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How the care managers handle the process when older people consider relocation to a residential home

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Abstract

The aim of this article is to reveal how care managers handle the process when older people consider relocation to a residential home in a Swedish context. The article is based on vignette-based interviews with seven care managers. The main findings in the article are that the care managers assist older people in their decisions by turning ageing in place and relocation respectively into seemingly natural choices. In both approaches they use warrants related partly to 'the best for older people', partly to 'the common good of economizing'. The conclusions drawn are that the care managers by applying risk management and extensive alliance-strategies are not really able to question their own work situation and that they perform their work in a context of different parties restraining themselves. The implications for social work policy and practice are that the approach referring to older people's self-determination while actually dealing in risk assessment must be thoroughly reconsidered. Other practical implications are that the idea of the purchaser/provider-model must be clarified, beyond the assessment of resources.

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Introduction

Many countries are facing challenges with an ageing population (WHO, 2011) and since very old age entails declining health, the demand for nursing and care increases just as the demand for residential homes. In Sweden everyone who needs help in their everyday life has the right to apply for assistance (Social Services Act, 2001:453) and the care managers are the occupational group in charge of needs-assessments and decisions related to initiating, coordinating and evaluating the care for older people. However with more people in very old age, available resources in Sweden like in several other European countries have not enlarged concurrently with the demographic development. An ever increasing demand for housing is apparent, just as the demand for innovative policies to achieve a better balance between supply and demand (Pavolini and Ranci, 2008). The care managers are the ones transforming the eldercare policies into daily practice, such as the partly contradictory assignment of combining the ideology of ageing in place (WHO, 2008) and simultaneously a policy where the respect for older people's self-determination is treasured (UN, 1991). The welfare provision is declining. Risk management systems and structures are supplanting ideologies of meeting needs or welfare provision, and issues of risk influence the priority setting also when it comes to potential admissions to residential care (cf. Miller and Weissert, 2000; Taylor and Donnelly, 2006). Arising out of a study about when older people consider relocation to a residential home, this article deals with the care managers' way to handle the process.

On an international level and in different societal systems, research has previously paid attention to the care managers' balancing between procedural requirements and a more flexible professional practice (e.g. Dunér and Nordström, 2006; Lymbery, 1998). Several researchers

argue that the procedural requirements are increasing in spite the fact that flexibility is a prerequisite for the status of social work (Lymbery, *et al.*, 2007; Postle, 2001). Other researchers conclude that practitioners in social work, or in public services in general, are able to hold on to pockets of freedom when it comes to style and manner of practice (Howe, 1991; Lipsky, 1980). However, it has been found that care managers use their discretion within the framework of thoughts that underpins the organization (Dunér and Nordström, 2006; Lindelöf and Rönnbäck, 2004), but also that they are facing dilemmas when dealing with the gap between demands and resources (Dunér and Nordström, 2006; Parry-Jones and Soulsby, 2001; Phillips and Waterson, 2002; Postle, 2001). Elsewhere it is argued that more rules should not automatically be equated with less discretion and, additionally, that discretion in itself should not be regarded as either 'good' or 'bad' (Evans and Harris, 2004).

The aim of this article is to reveal how care managers handle the process when older people consider relocation to a residential home in a Swedish context. The research questions are:

- What is the assignment of the care managers when older people consider relocation to a residential home?
- How do the care managers use their discretion when older people consider relocation to a residential home and what are the consequences?

This article is based on data collected in the framework of the research programme 'Changing Place of Living in Old Age', carried out within the context of CASE (Centre for Ageing and Supportive Environments) and the School of Social Work at Lund University in Sweden. With

the main attention to older people, the aim of the research programme in its entirety is to explore the process related to relocations to residential homes from the perspectives of older people, family members, and care managers. With the intention to understand how the care managers handle the process when older people consider relocation to a residential home in times of scarce resources, the analysis is based on the perspectives of discretion in professional work (Molander and Grimen, 2010), the aspects of risk management (Taylor, 2006), and professionalizing as a strategy applied by occupations in sub-ordinated positions (Selander, 1989).

