To Thematic panel 3 *Do not quote – this paper is work in progress*

TRAVELS OF THE IDEA OF REABLEMENT

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Introduction

"Nothing is stronger than an idea whose time has come," wrote Victor Hugo in 1852.[2] In this paper, we argue that reablement is an idea whose time has come. Reablement is in many countries described as a person-centred practice that aims to enhance persons' functioning by training and activating for increasing their possibilities to be independent and living in their own home. Throughout the Western world, reablement services are given different labels, such as reablement, restorative care or everyday rehabilitation, are enacted in different localisations, both in home care and in residential care, and operate in different welfare systems such as liberal, conservative and social democratic regimes (Esping-Andersen, 1990). Despite these variations, we argue that the idea behind the different institutionalisation of reablement is common across time and space. There is a political aim in many countries, that is to train older and impaired people to be able to live at home longer, to become independent citizens, and at the same time reduce the nations' use of institutional, residential care.

Our research questions are: *how* the idea of reablement does travel between and within different places and systems and *why* the ideas of training and activating older people to become independent and living in their own home are spreading across different geographical places and institutional systems today; We all know that the idea of a healthy and active old age, living independently at home, have been with us for years; so *why* and *how* have this idea

[1] Email: mafei@oslomet.no
[2] Victor Hugo(1977). *Histoire d'un Crime* (The History of a Crime) [written in 1852, published in 1877],

during the last two decades materialised into a new philosophy (slogans) and organisation of services for people, named *reablement* in the UK, *everyday rehabilitation* in the Scandinavian countries, *restorative care* in the USA and *restorative home support* in Oceania? We also ask *why* and *how* do professionals, social entrepreneurs, service managers and politicians materialise these set of ideas between the late 1990s and 2010?

The paper is work in progress and illustrates how the analysis may be applied by following one country only. It is organised as follows: First, we shortly address the theoretical and methodological framework, then we use this framework on one empirical case, that of New Zealand before we sum up and introduce some questions for discussion and further research.

Theoretical framework

To analyse these questions, we are inspired by institutionalist theories of Barbara Czarniawska and her co-writers on the text "Travels of ideas" from the mid-1990s (Czarniawska & Joerges, 1996) and "Shadowing" published a decade later (Czarniawska, 2007). Czarniawska applies the theory of *translation* from the Science, technology and knowledge-tradition (STK) and outlined in the book "Science in Action", by Bruno Latour (1987) and some terms disembedded and reembedded as described by Anthony Giddens in his book, *The Consequences of Modernity*, from 1990 (Czarniawska-Joerges & Sevón, 1996; Czarniawska, 2007; Czarniawska & Sevón, 2005).[3]

We use the notion *idea* to refer to a mental image and a type of local knowledge (Geertz, 1983). This knowledge about reablement may be located in one head of a professional, political or civic entrepreneur, or as a type of collective public knowledge. To become public knowledge, an idea (in our case reablement) must be turned into objects, and disembedded

[3] Beland, D. (2009) 'Ideas, institutions, and policy change',Journal of European PublicPolicy16(5): 701–18.Be´land, D. (2010) 'The idea of power and the role of ideas',Political Studies Review8:145–54.Be´land, D. and Cox R.H. (2011) 'Introduction: ideas and politics', in D. Be´land andR.H. Cox (eds),Ideas and Politics in Social Science Research, New York: Oxford University Press, pp. 3–20.

from its localisation to travel between places and moments. In this way, ideas turn into what Czarniawska and Joerges (1996) name translocal time-spaces. I will outline the three components of this model shortly:

First, following Czarniawska and her co-writers, we will analyse reablement as an idea that has both local and global trajectories, following the path from being an idea, to become materialised into objects, actions and institutions and back to ideas again.

Second, we apply the concept of translation for "the spread of time and space of anything – claims, orders, artefacts, goods – is in the hands of people; each of these people may act in many different ways, letting the token drop, or modifying or defecting it or betraying it, or adding to it or appropriating it" (Latour, 1987, p. 267). We understand the travels of ideas, as processes of *translation*, meaning "to set something in a new place is to construct it anew" from (Czarniawska & Sevón, 2005, p. 8). This brings us to our third conceptual tools, as outlined by Giddens (1990, p. 53): disembedded meaning a type of "*lift out* of social activity from localised contexts, reorganising social relations across large time-space distances." While reembedded, meaning how an objectified idea is relocated in a new location.

