Special Issue

Quality reforms in Danish home care – balancing between standardisation and individualisation

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What is known about this topic

- Home help services in Denmark are based on the principle of universalism, are professionalised and widely used, and there are no user fees.
- Nevertheless, this service sector is often criticised in the media and public opinion polls.
- Denmark has been at the forefront of introducing New Public Management principles in home help.

What this paper adds

- Identifies that reforms of home help services in Denmark have focused on quality through the introduction of transparency measures.
- Reforms revolve around the conflicting principles of standardisation and individualisation and have not enhanced user control.

Abstract

Despite relatively generous coverage of the over-65 population, Danish home help services receive regular criticism in the media and public opinion polls. Perhaps as a consequence, reforms of Danish home care policy for senior citizens have placed a strong emphasis on quality since the 1990s. This reform strategy represents a shift from the welfare state modernisation programme of the 1980s, which built mainly on economic strategies of cost-efficiency and New Public Management principles, including contract management and performance management. Recent reforms have instead attempted to increase the overall quality of care by increasing the transparency at the political, administrative and user levels. However, reforms have revolved around the conflicting principles of standardisation and the individualisation of care provision. This approach has succeeded in increasing the political and administrative control over home help at the expense of the control by users, care workers and case managers.

Keywords: Denmark, home help, individualisation, New Public Management, quality, standardisation

Introduction

As in the neighbouring Nordic countries, care in the home in Denmark for senior citizens and disabled persons is mainly organised, financed and provided by the State. Nordic welfare is generally characterised by the availability of extensive public services, often claimed to form the core of the Nordic model (Anttonen & Sipilä 1996). The availability of services, which are organised locally, is based on the principle of universalism, which implies a generally uniform standard of services across the country. Services are available for all citizens, and provision is highly regulated, and is primarily provided by professional and qualified staff members (Anttonen & Sipilä 1996, Rostgaard 2004). For instance, more than 70% of nursing home staff and home helps have received between 1 and 3 years of formal care training, and the assessment of need is in the hands of specially trained, municipally employed case managers (Rostgaard *et al.* 2011).

The objective in Denmark of the main home care service, namely home help, is to provide for everyone in need, regardless of age, income and any potentially available informal care givers. Nearly one-fifth of the over-65 population receives some form of home help, which provides personal care for example bathing and practical assistance for example cleaning. Nevertheless, it is a service sector often under heavy attack from the media and, the home help service is often found to be the poorest rated service in public opinion polls when compared with public libraries, child care services, public schools and the hospital sector (Nielsen & Andersen 2006). It is a low-status job sector with poor working conditions which struggles to attract labour (Rostgaard 2011). It is also a sector which has seen the introduction of New Public Management (NPM) principles (Hood 1991), like no other public sector in Denmark, vastly exceeding the other Nordic countries in this regard. Among the Nordic countries, a considerably higher proportion of Danish care workers have experienced the introduction of market-based practices such as quality control, the separation of the purchasing and provider functions, customer choice and competitive tendering (Kröger 2011). Consequently, many recent changes have been implemented to increase care quality, and this article addresses the main reforms of the home help service since the 1990s. The article examines the conceptualisations of quality in these reforms and how elements of quality reform strategies have been utilised. Of particular interest is how the reforms, despite the common focus on improving quality through political, administrative and user transparency, have revolved around conflicting objectives regarding the individualisation and standardisation of the provision of care in the home. The result of this conflict has been to increase the complexity of the system which is the reverse to what was intended.

This article is based on an analysis of the relevant legislation, policy documents and policy analysis pertaining to the reform of elder care in Denmark from 1990 to 2010. The texts have been analysed using content analysis and NVIVO software. What follows is an analysis of the main driving forces for reform and the overall reform strategies applied.

Main driving forces for reforms and reform strategies

Overall, the ageing population in Denmark as elsewhere is projected to result in escalating costs for the State. Denmark has already undergone its first period of ageing from the 1940s–1990s, and the population is currently ageing less rapidly than in many countries. Between 2002 and 2009, spending on elder care has remained stable at 1.8%–1.9% of GDP (Nielsen & Andersen 2006,

Eurostat n.d.). Nonetheless, the number of over-65s is projected to increase by 50% over the next three decades, with a particular increase in the over-80 age group. As in all other industrial countries, this is projected to increase elder care spending considerably (Colombo *et al.* 2011).

