

## Special Issue

# Norwegian home care in transition – heading for accountability, off-loading responsibilities

Mia Vabø D.Phil

NOVA – Norwegian Social Research, Elisenberg, Oslo, Norway

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### Correspondence

Mia Vabø

NOVA – Norwegian Social Research

P.O. Box 3223 Elisenberg

N-0208 Oslo

Norway

E-mail mia.vabo@nova.no

### What is known about this topic

- Across countries, there has been an intensified quest for transparency and accountability within welfare.
- The quest for transparency and accountability is fuelled by multiple motives and values.
- Scholars have demonstrated that vertical accountability arrangements may have unintended consequences.

### What this paper adds

- Within the Nordic home care sector, accountability requirements have been fuelled by demand of activist citizens speaking on behalf of disabled and older people.
- Accountability arrangements may provide security for care staff although it is also perceived to be time consuming and distracting.
- Accountability arrangements may indirectly contribute to disperse responsibility and to intensify work processes within care.

### Introduction

Norway belongs to the Nordic family of welfare states characterised by generous public funding and a welfare policy aimed at providing health and social care to everyone in need regardless of their financial situation,

### Abstract

In Norway, home-based care forms part of the universal welfare model in that services are offered to and used by all groups of citizens. An infrastructure of in-home services has evolved within a multi-level government characterised by a combination of local autonomy and strong integration between central and local levels. In the mid-1980s and early 1990s, home care was typically organised in teams characterised by collegiality and flexible organisation. Over the past two decades, this framework has been challenged by new modes of governance introduced under the banner of transparency and accountability. This paper focuses on how this new trend in governance has been justified and put into practice. Against the backdrop of the institutional history of home care, the paper demonstrates how accountability arrangements became entangled with ongoing effort of local authorities to control costs. Drawing on existing case studies conducted at different points in time, the paper reveals how these arrangements have reshaped home care organisations in a way that also contributes to splitting up and curtailing responsibilities. It is argued that steps taken to make home care services more transparent and reliable have made them less sensitive to the particular needs of individual service recipients. Although no firm conclusion can be drawn from a limited number of case studies, the paper concludes by arguing that accountability arrangements in home care have enhanced the predictability and reliability of service delivery. However, as off-loading responsibilities may be disempowering for those who do not have additional coping resources, institutional changes may also serve to undermine the enabling role of home care services. These findings suggest a need to address the dilemma inherent in the rationing of home care services and to rethink how a contextual and situated approach to care can be better balanced against the requirement of due process.

**Keywords:** accountability, change, home care, nordic, transparency

social status, age, gender and family situation. The comprehensive infrastructure of statutory services, including out-patient health services and long-term care, is traditionally channelled through local authorities (Albæk 1995, Baldersheim 2003). Local service provision is influenced by central government through judicial acts,

monitoring and substantial block-grant funding. Still, local authorities are free to organise and accommodate services to local conditions. In long-term care, the local population structure and density, topography and travel distances and so forth have resulted in a variety of service profiles (diverse fusions of traditional institutional care facilities, home-based care and intermediate solutions) (Huseby & Paulsen 2009, Vabø & Burau 2011).

The twin features of local autonomy and strong central–local integration have been balanced through consensus and mutual trust. Baldersheim & Ståhlberg (2002, p. 76) characterise the Nordic model as a ‘guided democracy’ – a mild version of the Napoleonic, prefectural model with the prefect as the benevolent father (the central government) willing to listen to local family members. Administrative reforms have been conceived as joint central–local projects with substantial elements of experiment, mutual learning and replication across municipal borders and also across the borders with neighbouring Nordic countries (Baldersheim 2003).

This pragmatic collaborative reform strategy has proved to be resilient, although over the past decade, it has been accompanied by a parallel trend towards centralisation of power through ‘harder’ control measures such as individual rights legislation and detailed reporting systems (Fimreite *et al.* 2007, Vabø 2010). Local authorities are called to account by central government. This trend towards centralisation has overlapped a wave of reforms generally referred to as the New Public Management (NPM) (Hood 1991) – a wave of reforms impelled by the quest for efficiency, aiming at reshaping public sector into more market-like and corporate-like structures. For local service providers, this implies that services are increasingly accounted for and audited along the same lines as private companies. Service staff are required to give an account of what they have done/not done to purchasers and strategic managers.