Applying these conceptual tools, Czarniawska and Joerges (1996) have developed a "model" for analysing how ideas materialise into practices; they use the notions of localised and globalised time and space. To trace reablement as an idea and a practice we have to follow its travelling, where it moves in time and space. We will approach the question of how local activities, such as reablement, emerges and becomes enacted and institutionalised practices on a more global scale (Czarniawska & Joerges, 1996).

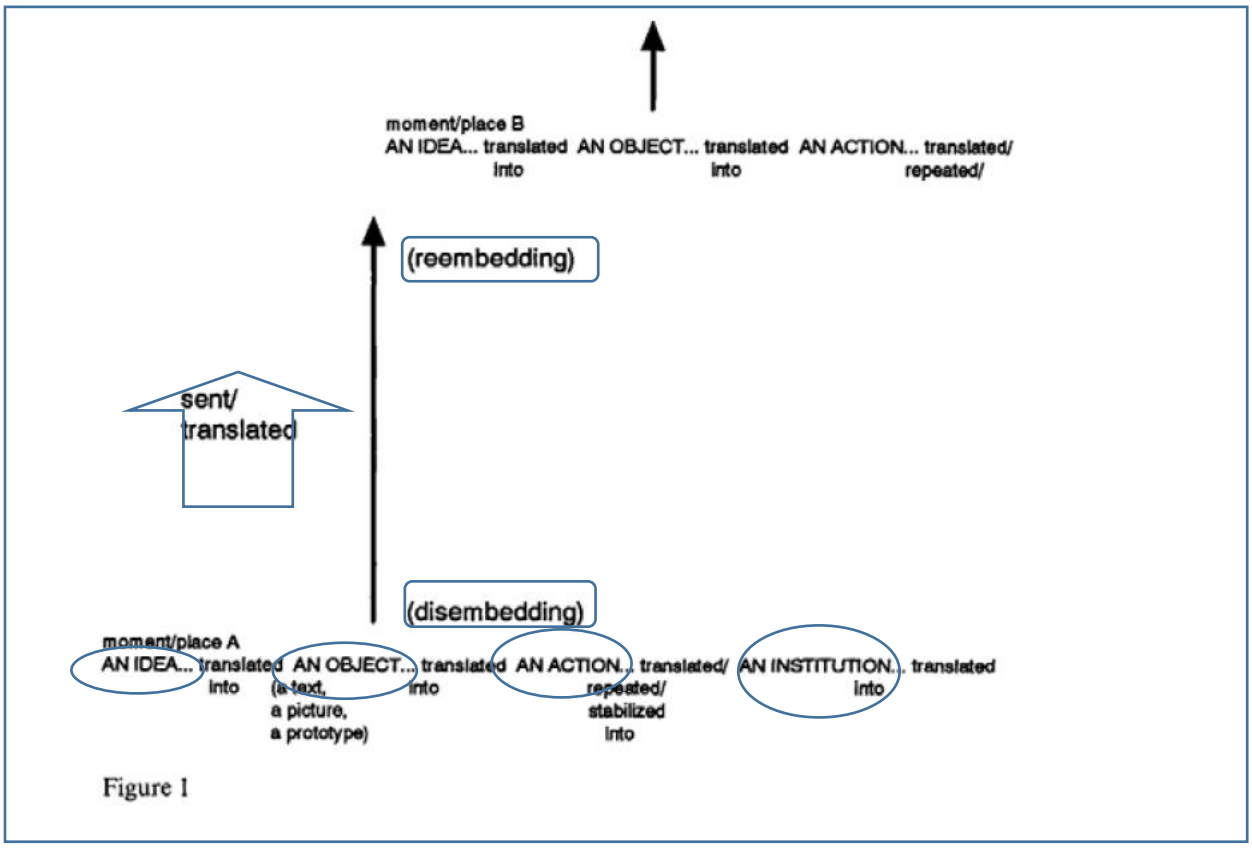

Figure 1

Figure 1 From "Travels of ideas" by Czarniawska and Joerges (1996, p. 26)

Figure 1 illustrates two processes of translation one horizontal and one vertical. First, the model identifies the process of "turning ideas into objects, actions and institutions and again into ideas". This is analysed as several stages of translation, or of entering a chain of translation: for example, an idea is translated into an object, a name, a project or a programme, and if not rejected the idea is further translated into actions that may be institutionalised at the local, regional or national level.