The impending demographic shifts have not resulted in major reforms of the main principles of financing of home help. Home help services are financed by income taxes and local subsidies and are still free for the user. This is despite recommendations from the OECD to introduce user fees for this service to keep demand under control (OECD 2008). In Denmark, home help is considered one of the central elder care services; analysis of voter preferences reveals consensus along all party lines (98% of all voters) that home help should be financed by the tax system (Juul 2002).

Elder care in Denmark is driven by the principle of 'ageing in place' that is to provide help and care in the community so that seniors can remain in their own homes as long as possible. More than any other EU country, Denmark has granted explicit priority to home care over institutional care. Reforms in the 1980s thus focused especially on principles of care, as exemplified by the work of the National Commission on Ageing, which emphasised continuity and normalisation as main principles in care service provision and establishing home help as the main service benefit (Ældrekommissionen 1981).

Since the late 1980s, the most important service has accordingly been home help, which is organised locally in the 98 local authorities, and provided by a municipal or for-profit provider. Home help covers personal care, (e.g. assistance with bathing, getting dressed) and practical assistance (e.g. cleaning and shopping), but such practical assistance has generally been cut back in recent years. Home nursing is provided within a separate system by the municipal home nurse.

Home help coverage has remained high, even by Nordic norms. In 2008, provision in Denmark was second highest for the over-65s (18%), only surpassed by Iceland (20%), whereas provision in the other Nordic countries ranged from 6% – 12% for the over-65s (NOSOSCO 2009). Coverage rates have dropped since its heyday in 2002, however, when 29% of the over-65s were covered (Rostgaard & Fridberg 1998, Nielsen & Andersen 2006). The main reason appears to be a tighter assessment practice in the municipalities focused on the frailest of the frail.

Major reforms initiated at the national level have taken place in this policy area. The introduction of new governance, control and steering mechanisms adhering to the NPM principles has affected this sector more than any other public sector since the 1990s. Significant changes have also taken place with the introduction of market-based home help provision.

As Kröger (2011) reports, Denmark appears to have been more eager than other Nordic countries to introduce NPM principles in elder care, including the introduction of customer choice, competitive tendering, quality-control mechanisms, purchaser–provider split and market-based care provision. As this article will outline, however, other procedural reforms have also been introduced.

Common for many of the reforms is the aim to increase the 'quality of care'. Quality thus seems to have been a common overall denominator for the reforms to modernise elder care and has become the key steering instrument for the development within the sector. Quality is used both as an end goal, to increase the quality of care, and as a term used to name the various reform strategies. And paradoxically, the quality reform strategies have often been guided by the principles of both individualisation and standardisation, hence the reform course has, on occasion, seemed contradictory.

The focus on quality follows a period of politics since the early 1980s concerning welfare retrenchment, during which the modernisation programme of the Danish welfare state (although it initially had loftier ambitions) focused on cost-cutting and reducing the size of the public sector, both in terms of the number of employees and in terms of percentage of GDP (Melander 2008). This primarily economic strategy was later criticised for having endangered the quality of public services, from the perspective of both users and staff and for having failed to improve cost-efficiency. To regain users' trust and the motivation of staff members, the modernisation strategy was amended in the 1990s to focus on quality improvements, which were to take place through the introduction of modern rational steering principles, including NPM-inspired performance management and contract management (Melander 2008).

Quality terminology has gained visibility in reforms of elder care, which emphasise the development of quality provision, quality assurance, quality standards, indicators of quality and a quality reform. Many of the reforms thus carry with them the promise that the changes can potentially improve the quality for the end-user as opposed to merely being cost-cutting reform strategies.

Reforms of the 1990s – introducing transparency

Overall, the reforms reflect the ambition to introduce transparency in a policy area, which has been notorious for the very lack of political and administrative insight into how resources were spent and which services were being provided (Nielsen & Andersen 2006). The complexity characterising the home help policy area thus also created a need for administrative and political transparency. Moreover, while the provision of care encompasses more instrumental and easily documented tasks, such as assistance with household chores and bodily functions, there is also a 'caring about' component, which is more difficult to quantify and control (Ringsmose & Hansen 2005), and care needs are known to differ from day to day and from user to user. Transparency was necessary for administrators and politicians to steer and govern the policy area, for providers to compete on equal terms, and transparency was also required if citizens were to claim their rights and act as empowered and responsible welfare agents (Højlund 2004).

However, closer examination of the various quality reforms initiated in this sector since the 1990s reveals that while the different reforms are based on the same perspective of transparency to achieve better quality care, very different procedural principles have been applied.

