as being unstructured, lacking an effective management of meetings, lasting too long and that home care workers had difficulties seeing the relevance of the meetings. A reablement therapist, on the other hand, remembered that home care workers did not prioritize these meetings and often no home care workers showed up to these meetings. Consequently, these meetings were phased out, as a reablement therapist explains.

"Det faldt også til jorden, fordi vi oplevede at vi sad to terapeuter og ventede på de medarbejdere. Det blev ikke prioriteret, enten fordi man ikke havde tid eller fordi man ikke havde overskud eller fordi man ikke syntes, at det var relevant." (Hverdagsrehabiliterende terapeut, Kommune B).

In both municipalities, interviewed representatives from every interviewed occupational group want the interdisciplinary meetings reintroduced while they argue for the potential benefits of the meetings; The meetings provide the opportunity to share knowledge, experiences and competencies between the involved occupational groups. Meetings enable interdisciplinary sparring and mentoring. Meetings support a shared understanding and shared goals and coordination in relation to this. Additionally, the simple fact that people and occupational groups meet face-to-face is highly valued because it is believed to strengthen the knowledge of and understanding between each other – which ultimately strengthens collaboration.

Interdisciplinary meetings providing opportunity to meet face-to-face and discuss cases are thus requested. However, if interdisciplinary meetings are reintroduced it is demanded that meetings in the future are well structured, purposeful, specific and systematic. At the same time, meetings must be giving priority by all occupational groups – but not least by home care management. In municipality A, both team leaders and district managers see the advantages of regular interdisciplinary meetings and want the meetings reintroduced. However, they stress that organizational structures and incentives for interdisciplinary collaboration

through meetings currently are inadequate. Meetings are often perceived as waste of time in a highly efficient organization – not due to unstructured meetings but due to the applied overall governance model – an activity-based rate-charging and financial management model – in which the home care unit is paid based on the activities provided. However, formally interdisciplinary meeting with reablement therapists are not seen as part of the home care core operations and activities, thus are not activities that the home care unit cannot charge for. In consequence, interdisciplinary meetings have in several local areas been phased out temporally, which both the chief executive of the senior and health administration, a home care district manager and a home care team leader emphasize:

"(…) [D]et er jo noget vi drøfter meget generelt, den der med, hvordan er det man får både en kultur - som det [hverdagsrehabilitering] jo rigtig meget er det her - og noget viden og noget samarbejde ud i en hverdag, som skal køres super, super effektivt og hvor mødetid - den der tid, hvor vi sidder og har den der lidt frie drøftelse - er svær at putte ind i en BUM-model. Det giver da udfordringer." (Sundheds- og ældrechef, Kommune A).

"(…) Så har der været ekstremt mange besparelser på vores område som gør, at den der tid til at mødes, at den er der ikke ret meget. Altså det er meget med at man skal være effektiv. Altså man skal møde ind og så skal man ud og tjene nogle penge, fordi det er jo når hjælperen og assistenten leverer ydelsen, det er jo der pengene ruller ind. Så snart de sætter sig ned, så skal de have en løn, men jeg får ikke nogen indtægt. (…) Altså det [hverdagsrehabilitering] er jo en investering kan man sige. Noget af det der skal til, det er også noget af det økonomiske. Hvis vi nu skal sætte nogen på kursus i rehabilitering, så skal vi betale deres løn og vi skal betale kursusafgift. Vi får godt nok en godtgørelse, men det er en udgift for os. Og der mener jeg jo, at visitationen skal på banen, fordi det her er faktisk en investering i en fremtid med besparelser. Så de skal hjælpe os. Fordi vi bliver lidt straffet. Fordi ligeså snart vi kører hårdt på med det her [hverdagsrehabilitering], så mister vi vores ydelser, som er vores levegrundlag. Det er noget, der ligger overordnet. (…) Så der skal vi have en afklaring af, hvem betaler når vi sætter os ned og har et møde. Og lad os bare sige at ugemøderne har en overskrift, der hedder rehabilitering, fordi det ville være så oplagt, hvem betaler det så? (…) Fordi jeg sidder med pengekassen, så der kan jeg jo godt se, at det her det skyder mig selv i foden på en eller anden måde." (Områdeleder af hjemmeplejen, Kommune A).

"Der er ingen tvivl om, at vi gerne vil holde alle de møder der kunne være, og vi gerne ville have alle de medarbejdere med i det, og inddrage dem - men hvem skal betale? Det er jo lidt der vi står. Har jeg 10 medarbejdere på arbejde i otte timer en dag, det er 80 timer jeg har. Jeg skal jo helst have penge i alle de timer, og det får jeg altså kun når de udfører visiterede opgaver. Jeg får ikke for et møde med en hverdags-træningsterapeut. Alle de der ekstra ting, det får jeg ikke for. Så der skal vi finde et eller andet sted at få pengene fra. Og det er også mange gange der den strander, så det bliver altså skåret ind til et absolut minimum indimellem." (Gruppeleder, Kommune A)

In municipality A, having interdisciplinary meetings are activities that the home care unit pay from 'their own pocket', and thus have no incentives to prioritize these kinds of meetings. Prioritized are activities that the home care unit is paid for, i.e. face-to-face time with citizens' and time spent on visit-specific work – and to a lesser extent interdisciplinary meetings and coordination through meetings.

Discussion (to be elaborated!)

Based on our findings we have learnt that we cannot simply expect street-level home care workers to implement a policy – in this case reablement – by trying to reform their mindset of good elderly care. The motivation and competencies of home care workers are certainly key to the success of reablement. However, by crediting the successes or failures to street-level bureaucrats, alone, can easily distract us from an analysis of the political, policy design and organizational factors that shape the action of street-level bureaucrats (Meyers & Vorsanger, 2003) Additionally, it is necessary to change the organizations responsible for putting the policy into practice (Brodkin 2011) in order for the implementation to succeed. The organization and the organizational structure including the day-to-day organizing of reablement work and structures and incentives for interdisciplinary exchange of knowledge and experience and the funding model must support the policy being implemented. Thus, the organizational structures and framework should be designed supporting reablement and interdisciplinary work in such a way that reablement can be optimally implemented in the frontline of elderly care services. This means that it is essential to remedy the organizational barriers inherent in the current system against its implementation of reablement.

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