The vertical arrow in Figur 1 illustrates the second process: An idea (in the form of an object) is disembedded and travel to new localisations, where it may be re-embedded and translated into new *objects*, such as texts, plans or programmes in a given time and space.

Methodology

In this paper, we will combine documentary analysis with informant or expert interviews.

First, we have conducted interviews with key informants from eight selected countries (the United States of America (USA), New Zealand, Australia, the Netherlands, United Kingdom (UK), Denmark, Norway and Sweden). These countries were selected because activities and services of reablement have developed and institutionalised to a higher degree than in other countries, and they are all represented in the international research network ReAble, which focusses on reablement around the globe.[4]

Second, we will analyse the idea of reablement as objectified and embedded in policy documents, including web texts from governing authorities and the ReAble network.

Up to this date, we have interviewed six researchers/entrepreneurs from five countries (the UK, U.S.A, the Netherlands, New Zealand and Australia). Two of the interviews have been conducted face to face, while four are done via Skype, all interviews are recorded, (the Skype interview is videotaped) and transcribed via NVivo's transcription tool. We have submitted a notification form to the NSD (the Norwegian Data Protection Services).

A documentary analysis has been conducted in the New Zealand case. We have read policy documents (strategies), web pages of Ministry of Health, the web page of the ReAble network, as well as scientific texts on reablement.

[4] https://reable.auckland.ac.nz/

Empirical Case 1: New Zealand

In this example, we ask, from where has the idea of restorative care or restorative home support travelled to New Zealand? Our information about this phenomenon indicated an Oceanic trajectory from the U.S.A. to Oceania (and with a sidetrack from the U.S.A. to the Netherlands). In all these countries, reablement services are named restorative care/restorative home support. However, we have also identified some inspiration from the UK and two international organisations, OECD and WHO.[5]

The OECD is well known for its slogan: ”working to build better policies for better lives”.[6] Both OECD and the WHO have worked on: ”Active Ageing“ and later ”Healthy Ageing”. WHO understands Healthy Ageing as:”creating the environments and opportunities that enable people to be and do what they value throughout their lives”, and this includes maintaining the functional ability that enables wellbeing.[7]

According to an OECD report (1994, 1999), the level of institutionalisation of services (residential care) for people in New Zealand was 6,8 per cent and the highest rate among the developed countries together with Australia (OECD, 1994). This information may have been an eye-opener for New Zealand, even though it has a young population. Statistics and research revealed the fact that people live longer; they are healthier at the same time disability increases by age.

Moreover, improvements in health as well as in housing standards etc. contributed to people living longer. All in all, this led to a shift in New Zealand policies on elderly care.

[5] OECD = Organisation for Economic Co-operation and Development and WHO = World Health Organisation
[6] https://www.oecd.org/about/
[7] https://www.who.int/ageing/healthy-ageing/en/

Between 2000 and 2002, three political events frame New Zealand's new policies on elderly and disability care; first the Public Health and Disability Act from 2000 which created District Health Boards (DHB) across the country.[8] The following two years, the New Zealand Positive Aging Strategy (2001) and the Health of Older People Strategy (2002) were published and called for new and integrated service provision for the older population. The New Zealand vision was to "strengthening on the ability of the elderly to remain living in the community and their own homes." This led to the commission of a new slogan "ageing-in-place[9]" and several new projects funded through the District Health Board and the Ministry of Health.[10]

As one of three ageing-in-place initiatives around the country, Community FIRST was established in Hamilton, in Auckland to promote independence and recovery in elders.[11] The three projects all in elderly care were evaluated and published as Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE), which is a meta-analysis of RCTs, commenced in 2003 and reported in 2010 and 2012 (Parsons et al. 2010)(J. G. M. Parsons & Parsons, 2012).