One fundamental element is to assure that services respond to individual needs and preferences. Many of the initiatives are accordingly focused on the output for the user, using instruments such as more user choice, user involvement and flexible service delivery, which are all aimed at ensuring that care is provided according to individual preferences.

Parallel to this has been the wish to obtain more standardised and comparable local indicators of needs assessment and resource use, initially not so much to document local variation but for the purpose of improved administrative steering, locally as well as nationally. Such reform strategies aim at increasing predictability and transparency for the user as well as for local and central policy makers, and the strategies have focused instead on more standardised care solutions and ways of communicating about care needs.

Standardisation – policies and strategies

While the various reforms have certainly never openly aimed at standardising procedures, this is nevertheless the result of many of the changes in organisation and governance, which took place in the early 1990s to increase the transparency for users, politicians and administrators.

Purchaser–provider split

One of the early significant changes was the recognition of the need to separate the purchasing from the provision of home help. In other countries, the purchaser–provider split has been introduced as part of the home help privatisation; in Denmark, this step was originally part of the recognition of individual rights to care and to a fair care assessment as well as an attempt at controlling care

assessment. As Applebaum & Austin (1990) note, the goal of case management varies considerably across national contexts. In Denmark, case management at the time was more client-oriented and focused on assuring that clients received appropriate services supporting informal care, improving access to formal care and promoting individual and family well-being. Part of the criticism of the case management system was that individual case managers did not consider more administrative goals of how to increase horizontal and vertical efficiency to improve service utilisation and constrain costs.

In 1996, 4 years before the introduction of private-for-profit home help provision, a purchaser–provider split in home help was recommended. The argument was that individual purchasers, the case managers, paid inadequate attention to politically set goals and targets and were overly involved in the daily management of the home help service. According to a Ministry of Social Affairs report, local authorities were consequently unable to control costs, and need assessment became excessively dependent on the individual case manager's opinion. This was in conflict with principles of equal treatment of users, and the introduction of a purchaser–provider split was recommended (Schultz-Larsen *et al.* 2004, p. 54).

Contract management and accountability

Transparency in entitlement to care was also the theme behind the 1995 Provision Contracts Act (*Lov om Aftaleskemaer*). This legislation ensured that any home help care assessment is formally written out and provided to the seniors in question, representing a contract between the user and the municipality. The user is thus provided with a claim to services while simultaneously emphasising the boundaries of care, that is what will not be given, thereby ensuring that the care provision does not have to be negotiated every time the home helper visits the client in their home (la Cour & Højlund 2001). The new legislation allowed for a formal contract, which the home helper could refer to if the client requested services beyond the assessment, and vice-versa if services were not provided. The introduction of the Provision Contracts also ensured some level of accountability and contract management, but not only from the local authority to the user. The contract should also include a description of the allocated provisions as well as the specified objective of providing the care for the client; for example, services may be provided to enable the elderly client to participate in activities in the local day centre or until they regain their strength after surgery.

Care being given on the basis of a specific objective and not exclusively on the basis of need is a new principle inspired by NPM strategies of goal-oriented governing doctrines, thus rendering the various expectations and obligations between user and provider more explicit. It also serves to remind that care will not be provided on a permanent basis, but rather only as long as necessary, in accordance with the principles of rehabilitation.

Instruments of contract management and accountability were also applied to ensure quality of care but came to serve as a way of standardising care provision instead of taking individual needs into account. The Quality Standards Act (Lov om Kvalitetsstandarder), passed in 1998, made users' rights and obligations more visible and transparent, also across local authorities. Local authorities must now make their local standards of quality public, for example, by declaring how often cleaning is provided, to make it possible to compare service levels between different local authorities. For example, some local authorities stipulate the number of rooms that can be cleaned and how often (Olsen & Hansen 2004).

Standardisation of care assessment

To control rising costs and reduce complexity, a new common generic care assessment system was introduced in 1998 called Common Language (*Fælles sprog*). This Common Language standardises categorising functional capacity, as well as the various services provided by the local authority, including home help. This codification of need provides a conceptual framework for the various actors, such as case managers or care providers, and offers a tool for the creation of statistical indicators for use at the local political level as well as bench marking between local authorities (Dahl & Hansen 2005). In 2005, 82% of all local authorities used Common Language (Hansen & Vedung 2005, p. 193).