The transformation of work organisation to become more concerned with accounting has been related to global trends like the ‘audit explosion’ (Power 1994, Shore 2008) and the rise of ‘managerialism’ (Banks 2004, Duyvendak *et al.* 2006, Harris & Unwin 2009) – manifestations of rationalisation which reflect a hope for ‘greater calculability and precision in the management of human affairs’ (Gregory 2007). Accountability has been described as an ‘hurrah’ word – ‘nobody can be against it’ (Bovens 2005, p. 182) – or as an ever-expanding concept filled with different meanings (Mulgan 2000). Accordingly, the concept has also been related to a range of different institutional arrangements and relations (Ferlie *et al.* 1996, Bovens 2005). Research into various forms of accountability arrangements has identified a number of unintended consequences relating to the costs of operating such systems and the lack of veracity of the

measurements upon which they are based (De Bruijn 2002, Gregory 2007).

As neither ‘accountability’ nor associated arrangements have any clear operational meaning, it may be argued that they should be studied as social constructions situated within specific spatial, temporal and social settings (Yakel 2001), shaped by multiple motives (Blomgren & Sahlin 2007), and used for different purposes (De Bruijn 2002). This paper largely focuses on the Norwegian home care sector and the way in which new accountability arrangements have been justified and put into practice over the past decades. The aim is to explore how the quest for transparency and accountability has justified institutional changes in home care and how these changes have affected the working organisation of care staff and the way they relate to care recipients. The paper commences with an outline of the institutional history of home care and how criticism relating to local care service provision contributed to fuel a call for transparency and accountability. Drawing on existing case studies conducted over the past 20 years, the paper focuses more closely on the way accountability arrangements have reshaped the organisation of home care including routines for assessing needs and allocation of services.

### The institutional history of home care

The Norwegian public home care system was developed in the early 1960s as part of a more comprehensive universal care policy aiming to avoid segregation of older people from the population at large. In the postwar era, economic incentives were used to implement nationally mandated programmes and make services available for all. Generous grants from central government were made to local authorities through a system whereby 50% of costs for domiciliary care 75% of costs for nursing care were reimbursed. However, when an infrastructure of services was established in the mid-1980s, the funding system was replaced by one based on block grants. As central authorities no longer reimbursed expenses for care, incentives for expansion stagnated.

### An era of radical decentralisation and rationalisation

These changes in the funding system were part of a reform strategy assigning public sector functions as close as possible to the citizens concerned. It was argued that each individual local authority was best qualified to determine the most accommodating and cost-efficient long-term care solutions. The strategy corresponds with a logic of ‘self governance’ (Newman 2001) which assumed that local communities should develop the capacity to solve their own problems. As subsidies were

capped and local authorities had to curb expenditures, most local authorities changed their long-term care policy: the number of beds in institutions was reduced and typical nursing tasks transferred to the home care system. To improve the utilisation of staff resources, previously segmented services – home help (domestic care) and home nursing (nursing care and personal care) – became (more or less) integrated (Vabø 2007). To provide adequate care for those with the greatest needs, municipal home care was made available around the clock.

In the late 1980s and early 1990s, home care was typically organised in local service teams providing services for the population of a specific geographical area. Home care teams were based on a collegial organisation, characterised by flexible and broadly defined jobs, vertical communication, and practitioners and managers working co-operatively (Vabø 2011a). Decision-making power was decentralised, not only to skilled nurses and auxiliary nurses, but also to lower-skilled home helpers who spent more time with clients and thereby acquired first-hand knowledge of the everyday life of clients. It was argued that care needs are contextual, complex and have shifting variables, and that the needs assessments and allocation of services should accordingly be conducted by those closest to individual service recipients (Vabø 2006, 2009, 2011a).

Although widely recognised as a rational way of organising care work, the collegial home care organisation became increasingly problematic. Commentators argued that home care agencies had become overwhelmed by new tasks and new care responsibilities. However, as the collegial organisation was hampered by a lack of transparency, it was difficult to verify this statement. As noted by Nygård (1992), allocation and provision of home care services was hidden in the busy working day of care staff. Citizens were given no clear information on the limits of public care responsibilities.

### **The quest for transparency and new accountability**

In the years following decentralisation, quality problems of the local care sector became a topic in a heated public debate. This debate peaked during the winter of 1990 when a protest of activist (middle class) citizens turned into a nationwide people's movement – later known as 'the elderly revolt' (for more details, see Vabø 2011b). In response to the severe criticism, the government added one billion crowns to the state budget and introduced new ear-marked grants for the care sector, adding to the general block grants (Daatland 1997). Above all, considerable pressure was put on central authorities to demonstrate accountability in municipal long-term care.