Care management

In Sweden an organizational change in 1992 implicated that all care of older people, including long-term medical care, became a municipal responsibility. Organizationally it was placed under the Social Welfare Services Department governed by the Social Services Act (Social Department, 1989); thus perceiving care managers as social workers. A system with care management was introduced in the implementation of community care with the intention to facilitate the planning and coordination of support for older people in need of nursing and care, like for instance in England and Wales at that time (cf. Department of Health/Social Services Inspectorate, 1991; Phillips and Waterson, 2002). This process was closely connected to a trend of an increased economy- and market orientation inspired by the New Public Management with the introduction of different purchaser/provider-models (Blomberg, 2008; Phillips and Waterson, 2002) clarifying the distinction between assessment and intervention. One of the core elements in the reform was to expose the public care of older people to the idea of competition-governing with a partial privatization (Andrews and Phillips, 2000; Vabø, 2005), which was based on the assumption that the more state welfare was forced into a private mould, the more efficient its

organization would become (cf. Blomberg, 2008; Clarke, 1998). In line with this development, programmes were introduced with the intention of increasing individual choice and control in Sweden (e.g. Szebehely and Trydegård, 2012) as well as in the UK (e.g. Manthorpe and Stevens, 2010; Netten, *et al.*, 2012).

As the care of older people in Sweden is still financed with local taxes and the exercise of authority is a municipal responsibility (Blomberg, 2008), there are many decentralised decisions on incoming applications to be made by the care managers. According to statistics from 293 of 321 municipalities in Sweden, there are 1,988 care managers carrying out needs assessments among older people (65+) according to the Social Services Act (Socialstyrelsen, 2013a). On a national level every care manager is on an average in charge of the management of 161 older people with eldercare, sometimes even 360 older people (Socialstyrelsen, 2013b). In 2011 there were approximately 309,400 older people (65+) with at least one granted assistance, such as a place at residential home, home help service, safety alarm, daycare centre, and short-term housing. 89,800 of them were permanently living at a residential home and 162,300 received granted home help service in ordinary housing. These numbers correspond to 5 %, and 9 % respectively of the Swedish population 65 years and older, which in this case correspond to the percentages in the municipality where the study presented in the article was carried out (cf. Socialstyrelsen, 2012).

The direct performance of care management has been a field of interest for researchers in Sweden as well as in the UK. Within welfare services, there is a growing emphasis on rationing services and there are tensions between managing needs and risks, as well as between service

user autonomy and protection (e.g. Lymbery and Postle, 2010). Simultaneously, prevention, personalisation and active citizenship are emphasized (Manthorpe, *et al.*, 2010; Spicker, 2013). In the UK the development has been characterized by the implementation of the single assessment process for older people, a key change that derives from the focus on an improved person-centred care (Department of Health, 2001). The single assessment practice has been found to benefit from the multidisciplinary collaboration (e.g. Melin Emilsson, 2011), while tensions have been found at hospital discharges (e.g. Phillips and Waterson, 2002). In Sweden the development rather has been influenced by the fact that the municipal care managers to a large extent act as administrative coordinators of care services, following up applications for assistance in needs-assessments and in decision-making processes (e.g. Dunér and Nordström, 2006; Janlöv, *et al*., 2011). Presumably due to the character of the work and its collaboration with the health care system, the concept 'social care' is frequently applied in Sweden (Melin Emilsson, 2011), while in the UK the concept 'services' is widespread seemingly due to organisational changes aimed at improving the approach of person-centred care. Previous research on decisions concerning a place at a residential home has focused on the interaction between healthcare- and social care providers and their relationships to older people and their families during hospital discharges (e.g. Efraimsson, *et al*., 2006; Phillips and Waterson, 2002). Other studies have focused on decision 'thresholds' regarding admission to institutional care (e.g. Taylor and Donnelly, 2006) and on what care managers do during care home closures (e.g. Williams, *et al*., 2007). However, what has not been studied before and what is the focus of this article is how the care managers handle the process when older people consider relocation to a residential home in a Swedish context.