The Common Language system describes only four levels of functional ability and a catalogue of care services matching the need for care, including home help. This simplifies the regulation of allocation of time by setting a certain number of minutes for specific tasks and should ensure the equal treatment of the individual user regardless of which case manager carries out the assessment. But it has also been criticised for standardising the assessment of care needs, as it does not take individual care needs into account (la Cour & Højlund 2001) or enable the identification of complex needs, which may not lie within the set standards (Petersen & Schmidt 2003). It also further dislocates the negotiation of needs, as these are formulated already before the care assessment takes place, at the administrative level, and not in the actual care situation, when the home helper visits the client in their home (Rostgaard 2007).

Documentation of time

Common Language requires that case managers set off uniform amounts of time for identical needs, and equal efforts are made to ensure that care providers keep to the assessment of care and the time that is set off. Care providers, whether public or private-for-profit, must then minutely account for the time spent in the client's home. This monitoring of time is carried out using new technologies, such as Electronic Data Programming and Palm Pilots, whereby the home helper reports their use of time and the tasks performed, which is subsequently used to document and control what is provided (Nielsen 2008). A 2005 investigation by the trade union representing social care workers found that 44% of their employees had to register time. These employees were generally more dissatisfied with their work environment and felt that they provide poorer quality of care (FOA 2005).

Over the years, many procedures for monitoring time and documenting resource use have been introduced by decree from the central government. Much of the election debates in the mid-2000s dealt with what was termed the 'tyranny of minutes' and 'barcode tyranny' in home help. The latter refers to the practice in some local authorities of placing barcodes on clients' doorframes, which the home helper scans when entering and leaving. New reforms are currently being rolled out to accommodate this criticism. This follows a much debated event where several influential government officials apologised in a national newsletter in 2007 for their involvement in the introduction of excessive NPM strategies in the public sector (Gjørup et al. 2007).

Individualisation – policies and strategies

There has been a realisation that the reforms and NPM have gone too far in standardising needs assessment and service provision.

Introduction of flexibility

One attempt to counteract this development was the introduction in 2000 of flexibility in home help service allocation. The flexibility scheme entitles the care user to exchange services within the same category in the Common Language categories as long as the home helper can provide them within the same time span. In this way, it re-introduced some agency and room for the daily negotiation of needs and services between the home helper and care recipient, although this flexibility must remain within the standardised list of available services for which time is set off.

In practice, however, few users are aware of the rules on flexibility, 68% according to a 2009 survey (LGDK 2009), and few make use of them. Also, if the same

service is consistently exchanged over a period of time, a new assessment of needs is to take place. The organisation representing senior citizens in Denmark, *Ældresagen*, reports that users experience problems relating to not knowing exactly how much time is allocated, that there is often inadequate time to exchange services, and that the local authority 'threatens to make a re-assessment after exchanging services twice' (Ældresagen n.d., author's translation).

As already mentioned, the clients often do not know how much time they have in fact been allocated. The local authorities apply different strategies as to whether they inform about the allocation of time, some local authorities only informing in the Provision Contracts about the tasks to be carried out. This is intended to preserve some flexibility in the daily delivery of care, where the individual home helper can adjust the care provision to daily needs and also to avoid focus on the variation in the allocation of care from client to client. This practice has received extensive focus and criticism for violating the principle of accountability.

Entry of the market

A major recent reform in the home help sector attempting to introduce a more individualistic approach in home help provision has been the introduction of market forces. In 2003, a Liberal-Conservative government introduced free choice of provider in Danish home help to improve user autonomy and care quality, cut costs, and more implicitly, encourage the development of a market in care. From this point onwards, local authorities must ensure that private-for-profit providers of home help operate alongside municipal providers and that the purchaser–provider split is in force. In most local authorities, senior citizens (and other users of home help) can now choose between the two provider types once their needs have been assessed by a case manager employed by the municipality. The service remains free of charge and the number of care hours remains the same, regardless of whether using a public or private operator. In 2010, 31% of the recipients of practical assistance used a private-for-profit provider, compared to 5% of the recipients of personal care. Approximately a third of users remain unaware of the possibility of choosing between public and private-for-profit providers (Statistics Denmark 2010).

Many users also find it difficult to choose between providers, as the number of operating providers increases. By 2010, 611 private-for-profit home help companies were operating in Denmark, and only four of the 98 local authorities had no private-for-profit provision of home help. Excluding Copenhagen, which has 57 private for-profit companies, on average, six companies operate

in each municipality offering free choice, with urban areas having the highest concentration of for-profit providers (Statistics Denmark 2010). While in principle the case manager must not make the choice for the user, many users do in fact rely on the case manager to make this choice (Rostgaard 2011), indicating low transparency for the user in what the various operators offer as services and how they differ.