Since then, a range of accountability requirements has been imposed on home care agencies. One set of requirements has been to improve legal accountability (Mulgan 2000), that is to make local governments comply with legal prescriptions. Procedural rights of citizens were strengthened as the Social Service Act of 1991 stipulated the rights of citizens to have their needs individually assessed, to make their views known, to receive written and well-founded decisions and the right to appeal. Furthermore, a new clause to the Health Services Supervision Act of 1984 was added in 1992 requiring that health and care services should implement a system of *internal control* (internal audit). The system was based on a form of indirect control recognised by Power (1994) as 'control of control' in so far as it was acting indirectly upon systems of control rather than directly upon first-order activities. A sharpened focus on internal control systems was endorsed by the Quality Regulation (*kvalitetsforskriften*) of 1997 directed towards all agencies providing long-term care (Ministry of Health and Social Care 1997). All these regulations called for local home care agencies to put on paper what they had previously carried around in the heads of front-line staff (Vabø 2011a).

A second set of statutory accountability requirements concerns the requirement to report information about finances, services and governance. A national information system, KOSTRA (Local authorities State-Reporting system), is based on consecutive data records and annual reports from local authorities. Key indicators are published by Statistics Norway on the internet in a format that makes it possible to compare resource use by similar municipalities. Based on a set of rather broad quality indicators (level of educated staff, sickness absence among staff etc.), municipalities are also encouraged by central health authorities to learn from 'best practice' municipalities. In recent years, an additional reporting system, IPLOS, has been added to the national information system providing individual encrypted information about all recipients of care in Norwegian municipalities. IPLOS aims at providing comprehensive information on individuals' needs, resulting in added reporting burdens for local authorities.

### **The intertwining of interests behind the quest for accountability**

So far, the quest for transparency and accountability has been linked to the public concern about social rights for older people. However, to understand how accountability arrangements materialised at the local level, it is important to emphasise how statutory accountability requirements became highly entangled with endeavours of local authorities to find more cost-effective solutions in

care provision. This became evident as many municipalities were caught in the wave of NPM. In Norway, NPM was recommended by central government as a part of general strategy of public sector modernisation (NOU 2000). It was argued that a sharper focus on output in combination with competition from private providers would enhance cost efficiency and add value to public services. At the local level, however, the idea of bringing in competition from private providers was met with scepticism, in particular within eldercare. Thanks to firm opposition from left-wing parties and the care workers' labour union, Norwegian municipalities were more reluctant to rely on private for-profit providers in the care sector than was the case with Swedish municipalities (Vabø & Szebehely 2012). Still softer managerial tools associated with NPM such as contractual management, quality management and best-practice benchmarking were embraced by many municipalities (Vabø 2007).

A core model associated with the managerial turn in Norwegian home care was the purchaser-provider model, suggesting that responsibility for assessing and approving a contract for services should be separated from the responsibility of providing services. At first, the distinction between purchaser and provider roles was regarded as a necessary step towards competitive tendering. The idea was that the public care authority should tender and purchase services on behalf of the public, either from a private agency or a public sector agency operating at arm's length from the public care authority. However, it was subsequently argued by the Norwegian Association of Local and Regional Authorities that the separation and specialisation of roles would make in-house providers better positioned to demand quality and to control and manage quality at arm's length (Pape 2000). Local authorities were encouraged to use statistics from KOSTRA-IPLOS as a tool in their own efforts to enhance cost efficiency and to compare and compete with other municipalities.

Ironically, the purchase-provider model became associated with the new legal regulation in home care. Whereas in NPM textbooks, the model provides a focus on 'managing by contracts' (output) rather than by rules (input), pragmatic Norwegian officials found the purchaser-provider model to be especially appropriate for dealing with new regulations in home care (Blomberg 2008, Vabø 2011b). Specialised care assessors were presumed to take a more detached view of care needs than the care staff and would accordingly better ensure the procedural rights of citizens (Vabø 2009, 2011a).

### The social construction of accountability

Before turning to the question of how the quest for transparency has materialised in the everyday practice of

home care, it should be emphasised that the impact and significance of new organisational ideas varies greatly across municipal borders – even more than across national borders of the Nordic countries (Szebehely 2005). In small municipalities located in the fjords and mountains of Norway, communitarian values are strong and services provision governed pragmatically by first-hand knowledge about the sparse population rather than by abstracted management ideas (Aksøy 2009). However, surveys among municipalities indicate that organisational ideas associated with NPM have spread rapidly in the most populous municipalities (Gammelsæther 2006).