Theoretical framework and methods

The care managers' educational background varies and they lack an officially recognized knowledge- and performance base (e.g. Flexner, 1915/2001). Therefore their occupation does not fulfil some of the criteria for being a profession, but is instead referred to as one among several semi-professions strongly expanding in the development of the welfare-system during the post-war era (cf. Brante, 2009). With inspiration from Selander (1989) the care managers' position in relation to other occupational groups constitutes a theoretical interest in this article. Selander argues that an occupational group in an intermediate or a subordinate position periodically tends to apply an alliance-strategy, meaning allying itself with other occupational groups or with already established research institutions in order to strengthen its position and to mobilize resources (Selander, 1989).

Another part of the theoretical framework is Molander and Grimen's (2010) approach to discretion, including structural and epistemic aspects. The structural aspect refers to the fact that there is a space where professionals can choose between permitted, well-defined alternatives of action based on their own judgement. The epistemic aspect refers to a cognitive activity in terms of a kind of practical reasoning under conditions of indeterminacy, where a practical argument is an inference from 'a description of a situation' in combination with 'a norm' to 'an action'. In that way the norm bridges the gap between the description of a situation and the action like a warrant. As there is a shift in the care managers' needs-assessment practice with more working time spent on procedural requirements, a risk management approach is added to the theoretical framework based on six paradigms in a state of reciprocal tension: i) identifying and meeting needs, ii) minimizing situational hazards, iii) protecting this individual and others, iv) balancing

benefits and harms, v) accounting for resources and priorities, and vi) wariness of lurking conflicts (Taylor, 2006).

Data collection and context

At an initial phase of a larger research programme about older people changing place of living, ten care managers were involved in recruiting older people and partly also their family members. However at the time of following up the contacts with the care managers, two of them were on the sick-list and one did no longer keep the position. Therefore the findings in this article are based on data from seven care managers. All data was collected by the first author in a medium-sized municipality in the southern part of Sweden. The participating care managers were women aged between 28 and 64. Their educational background covered trained social workers and a trained manager. One interview took place outdoors and six interviews took place at the care managers' main office, even though five care managers had their office situated elsewhere in the municipality. The interactions in the interviews were inevitably influenced by the first author and the participants, as well as by the arrangement of the interviews (cf. Fontana and Frey, 2005).

The interviews were based on six vignettes, where short verbal examples of fictitious but realistic scenarios were presented and successively commented by the care managers (e.g. Brewer, 2003). The content of the vignettes was in general terms influenced by aspects that had been brought to the fore in previous interviews within the research programme. Even though they were not previously tested, the vignettes were subject to internal discussions between the authors. The vignettes were based on situations when older people motivated relocation to a residential home because they:

1. did not want to be a burden to family members
2. felt insecure or afraid at home
3. had difficulties in getting outdoors
4. were discontent with the home help service
5. wanted to relocate before their health deteriorated

One additional vignette was based on a situation when older people regretted relocation to a residential home because they:

6. experienced the personnel didn't have time and there was no contacts with the neighbours

All the care managers agreed to the request of recording the interviews. As an example of how a vignette was presented, the fifth vignette was introduced to a care manager called Ana in this way:

> First author: You know there are older people saying "Yes, I might be able to manage for a while, but I have to think ahead. I don't get any better" - and for that reason they want to relocate. What would you say in such a situation?

