

Between ideals and reality in home-based rehabilitation

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ABSTRACT

Setting and objective The growing elderly population and the rising number of people with chronic diseases indicate an increasing need for rehabilitation. Norwegian municipalities are required by law to offer rehabilitation. The aim of this study was to investigate how rehabilitation work is perceived and carried out by first-line service providers compared with the guidelines issued by Norway's health authorities. **Design and subjects** In this action research project, qualitative data were collected through 24 individual interviews and seven group interviews with employees – service providers and managers – in the home-based service of two boroughs in Oslo, Norway. The data were analysed using a systematic text-condensation method. **Results** The results show that rehabilitation receives little attention in the boroughs and that patients are seldom rehabilitated at home. There is disagreement among professional staff as to what rehabilitation is and should be. The purchaser–provider organization, high speed of service delivery, and scarcity of resources are reported to hamper rehabilitation work. **Conclusion and implications** A discrepancy exists between the high level of ambitious goals of Norwegian health authorities and the possibilities that practitioners have to achieve them. This situation results in healthcare staff being squeezed by the increasing expectations and demands of the population and the promises and statutory rights coming from politicians and administrators. For the employees in the municipalities to place rehabilitation on the agenda, it is a requirement that authorities understand the clinical aspect of rehabilitation and provide the municipalities with adequate framework conditions for successful rehabilitation work.

KEY POINTS

- Home-based rehabilitation is documented to be effective, and access to rehabilitation has been established in Norwegian law.
- The purchaser–provider organization, high rate of speed, and a scarcity of resources in home-based services hamper rehabilitation work.
- Healthcare providers find themselves squeezed between the health authorities' overarching guidelines and requirements and the possibilities of achieving them.
- Rehabilitation must be placed on the agenda on the condition that authorities understand the clinical aspect of rehabilitation.

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Introduction

The growing elderly population and the rising number of people with chronic diseases, combined with a goal to reduce the number of hospitalizations in the Western world, have created an increasing need for rehabilitation. More emphasis must be placed on rehabilitation in the municipality and in the patient's home. Rehabilitation in the patient's home makes it possible to align the rehabilitation process with each patient's daily activities in his or her home surroundings and to make use of various local services in the rehabilitation process.[1] Doing so, in turn, can make it easier for the patient to resume his or her former activities, possibly adapted to a

new situation. Home-based rehabilitation appears to be as effective as rehabilitation in day hospitals for older patients.[2] The benefits of rehabilitation are best documented for stroke patients.[3,4] Coordinated services are necessary, and multidisciplinary community stroke teams are preferred.[4] Patients with various neuromuscular disorders [5,6] and those suffering from dementia [7] also appear to benefit from rehabilitation. Older adults with musculoskeletal conditions appear to have equal or increased gains from home-based rehabilitation compared with inpatient rehabilitation.[8] These results in sum indicate that older people benefit from home-based rehabilitation. Even structured home visits by the GP and the district nurse three times following

discharge seem to benefit older patients, and as a result hospital admissions for persons aged 78 and older could potentially be reduced.[9]

Home-based rehabilitation in Norway

The increasing costs of healthcare services require initiatives to reduce costs. One initiative, as part of public-sector modernization recommended by the Norwegian Government, is reorganization inspired by New Public Management (NPM) in order to achieve more cost-effective solutions in care provisions.[10,11] These reforms include, among other factors, a greater emphasis on measuring outcomes with the introduction of explicit standards and performance metrics used to assess provider performance and a greater degree of competition through the creation of quasi-market mechanisms, for example, a purchaser-provider split model. In the two boroughs studied here, home nursing and practical assistance are organized according to a purchaser-provider split model, with a clear distinction between those who assess the need for services and determine the scope of those services and those who provide them in practice. This model implies a contractual management of services; the contract contains detailed specifications from the purchaser, and outcome control requires detailed reporting by the provider.[10,11] The purchaser-provider model has been introduced in the most populous municipalities in Norway, as well as in other Scandinavian countries.[12–14]

The Norwegian healthcare system is divided into two separate governmental levels: the specialist and the primary health care systems. Norwegian hospitals are organized within the specialist healthcare system, while municipalities have the responsibility for primary healthcare services, i.e. GPs, long-term care, home-based care, and social services. In accordance with the Norwegian Municipal Health and Care Services Act,[15] Norwegian municipalities are required to offer rehabilitation. The regulation on rehabilitation [16] defines rehabilitation as “time-limited, planned processes with clear aims and means, where a number of actors cooperate to provide necessary assistance to the user’s own efforts to achieve optimal functioning and mastery, independence and participation socially and in the community”. According to the regulation, the municipality shall ensure that all inhabitants in the municipality are offered the necessary assessment and follow-up if they need social, psychosocial, or medical habilitation and rehabilitation. Since 2001, patients needing coordinated services have had a statutory right to an individual rehabilitation plan and, since 2010, to a personal coordinator. The coordinator shall act as their contact person and follow up the input

from the patient/user and his or her family. According to the Norwegian Patient Rights Act,[17] health and care services shall, to the extent possible, be decided upon in collaboration with the patient, and in the case of rehabilitation, it is required that the user participate in determining the rehabilitation goals. The municipal nursing and care services shall provide for care for the elderly that ensures the individual service user of a dignified and, as far as possible, meaningful life, according to his or her individual needs.[18]

Context

A number of studies have documented the benefits to older patients of home-based rehabilitation. There is, however, a paucity of research on rehabilitation work in practice. This study is part of a larger research project focusing on home-based rehabilitation in two boroughs in the city of Oslo. According to the wishes of the boroughs, the project was limited to home-based services. In an earlier study, we used general policy guidelines and staff experiences of rehabilitation work to develop a model for the organization of and cooperation on home-based rehabilitation.[19]

Objective

The aim of this study was to investigate how rehabilitation work is perceived and carried out in the first line of service compared with health authorities’ acts and guidelines.