While users may experience problems of transparency regarding the various service providers, the introduction of free choice at the administrative and political levels in the local authorities has made it less complex to characterise the quality of care. Users are observed in how they exercise their choice between public and for-profit providers as a way of understanding users' preferences for the organisation of care. In this way, local home-care organisations, politicians and administrators now find it less complicated to observe how specific users wish to see care provided. The statistics concerning the share of users between for-profit providers and municipal providers, and changes in this distribution are interpreted by the municipality as a guideline of user preferences. Many users preferring a particular provider is seen as an indication of high quality rather than an expression of the provider's success in promoting their services – or that the provider is merely on top of the alphabetically ordered list. Users are assumed to take informed, non-random choices. When users are interviewed, however, their choice of for-profit provider often turns out to be arbitrary (Rostgaard 2007).

Discussion and conclusion – standardisation and individualisation in conflict

In the last two decades, home help in Denmark has undergone important adjustments and changes, not so much in the overall principles, but in the service levels and focus of service provision. In the overarching policy goals and objectives, Danish home care still adheres to the Nordic care regime in its overall principles of universalism, formalisation and professionalisation of care and therefore remains a good example of the Nordic model. The objective of 'ageing in place' or 'as long as possible in one's own home', the Danish term for this policy, is also continued.

Most of the changes that have taken place in the organisation and governing of home help have been at the institutional level. Since the 1990s, reforms of Danish home help have especially involved changes of a procedural nature and include NPM-inspired changes in the organisation and governance of home help, often under the motto of 'quality'. The quality terminology has been common for many of the reforms, reflecting the need for re-focusing beyond the economic reform measures

characterising the modernisation process in the 1980s. Many of the reforms in the 1990s emphasised the need to focus on the improvement of quality for the end-user instead. However, as the article describes, the instruments applied were mainly inspired by NPM strategies and never really succeeded in communicating the quality themes, not least as the reforms took place in a period where the weekly provision of home help was cut considerably.

Overall, the reforms have also had the common purpose of introducing transparency, both for the end user who has gained a new role as an informed and co-responsible welfare agent and for administrative and political agents, enabling the better steering and governing of this policy sector. While the respective reforms are based on the same perspective of transparency to improve the quality of care, very different procedural principles have been applied, emphasising either standardisation or individualisation of care and with very different end results for the user, care provider and case manager.

Some reforms have introduced elements of individualisation in opening up for user choice, autonomy and flexibility in daily care provision. Other – and more influential – reforms in home help have introduced control of time, codification, governance of details and contract management. Although some of these reform initiatives may have benefitted the position of the user, such as contract management, which makes the rights (but also obligations) of the home help client more explicit, most of these changes have increased the standardisation of home help and have in fact introduced more complexity in the system. Lewinter (2003) interprets this change as a shift from home help, where emphasis was placed on coherence and cooperation between various professional groups, recipients and relatives, to a home help system delimitated by strictly set tasks, tight control of time and less emphasis on coherence and cooperation. A form of Taylorism of the care work has taken place (Lewinter 2003, pp. 33–34, author's translation).

The changes affect the home helper and client alike. As Dybbroe (2008) notes, the increasing political and institutional control in the care sector has actually also led to a standardisation and manualisation of the care work. According to her, this development results in a de-qualification of care workers, as work is now

less dependent on the learning and development of the care worker and more dependent on political and institutionally directed constructions of caring practices. (p. 44)

The development may therefore not further the recruitment and retention to a sector, which already finds it difficult to hire and maintain staff as the work is characterised by low salaries, hard working conditions

and low status. Sickness rates are accordingly higher than in all other work sectors (Borg *et al.* 2007), and a shortage of 6200 full-time positions by 2015 is estimated (Rostgaard *et al.* 2011). Moreover, this article has argued that the reforms have also concerned the case managers as a professional group in the objective to introduce more political and administrative control over the assessment of need.

Overall, the various quality reforms may not have led to overall transformational changes of a paradigmatic nature to the home help system in Denmark, but the more piecemeal reforms focused on governance, especially after the turn of the century, seem to have led to more incremental changes in the system. As the quality reform course has tried to encompass strategies of both individualisation and standardisation, the various reforms have occasionally been conflicting and with consequences for the users, care workers and case managers.

Acknowledgements

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