The care managers' responses usually generated supplementary questions (cf. Patton, 2002) and the order of the six vignettes was adapted to aspects touched upon in the care managers' responses. At the end of the interviews, the care managers were asked if there was anything they wanted to add, which usually resulted in complementary reflections. The interviews lasted for approximately 30-40 minutes. After each interview the first author wrote down summaries of the

core issues in the care managers' responses. All the interviews were transcribed verbatim, and names of persons and places were coded. Fictive first names are applied in the finding section and minor details in the citations are changed to ensure confidentiality.

Data analysis

Data consisted of two types of written material: transcribed interviews and summaries in bullet-points. With the ambition to reveal how the care managers handled the process when older people consider relocation to a residential home the following three questions were focused in the data analysis:

- What do the care managers say they are doing?
- How do they perform their work from their own point of views?
- In which context do they do it?

Based on these questions, different patterns were outlined and related to the theoretical approach and to the empirical data as a whole. Particular statements were elevated to the level of an analytic theme, defined as "the manifest generalized statements by informants about beliefs, attitudes, values, or sentiments" (Luborsky, 1994, p. 195). The themes were organised and separate elements were unified into overarching meanings. At the time when two themes and three sub-themes were identified, they were matched to the components of the epistemic aspect of discretion (see Table 1 and Table 2) (cf. Molander & Grimen, 2010). The analysis was inevitably influenced by previous work within the research programme, as well as by the gathered personal, cultural and professional experiences of the first author (cf. Alvesson and

Sköldberg, 1994/2008), who made the initial analysis. Nevertheless, the validity of the coding system was strengthened through frequent scrutiny and internal discussions between the authors.

Ethical considerations

The project was approved by the Regional Ethical Review Board (Dnr 2009/16). Nevertheless, some additional ethical considerations emerged along the research process. As the care managers already were involved in the research programme with signed letters of consent, it cannot be excluded that they felt forced to participate in the interviews. Furthermore the implementation of the interviews was approved by their superior. This fact might even more have strengthened the expectations on them to join in, but how this influenced the data is hard to know (cf. Kvale, 1997). This awareness contributed to that each care manager was reminded of the research ethics according to the principles of the Swedish Research Council, such as that their participation was voluntary and that they could choose to interrupt the interview at any time.

The choice of building the interviews on vignettes instead of just asking the care managers about their views and experiences was made in order to avoid interference in the decision-making processes related to the older people in the research programme. As Sweden is a small country, it was also made to decrease the risk of identifying the municipality and the care managers. Otherwise, open semi-structured interviews with the care managers just as with the older people and their family members would have permitted extensive comparisons. After closer considerations the idea was deserted for ethical reasons.

Findings

A prominent feature in the care managers' way to handle the process when older people considered relocation to a residential home was holding on to the rightness of one specific decision while simultaneously making older people experience they were the ones in charge. The two main-themes *Turning ageing in place into a natural choice* and *Turning relocation into a natural choice* both included the sub-themes 'Helping to decide', 'For the best of older people', and 'Toward the common good of economizing'. In the findings, citation marks were used for concepts the care managers referred to as though they had an implicit significance; which reflected their line of talk and occupational reasoning.

Turning ageing in place into a natural choice

Once older people had reached the conclusion that it was time to relocate to a residential home, it did not implicate that the decision was set as the care managers subsequently were expected to draw their conclusions.

Table 1 Turning ageing in place into a natural choice *(Action)*

Helping to decide *What the care managers said they did (Description of a situation)*	**For the best of older people** *How the care managers perceived their own performance (Norm)*	**Toward the common good of economizing** *In which context (Norm)*
Strengthened older people's self-determination and knowledge about the range of potential home-based care arrangements	With concern drawing attention to the disadvantages of residential care in the conversations with older people	Searching for concordance between the outcome of the needs-assessment, possible measures, and available supply with support from alliance-strategies

Helping to decide:

Taking risks was to some extent considered to be a part of everyday life (cf. Giddens, 1991), such as in terms of the risk of falling. Lisa commented:

> It's important to sit down and tell "You can fall everywhere. You could fall at a residential home as well, without anybody noticing it, because you are at your own room (---). We have to find out what makes you fall and attend to that instead".