In the remaining parts of the article, I draw mainly on findings from my own published case studies conducted in urban home care districts. Cases represented in these studies were intentionally selected to illuminate how the entanglement of statutory accountability requirements and NPM-related measures has affected routines and service allocation. Some urban care districts were also selected for the purpose of making comparisons over time with case studies conducted in the early 1990s (for further details, see Vabø 2006, 2007, 2009, 2011a). These cross-time comparisons of case studies have been useful as an approach to avoid simplified and stereotyped notions of the past and to make visible the historical-institutional context of the reform steps to be analysed (Vabø 2007).

### Advantages and disadvantages of the collegial home care teams

The above-mentioned team-based home care organisation was a widespread and taken-for-granted way of organising practical care. The autonomous and flexible role of front-line staff has been characterised by the term 'rationality of caring' (Wærness 1984), a phrase highlighting the rationality of looking after the specific and changing needs of care recipients in the delivery of home care services.

Case studies conducted in the early 1990s revealed that 'the rationality of caring' remained a dominant logic of action in home care (see Szebehely 1995, Thorsen 1998, Hansen *et al.* 1999, Lewinter 1999). Local home care teams appeared as 'negotiated orders' where front-line staff continuously asked questions about needs and the coping capacity of individual care recipients (Vabø 2007, 2011a). Team leaders and staff made holistic assessments of the particular needs of individuals and on that basis came to agreement on how they could best be supported to carry on a life at home. Home care staff, including skilled nurses, were typical 'social professionals' (Banks 2004) making use of multiple knowledge and skills, including everyday knowledge shared by members in

the community in which they were working. Open-ended dialogues and in-depth knowledge about the needs of clients brought about care solutions adapted to individuals' life situations (Vabø 2006, 2007). Their autonomous role was underpinned by a working principle suggesting that the *raison d'être* of home care was to enable older people to promote their own self-care and daily living skills. This principle has been associated with public home care in several countries (Anderson 1990, Szebehely 2005), including the 'home care re-ablement services' being set up in contemporary English adult care (Rabiee & Glendinning 2011).

However, at times of severe resource constraint, home care staff strived to protect those in greatest need from the worst effects of cut-backs. Their way of managing competing needs with scant resources corresponds to some of the strategies described in the seminal work of Lipsky (1980, pp. 61–65). For instance, care staff informed clients about their busy day and difficulties of their jobs to gain understanding and sympathy for their situation; they informed clients that many people have to be attended to and accordingly they should be happy that home helpers had the time for them (Vabø 2006, 2007). Care staff were encouraged not to 'damage good family resources' and not to 'spoil people who were fit to manage by themselves'. In their day-to-day decisions, they frequently referred to the core principle of enablement, a principle sometimes referred to as an ulterior motive to keep services at a minimum level (Vabø 2007, 2011a).

Based on inquiries into the micro-level decisions of home care staff, scholars became aware that the lack of resources invited home care staff to take strategic action (Daatland 1992, Thorsen 1998). According to Nygård (1992, p.107), families who provide comprehensive care for an older frail parent were *de facto* punished by the community. On the other hand, Nygård argued that if scant resources were to be distributed more equally between people with unequal coping resources, those who had neither close relatives nor material coping resources would clearly suffer the most. The dilemma pointed to by Nygård on these different notions of justice was never a part of the heated public debate of the 1990s. It was, however, a core issue embedded in research questions in the case studies focussing on changes in allocation and provision of care (Vabø 2007, 2009, 2011a).

### The new transparent home care organisation

The purchaser–provider model introduced in home care in the late 1990s appeared to be radical as it suggested that some of the decision-making power of staff was to be handed over to specialised need assessors and 'over-

seers'. Care staff figured as 'providers' and care provision became talked about as 'deliverance of goods', and not as communicative, relational work concerned with a process of enabling. The previous discourse of care staff focusing on the coping capacity of individuals situated in different social and spatial contexts was challenged by individualised entitlement discourse stressing that citizens were entitled to receive care according to predetermined assessment criteria and citizen's charters. Hence, the implicit message was that all citizens should be treated the same. With reference to the dilemma mentioned by Nygård (above), the issue was then raised by scholars whether the balance between the two different principles of justice was unsettled in a way that disfavoured those who had no additional coping resources (Vabø 2007).