As far as we have documented, the local concept of ageing-in-place was well integrated into several government strategies in New Zealand and concerned the ability for people to "make choices in later life about where to live, and receive the support to do so" (Positive Ageing Strategy, 2001). In 2008 the slogan was renamed to ageing in community. [12]

[8] The Regional Health Authorities were established in 1993.

[9] We don't know whether the concept age in place has travelled from New Zealand to the USA or the other way around. It is defined as " The ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." We have identified projects held from 2002 in New Zeqalnd and from 2007-2009 in the USA https://www.cdc.gov/healthyplaces/terminology.htm; https://assets.aarp.org/rgcenter/ppi/liv-com/fs177-village.pdf

[10] https://www.uniassignment.com/essay-samples/health-social-care/the-historical-response-to-ageing-health-and-social-care-essay.php

[11] The three projects were Community FIRST, COSE and PIP:
Community FIRST, stands for Flexible Integrated Restorative Support Team, COSE stands for Coordination of Services for Elderly in Christchurch and PIP for the Promoting Independence Programme in Lower Hutt.

[12] https://www.health.govt.nz/system/files/documents/pages/aspire-research-report-section1.pdf

In 2002, the new project Community FIRST was initiated by a registered nurse with a PhD from the UK, now a university employee in Auckland in partnership with the Presbyterian Support Northern, the Waikato District Health Board, and the Ministry of Health. This was the first example of restorative home support for older people with high and complex needs in New Zealand. Community FIRST, dealt with the delivering of services in older persons' home by a multidisciplinary team – primarily registered nurses, physiotherapists and occupational therapists in addition to support workers/therapy aids. It differs from the reablement services in the UK and the everyday rehabilitation in Scandinavia not being time-limited.

Besides the importance of the OECD reports and the WHO strategy on Active Aging, the Community FIRST project, was based on evidence-based knowledge. According to Parsons et al. (2010) in the ASPIRE report, p 9), the Community FIRST was grounded on an evaluation of a UK project on supported discharge team, in South London. This UK model was evaluated by Martin, Oyewole, and Moloney (1994) through a randomised controlled trial design, and they concluded that the high support hospital discharge team had led to a reduction in readmission to hospital care as well as to residential care. The discharge team provided practical help to promote the independence of patients living in their own home for up to 6 weeks after hospital discharge.

Parsons also refers to the importance of the study from Connecticut, USA by Tinetti et al. (2002) and their article "Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care", based on an intervention using prospective individual

matching taking place between November 1998 and April 2000 (J. Parsons, Jacobs, & Parsons, 2015).[13][14]

The idea and program of restorative care were enacted into government policy to support the ageing-in-place slogan, an initiative that helps older people to remain living in the community for as long as they choose. There was a growing awareness that something could be done to increase older peoples time living at home (J. G. M. Parsons & Parsons, 2012). Although New Zealand had home treatment teams from 1994[15], they started to develop restorative home care for older people around 2002. Parsons et al. (2010) argue that restorative home support programs together with an associated shift in the funding structure would be an effective response to major issues identified in the New Zealand home support sector including poor morale, high staff turnover, and inefficient funding models.

In enacting Community FIRST as a restorative support service from local to the national level, three tools were chosen, expanded and developed, in other term translated into New Zealand context. They are:

1. A goal setting tool developed as the TARGET between 2002 and 2006.
2. An assessments tool, interRAI developed between 2003 and 2015
3. A funding system, case mix designed from about 2008 onward.

[13] USA: EG date the start of restorative care in the USA back to the OBRA, (the Omnibus Budget Reconciliation Act): " so there was restorative care and a number of reserachers who were kind of looking at different models of restorative care". The model of restorative care, as outlined by BR are mainly based in nursing homes and the main profession are nurses.
In an article from 1998 by Radu et al, published in Journal of Gerontological Nursing "examples of restorative care in the nursing home", John Hopkins Geriatric Center are outlined. Radu is a Restorative Nursing coordinator and what she names the formal restorative program, started one year earlier.