The risk of falling was not in itself regarded as a motive for relocating. Instead, the tendency to fall had to be investigated from a medical point of view before any further measures could be taken (cf. Selander, 1989). Even though older people's 'own desire' was considered catchwords in the decisions the care managers noted a lack of knowledge about available home-based alternatives. The care manager Betty put it this way:

> One might have to carry out many home-visits in order to get that confidence and to talk more. It's "Well, I do it because my family members want me to", "Now I do it because I have a hard time with the home help service". So it's a matter of strengthening their self-esteem about that "I'm the one expressing this".

A distancing attitude dominated towards family members, who were regarded a potential threat to older people's 'own desire' (cf. Janlöv, *et al.*, 2011). Another potential threat to older people's 'own desire' constituted of problems with the home help service, which was not regarded as a well-founded motive for relocation as one agency could be exchanged to another according to the 'customer choice' (cf. Andrews and Phillips, 2000; Vabø, 2005). Additionally, the managers were expected to be keen on correcting internal problems because of the increased competition.

For the best of older people:

According to the care managers many older people imagined residential homes in terms of the homes for older people in old times, where the residents could sit and talk and have a cup of coffee together. Now the situation had changed and the care managers felt it was their duty to make older people realize what they actually applied for; meaning a place for older people with 'extensive' needs of nursing and care. The care managers regarded carrying out conversations constituted their professional forte (e.g. Lymbery, 1998). Lisa stated with a dedicated tone:

> It´s important to be honest and say (---) "You are going to be depressed when you get there because you won´t have anybody to talk to (---). You will only see diseases, while you still feel you need the healthy part to get you up" (---). Because it´s a matter of caring about the person who applies.

Based on the intention of caring about the applicants, relocation was not considered to meet individual needs. Instead such a measure was referred to as a way of making the situation worse (cf. Taylor, 2006), whereupon older people's interest in relocation tended to fade. The citation also indicates that the prevalence of a formal application vis-à-vis an informal request for relocation was not always crystal-clear (cf. Lindelöf and Rönnbäck, 2004). By instead reaching an agreement 'before' application, the care managers avoided having to reject an application and thereby they also avoided criticism and legal appeals (cf. Dunér and Nordström, 2006). Laila declared:

> It is not just "feel free, make an application!" and then the application is rejected. It doesn´t turn out well. Instead we have to tell what a residential home looks like (---). The residents have extensive needs of care (---). They are not a human being longing for company, if they have extensive need of care and are very ill.

Thus based on stereotyped pictures, residential care was presented as a hindrance rather than a help and the health of applicants were contrasted to the health of residents.

Toward the common good of economizing:

Facing dilemmas related to the gap between supply and demand, the care managers searched for concordance between the outcome of the needs-assessment, possible measures, and available resources (e.g. Parry-Jones and Soulsby, 2001). In what appeared to awake feelings of being hard pressed, Lisa referred to conversations with older people claiming their right to relocate to a residential home like this:

> "You have worked and you have paid tax, but we have to look at what needs you have today and in what way we can provide for them, and what we have to offer. We can't offer more than what we have!"

The needs were regarded 'here and now'. However, the signification of 'we' in 'we can provide' and 'we have to offer' made the division in the purchaser/provider-model unclear, as 'we' obviously even included the coordinator of available places at the provider-side. In this process the needs-assessment gradually turned into assessing those at risk (cf. Taylor, 2006). Personnel from the home help service, just as at the day-care centre, were included in these continuous reconsiderations of the appropriateness of existing care arrangements like in alliance-strategies.