Case studies exploring how the purchaser–provider split was negotiated and put into practice in local settings gave no clear answers to how unstable and conflicting needs were to be addressed. Case studies conducted shortly after the model was introduced revealed that new formalised routines for assessing, reassessing and providing care came into conflict with established staff practices in dealing with ambiguous, changing and unstable needs (Vabø 2006, 2007). As formalised procedures and duplication of assessments were perceived as cumbersome and time consuming, a range of pragmatic temporary routines was set up. Rather than acting as contractual partners where purchasers assessed and approved a contract, purchaser officers and care staff collaborated to manage all the fluctuating needs and everyday dilemmas of care (Vabø 2006, 2007, 2011a, see also Lewis & Glennerster 1996).

Contemporary case studies suggest that some of the tensions have eased off, partly because of more adequate computer systems and partly because strategic managers have acquired a more pragmatic view of the purchaser–provider relation (Vabø 2009, 2011a). Whereas strategic managers in the late 1990s revealed an optimistic belief in the power of contractual relations (Vabø 2007), they are now aware that collaboration and partnership across the purchaser–provider divide is inescapable. In order that need assessments should be properly carried out, it is necessary to include the knowledge acquired through day-to-day observations of care staff (see also Banks 2004, Evans & Harris 2004). Thus, even though the formal responsibility for needs assessment is placed within the purchaser unit, care staff from provider units are expected to be jointly responsible for making sure that reassessments are made and files updated. A certain degree of trust and collaboration is regarded necessary, even in the relation with private providers (Asplan/Kaupangen 2007).

Together with the purchaser–provider split, everyday life of home care staff has been highly influenced by the

reporting requirements embedded in internal control systems and the KOSTRA-IPLOS system. A considerable number of working hours of care staff are spent in front of computers, reporting on what they have done/not done, on how much time has been spent on various tasks, and for travelling between homes and so forth. In addition, they have to register and report IPLOS statistics and also respond to various forms of audit and surveys related to quality assessments at regular intervals. Case studies reveal that local reporting routines had caused an overload of administrative work and a need for extra staff and time for reporting (Vabø 2009).

Performance measurements had also made an indirect impact on the work organisation as these measurements were used to justify continued intervention in the work organisation. As 'cold figures' are conventionally associated with precision and accuracy, they are potentially powerful tools for control (Denise *et al.* 2006). In Norway, statistics from the KOSTRA-IPLOS went hand in hand with the growth of new management staff. External consultancy firms and strategic managers employed by local authorities have been empowered with quantified information informing them of the performance of different service providers (see also Harris & Unwin 2009). Accordingly, performance measurements contribute to substantiating that more control, better routines and improved utilisation of staff resources are needed (Vabø 2011a).

### Implications for service users

A survey among purchaser officials in the Norwegian municipalities revealed that a majority reported the most important reason for making the purchaser-provider split was to ensure that decision-making procedures were more correct and proper (Gammelsæther 2006). The significance of 'doing things right' is echoed in interviews with home care staff. They tend to agree that the specialised purchaser units are more appropriate than busy front-line staff to deal with initial referrals and requests (Vabø 2007, 2011a). Referring to the formalised communication between purchaser and provider, some also argue that it may be advantageous for clients that staff are now able to demonstrate to an external authority that re-assessments are required. This was highlighted by several home care managers working in a purchaser-provider organisation based on fee-for-service reimbursement (Vabø 2009, p. 353). Whereas in the 'old system', a sudden increase in the needs of one client often meant that another client was given less priority, the new purchaser-provider organisation provided the opportunity to allocate more resources (by filling out a 'needs-change' report). Hence, within the new institutional framework, the predictability of service provision has

been enhanced, in particular for people who earlier were regarded as being able to mobilise coping resources.

However, despite the fact that clarity and transparency was regarded as an improvement for users, discussions between staff members also pointed to disadvantages. A commonly reported disadvantage was that time and attention used for formal re-assessments and various forms of registering and reporting often meant less time for people in need of care. They regretted that accountability requirements had been imposed on them without sufficient resources. Some pointed to the absurdity of not having the time for pottering about with the older person because they were busy pottering about with their computers and papers (Vabø 2007). It further appeared as a mental strain and a disadvantage for clients that they constantly had to keep an eye on the clock and an eye on the work schedule (Vabø 2011a).