[14] In an article in JAMA in 2002, Mary Tinetti and colleagues wrote: "Clinicians, policy makers, and older persons themselves increasingly acknowledge that a primary goal of health care for older, particularly multiply and chronically ill, persons should be to optimize function and comfort rather than solely to treat individual diseases." "Compared with usual care, the restorative care model was associated with a greater likelihood of remaining at home following completion of an episode of Medicare-covered home care, and a lower likelihood of requiring an ED visit or of complaining of pain at the time of discharge from home care. Restorative care recipients had slightly higher self-care, home management, and mobility functioning scores at completion than did usual care recipients."

[15] We need more information about these teams.

First, *the goal-facilitation tool, TARGET* (Towards Achieving Realistic Goals in Elders Tool) was developed from 2002 and implemented in 2006. In a book chapter from 2015, Parsons, Jacobs and Parsons describe the development of the TARGET approach. In the introduction of the article, they refer to the OECD consensus in 1994 on the demographic changes and the increasing number above 65+ as the "greatest challenges of our time" (OECD 1994, p. 306), and they refer to the WHOs definition of home care (Report of a WHO Study Group, 2000).[16] Further, they frame their goal setting paper relating to the concept of 'successful ageing' and the SOC model (Selective Optimization with Compensation Model) as developed by psychological theorists in the USA, Rowe and Kahn (from New York and Michigan), and Baltes & Baltes (German-American).

The restorative home care support is based on four key components: i) the involvement of the older person and his family, ii) a training program for the home care team and support workers, iii) a reorientation towards maximising functioning and iv) a comprehensive assessment and diagnosis leading to a treatment plan. They see a standardised goal-setting process as an integrated part of the assessment tool and the treatment plan.[17] The tool is based on ICF (International Classification of functioning, etc., from WHO as a framework.

This goal facilitation method was also a coordination tool located close to the client. To train the staff, a national training program was established around 2004, training of support workers and registered nurses started a few years earlier.

Second, the *assessment tool, interRAI:* The Ministry of Health recommended interRAI as an assessment tool in elderly care as early as in 2003 (ref New Zealand Best Practice Guidelines). They write: "All older people with complex needs should receive a comprehensive, multidimensional assessment when they come into contact with health care or

[16] The WHO report is eferred to as Havens 1999, p 308.
[17] They develped TARGET as a criticism of COPM (Canadian Occupational Performance Measure) and GAS (Goal attainment scaling)

social services, or when an assessment is requested by carers, family or professionals involved in their care and support."[18]

An assessment tool is an extensive collection of appropriate measures, and are seen as a key part of a programme for elderly care at home.[19] interRAI was implemented as a business unit in 2015.[20] New Zealand imported this instrument from the USA and has as the first country in the world applied this tool nationwide in-home care, community care and residential care. In interRAI, all assessments are conducted in a single software platform.[21]

Third, a new funding system, named case mix was developed and implemented in Auckland in 2008, and after two years, 75 per cent of the population in New Zealand was covered. Case mix is a funding system that classifies people that are homogeneous in their use of resources. Initially, it is a type of "predefined average care package, which is applied with a fixed price when a specific diagnosis occurs". In New Zealand, the case mix model for home-based care is described like this:

> A case mix funding and delivery model involves clients being assessed to identify their needs and then being allocated accordingly to receive a suite of services that will best meet these needs. Through a case mix model, services can be funded according to the identified needs of a population grouping, while retaining an appropriate degree of tailored service provision without needing to develop a bespoke service offering for every client. http://www.hcha.org.nz/assets/Uploads/Fernhill-HCHA-Casemix-2018.pdf; pp. 1 and 7.

[18] https://www.health.govt.nz/publication/assessment-processes-older-people

[19] However, the tool which most closely meet requirements are the UK version of the MDS-HC (Minimum Data Set for Home Care) for comprehensive assessment, combined with EASY-Care for screening and proactive assessments. The MDS-HC plus EASY-Care are modular, computer-based tools, and the developers are currently working on modules for specific cultural groups. https://www.health.govt.nz/system/files/documents/publications/assess_processes_gl.pdf

[20] … at TAS (The Central Region's Technical Advisory Service)