In what seemed to constitute efforts to make older people reconsider the possibility of prolonging the home-based care (cf. WHO, 2008), the care managers told older people they would be 'allotted a place' in the municipality according to local policy if their future application would be

granted. This implicated that there would be efforts to respond to personal preferences according to the principle of older people's self-determination (cf. UN, 1991), even though there was no guarantee this would be the case. In what seemed to constitute yet another effort to make older people choose to age in place, the organization of the care had changed in such a way that the short-term housings were no longer integrated in the residential homes. Judy summed up from an older person's perspective: 'If I know "Here I'm not allowed to stay anyway", then I may hold the door open a little bit longer'. Thus, the care managers seemed to prefer referring to possible inconveniences entailing a potential relocation rather than only referring to that there were restricted resources.

Turning relocation into a natural choice

For various reasons some older people hesitated right to the very end in the relocation decision and at this point the care managers tried to convince them about the fact that now it was time to relocate after all.

Table 2 Turning relocation into a natural choice *(Action)*

Helping to decide *What the care managers said they did (Description of a situation)*	**For the best of older people** *How the care managers perceived their own performance (Norm)*	**Toward the common good of economizing** *In which context (Norm)*
Strengthened older people's self-determination and awareness of the importance of continuity and security	With concern drawing attention to the advantages of residential care in the conversations with older people	Searching for access to residential care with support from alliance-strategies, as home-based care was excluded

Helping to decide:

There was a sensitiveness among the care managers regarding older people's personal level of tolerance for the highest possible amount of visits from the home help service. When the visits

started to be required in the night the turnover of personnel increased and for some older people thereby also the level of stress. The care manager Judy declared:

> It might be that they can´t cope with having that many visits that might be demanded. Then we can´t push it any further.

During such circumstances there was a risk of passing the threshold for what was considered ‘a reasonable standard of living’ (cf. Taylor, 2006), whereas relocation was regarded a measure in order to increase older people’s sense of continuity and security. At this point family members were regarded as important counterparts in strengthening older people in their relocation decision.

For the best of older people:

At this point the care managers turned from being a gate-keeper into an active gate-opener, partly supported by family members. Still when there was no doubt older people fared badly at home, much concern was devoted to making older people realize the advantages relocation would bring. Betty stated:

> There is a balance all the time in order not to violate their self-confidence and their experience of not being allowed to be in charge anymore.

In this work the care managers referred to approaches they personally had developed in the conversations or learnt from the dementia nurse, which in terms of style and manner of practice corresponded to pockets of freedom (cf. Howe, 1991; Lipsky, 1980). Such approaches consisted

of ‘applying a positive attitude’, using words like ‘test moving’, referring to that ‘no one can force you to stay there’, ‘not using the word housing, but apartment’, and presenting pictures verbally to support their remembrance. Another way to turn relocation into an advantageous choice was to draw attention to that there were ‘people in the same situation as you, there are personnel close by and you have your own things’, which was contrasted to the unsustainable situation with loneliness every time the home help service left.

Toward the common good of economizing:

When the care managers regarded older people to be ‘a danger to themselves or others’, the ‘extensive needs’ of care were confirmed also by other occupational groups like in an alliance-strategy, or by a legal representative once approved. Ana stated:

> Of course the viewpoint of family members must be considered, but they are no legal representatives. So according to the legislation, in that case there should be a legal representative, maybe in combination with a doctor or possibly a dementia nurse, who writes a certificate of that this person actually fares badly at home.

Thus, the care managers were expected to turn to a legal representative and/or to medical expertise (cf. Selander, 1989), which could be interpreted as a way of asking for a second opinion. In practice it also implicated that the care managers partly adapted to the health care agenda (cf. Lymbery, *et al*., 2007; Phillips and Waterson, 2002).

Within the administration certain practice had been developed in what seemed to constitute efforts to facilitate older people’s final decision. For instance once approved applications for older people with dementia formally remained without time-limits, while older people without

dementia were told a rejection of an offer could be perceived as an expression of a wavering motivation and therefore their next application could end up in a refusal. These examples illustrated that neither the rules nor the lack of rules created discretion, but rather the possibility to act between them (cf. Evans and Harris, 2004); a coherence which further marked who had the power in the relation (cf. Handler, 1992).