A second indirect implication for users is linked to the way accountability measures are used as a part of a constant process of rationalising care work. Empirical evidence demonstrates that accountability arrangements do not necessarily contribute to extending the social rights of citizens or to raise the level of quality (see also Ferlie *et al.* 1996, p. 195, Clarke & Newman 1997, Harris & Unwin 2009). For instance, standards and citizen charters provide information not only about entitlements, but also (more or less explicitly announced) what people are *not* entitled to expect. As service entitlements become defined in terms of predefined tasks, other tasks (domestic tasks) are tacitly off-loaded from publicly funded home care (Rønning 2004, Vabø 2007, Vabø and Szebehely 2012). In a similar manner, information from various forms of reporting systems is used primarily for the purpose of keeping costs down. Similar to research findings in the UK (Harris & Unwin 2009), performance management in practice seems to be very much about 'driving down', 'drilling down' and 'tying down' to 'do more for less'. For instance, in one care district where home care staff regularly reported changes in needs, a problem of escalating costs had recently been exposed, and strategic managers had decided that the number of 'Need Change Reports' had to be reduced as they indicated that the care staff cared too much for their clients. Plans were in the making suggesting that a benchmarking strategy would be used to drive down the number of reports (Vabø 2009). Similar strategies had been used in other care districts to reduce the staff time used for administrative work (i.e. time used to discuss problems with colleagues and GPs, to answer phone calls from relatives) or to reduce the estimated time use for certain tasks, that is cleaning a bathroom or assisting a person with a shower (Vabø 2011a). The core message implicitly expressed through these efforts of performance management is that home care staff should be responsible for

less, spend less time on making inquiries into the well-being of their clients and perform care tasks within more strict timetables.

The problems related to fragmentation of services and strict timetables for staff were echoed in interviews with service recipients from urban care districts (Vabø 2009, 2011a). Care workers were generally perceived to be polite and friendly although narrowly attentive to the tasks defined for them in work schedules, making it almost impossible to ask for a helping hand with passing problems. However, many of the older care recipients who had close relatives to support and help them, expressed that they managed well despite the bustle of care staff. Others, including younger people with disability who did not want to be a burden to friends and family, told stories indicating that no alternative sources of help were mobilised when passing problems had occurred. They had either resigned or had felt incapacitated by communication problems because of the bustle of staff and constant staff replacements. Although the problems referred to in these narratives may seem minor (they concerned small tasks like extra help for dressing up for a birthday party, assistance to meet at the hospital for a health check), they had extended effects for those who were distressed both socially and mentally.

While the perspective expressed in these interviews calls for an appreciation of stable relationship, flexibility and 'inner' responsibility in care work, that of various advocates speaking on behalf of disabled and older people, continues to call for clear entitlements and enforceable rights (Vabø 2011b).

## Conclusion

In Norway, the quality of public care services is a matter of significant public concern – in fact one of the most decisive issues for voters (Karlsen 2009). Public opinions are often wrapped in statements about what a shame it is for a rich oil nation not to ensure dignity and care for its most frail and vulnerable inhabitants. The struggle of citizens to enhance enforceability of social rights has placed great pressure on governments to *demonstrate* that something is actually being done to guarantee high quality care.

However, behind the public scene of electoral debates, local governments are expected to control costs and to prioritise and find cost-efficient solutions to local care needs. In this paper, I have demonstrated how endeavours of local governments to make services more cost-efficient have been entangled with the measures, and steps taken to make social rights of citizens enforceable. The analysis put forward here – based on case studies from some of the most populous municipalities of Norway – indicates that efforts to make home care

organisations more transparent and well-run may generate some unintended consequences. The combination of dispersed responsibility for needs assessment and the propensity to focus attention on fragmented and predefined tasks has made staffs less sensitive to the particular social context of individuals' lives and accordingly less able to respond adequately to the needs of people who lack complementary coping resources. This finding indicates that home care as a creative enabling process is being undermined when too much time and attention is required for accountability work (formal assessments, reporting, monitoring).

It may be tempting to idealise home care provision as it was conducted within the collegial teams of the early 1990s. The situated approach typical for home care teams of that time proved to have a potential for providing personalised services, tailored to the specific life situation of individuals. However, one should bear in mind that the lack of transparency of the collegial home care teams generated opposition and a call for less arbitrary distribution of services. The institutional history of Norwegian home care demonstrates that it is hard to escape the problem of defining the scope of eligibility for services – even when services are provided as an entitlement of citizenship. As noted by Banks (2004), the inescapable dilemma calls forth the need for a balance between two different moral voices – an imperialist voice stressing equity and accountability on the one hand, and an empathic concern for individual service users stressing particularity and context on the other. For Norwegian authorities, the greatest contemporary challenge is to rethink this balance to ensure that the ubiquitous call for accountability does not lead to excessive and dysfunctional accountability work on the cost of improved care.

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