[21] https://www.interrai.co.nz/about/timeline/

The application of case mix is broad; it provides payment and benchmarking facilities, and it serves as an information tool for policymakers. The funding system was initially made for hospitals. Casemix based funding for reimbursement of the cost of patient care in the health care system is used in Australia, in the Netherlands (named DBC for (Dutch:Diagnosebehandelcombinatie), and in the USA, referred to as the Resource Utilisation Groups –Version III for Home Care (RUG-III/HC)). The diagnose oriented model was first developed in Michigan, USA, while the needs-based model is, as far as we know, developed in New Zealand.[22]

The *institutionalisation* of restorative home support started in Auckland and was later localised, translated and enacted onto other municipalities and regions. Elderly home care is today a service at the national level. The *institutional process* started as early as in 2002 with the involvement of the Ministry of Health.

Summing up – a preliminary model

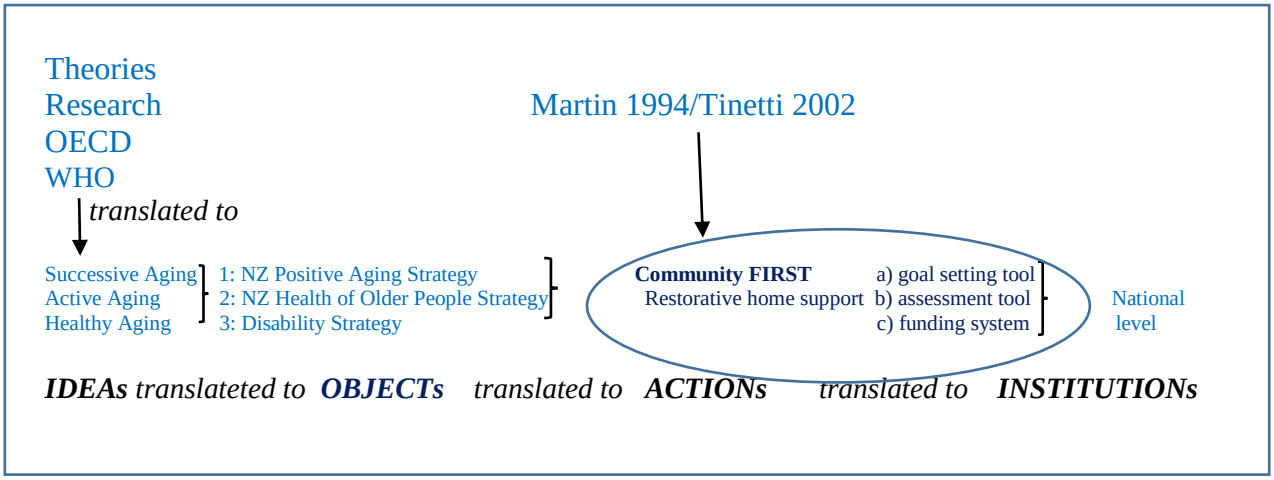

Figure 2 is based on figure 1, copied from Czarniawska and Joerges (1996, p. 26)

[22] https://www.southerndhb.govt.nz/files/20110921142336-1316571816-1.pdf It consists of seven core headings and 23 groups overall, with the Minimum Data Set – Home Care (MDS-HC) and is a comprehensive assessment tool being used to identify client-specific needs.

It is possible to interpret the two national strategies: Positive Ageing Strategy and Health of Older People, as influenced both by OECD and WHO and the concept of Active Ageing and Healthy Ageing as well as the even older concept of ”successful aging” from psychological scholars as Baltes and Baltes (1993); Rowe and Kahn (1987).

There is also a trajectory from these two national strategies, invented in 2001 and 2002 and the age-in-place slogan on which the Community FIRST was funded and enacted as a primarily humanitarian service for the elderly delivered from the Presbyterian church.

Lastly, the goal setting tool, TARGET, the assessment tool, interRAY and the funding system case mix are all product of the Community FIRST initiative – also known as the New Zealand restorative home support. TARGET is made in communication with other international goal setting tools as COPM and GAS (see earlier in this paper). It is integrated into interRAY – assessment tool. Another USA invented health technology is the case mix, which is a local translation of the hospital system of diagnosis-related groups, into needs-related groups and as a funding system for home-based health care activities.

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