Conclusions and reflections

Swedish law requires a formal application for assistance from older people, which implicates that the care managers turn responsible for the exercise of authority at the same time as older people are assured their individual right to self-determination. As the care managers are appointed to decide on these applications emerging from the principle of older people's self-determination, it indicates in itself the multidimensional character of their assignment. Following up the first research question about what is the assignment of the care managers when older people consider relocation to a residential home, the findings indicate that the care managers are expected to:

- simultaneously be a person in authority, a social worker, and an administrative coordinator
- take measures based on the legislation, the guidelines of the organisation, and their delegated responsibility
- prioritize the principle of ageing in place simultaneously as the principle of older people's self-determination

Referring to the second research question about how the care managers use their discretion when older people consider relocation to a residential home, the findings indicate that the care managers build their reasoning on two norms hard to question: partly the interests of individual citizens, partly the common good of economizing. In this way the care managers seemingly strive for making older people experience they are the ones in charge of the decision, even though their own occupational standpoint is clear. Further, the care managers tend to refer to built-in inconveniences in the system, rather than having to apply an openly offensive approach. Other aspects are that the more extensive alliance-strategies the care managers apply in the fulfilment of the norms, the more parties agree on how the norms should be interpreted (cf. Selander, 1989). Thereby the care managers adapt to the framework of thoughts that underpins the organization (cf. Dunér and Nordström, 2006; Lindelöf and Rönnbäck, 2004) without really being able to question the work situation. Like street-level bureaucrats, they remain engaged in embracing human interaction, caring, and responsibility, as well as in invoking detachment and equal treatment under conditions of scarce resources, turning care and responsibility conditional (cf. Lipsky, 1980).

Nevertheless, there are indications that self-determination and choice for older people, in contrast to rationing and risk assessment, create dilemmas for the care managers and in practice tensions between social support and advocacy (cf. Manthorpe and Martineaus, 2010). At an overall level, this approach contributes to an environment where various participants are restraining themselves. The consequences of the care managers' way to use their discretion when a potential relocation comes to the fore are for the part of older people and their family members for instance that:

- Older people tend to hide their declining health, pushing the limits for what is possible. In this process they feel stigmatized when they no longer correspond to the societal expectations of ageing in place (Authors' own, 2013).
- Family members adhere to the ambition to make their old relative in charge of the relocation decision, even though in their minds their personal preferences are clear (Authors' own, 2012).

A special concern is to consider what happens to the element of social work in the establishment of purchaser/provider models. It is noteworthy that the care managers adapt to the restrictive approach in relocation decisions rather than concentrating on the prevailing needs of older people; especially as many arguments in favour of the reform in Sweden were tied to hopes for being able to concentrate on needs-assessment and no longer having to be responsible for budgets and personnel (Blomberg, 2004). As it is now, the care managers are regulating the amount of granted places in favour of the provider-side. Potentially contributing explanations paving the way for this restrictive approach are for instance:

- the increasing application of a family- and market-orientation in the care of older people
- a cross-professional insecurity related to the introduction of the purchaser/provider-model, as new occupational boundaries are established within an already heterogeneous group of care managers
- the tight collaboration which previously has been a prerequisite for the restrictive approach now contributes to preserving it

The implications for social work policy and practice are that the idea of the purchaser/provider-model must be clarified with a reinforced focus on the assessment of needs beyond available resources. Other practical implications are that approaches referring to self-determination and choice, but which actually deal in rationing and risk assessment (cf. Jordan, 2004), must be thoroughly reconsidered. There is a need of further research on how the care managers carry out their assignment under the influence of the restrictive approach, how such a point of departure influences the interaction in the relocation process, but also how it influences the care managers' occupational status - and the confidence for the welfare state.

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