Material and methods

The main project was conducted as a practice-oriented study with an action research design that combines knowledge generation and improvement of practice.[20] The study was accomplished through collaboration between two researchers (SS and JWL) and employees in home-based services in the two boroughs. We also collaborated with the Norwegian Association for Stroke Survivors, who contributed user experiences at three meetings. The action research method and data collection are described in detail elsewhere.[19] We acquired knowledge of rehabilitation work in practice in the boroughs through meetings and individual interviews carried out during the period from February 2010 to June 2011.

Group meetings/interviews

The two researchers together conducted four group interviews/meetings in one borough and three in the

other. The meetings were arranged at our initiative and functioned as a combination of work meetings and focus-group interviews at which the participants answered questions asked by the researchers and then discussed the topics introduced. In each borough, seven to 10 employees attended each meeting. The questions asked in the group meetings were formulated according to action research design as follows: (1) problem identification, (2) researchers' work (gathering, analysing, and interpreting the data), (3) feedback in the group meeting, (4) action, and (5) testing and evaluating the action.[19,20] These five points constitute an action circle. New circles including the same steps on ever-new topics together form an action spiral. We started by asking how the rehabilitation work was carried out in the boroughs, how the rehabilitation should be conducted and organized, and about the informants' experiences with and views concerning rehabilitation. Both researchers took notes at the group interviews.

Individual interviews

Individual, semi-structured interviews were conducted in parallel with the group interviews. We used a thematic interview guide developed in advance that covered questions regarding the practical rehabilitation work in the borough, collaboration on rehabilitation, and important framework conditions for performing good rehabilitation work. We also asked in-depth questions' on the employees' opinion of topics discussed in the group meetings, and we gradually used the interview guides to a lesser degree.

Informants

The informants in the groups and for the individual interviews were selected with the aid of a contact person in each borough, with a view to obtaining the widest possible range of working fields and occupational backgrounds – both managers and practitioners. It was our aim to recruit persons with as much experience in rehabilitation work as possible. The informants/participants ranged in age from their late twenties to more than 60 years old and had from four to more than 30 years of work experience in the boroughs. Representatives of the purchaser office, service providers, and managers at different levels attended the meetings/group interviews. Various professional groups were represented: nurses, auxiliary nurses, home helpers, physiotherapists, occupational therapists, and social workers. A total of 24 persons, 19 women and five men, were interviewed individually (see Table 1). Of these, 15 were employees of the boroughs; five were

employees in two nursing homes; two were hospital employees; and two were general practitioners (GPs). Seven of the informants were managers or middle managers.

We also wanted to interview persons who collaborated on the rehabilitation process for one specific patient; therefore, we asked all participants in the project to identify rehabilitation cases. In one borough, a patient who was rehabilitated at home was found after nine months; in the other borough, none was found in the course of one year. Of the 24 interviews, eight were related to the rehabilitation of a woman who was approximately 65 years old and had suffered a stroke. No data were collected concerning this patient.

Data analysis

Similar to the first study, this study was based on transcripts from individual interviews and notes from group interviews/meetings. All the authors collaborated on the analysis. We analysed the entirety of the data material anew with our current objective as the starting point. We used a method for systematic text condensation (STC), a four-step, cross-case method for thematic analysis suitable for developing descriptions of experiences within a field, in this case, home-based rehabilitation.[21] In the first step, we read all the material to gain an overall impression of the data and noted preliminary themes relevant to the rehabilitation work in the boroughs, for example "organization" and "collaboration"; in all, eight themes were identified. We listed our own preliminary themes, negotiated confluent and divergent issues, and agreed on four themes for further analysis. The second analytical step included identifying meaning units related to the themes. Here, a meaning unit is a text element containing some information concerning rehabilitation work in the boroughs. We systemically reviewed the transcripts to identify meaning units. These were developed, refined, and systematized to codes by sorting meaning units that could be relevant for the themes we had agreed on. The identified meaning units were marked with a label, i.e. a code. These codes were assembled in code groups under appropriate headings, for instance, "Purchaser-provider model". The process of assembling the codes in groups involved adjusting them until all the codes fitted into relevant groups, and then finding the most appropriate heading for each code group. In this back-and-forth process, codes were transferred from one group to another, and two code groups were merged: "collaboration" and "user involvement". In the third step, we analysed and condensed the contents of each code group as an analytic unit containing a number of codes

Table 1. Persons interviewed.

	Nurses	Physio therapists	Occupational therapists	Doctors	Social worker	Care worker	Social educator	Educationist
Borough 1	3	1	2					1
Borough 2	3	2	1		1	1		
Nursing home		2	2				1	
Hospital		1		1				
GPs				2				
Total	6	6	5	3	1	1	1	1

developed from the meaning units. We sorted the coded meaning units in each code group into sub-groups. We further reduced the content of each sub-group into a condensate – an artificial quotation – by reviewing every meaning unit in the sub-group. Reviewing the remaining sub-groups in the same code group led to different aspects representing the thematic content of the code group. The fourth step of the STC method implies synthesizing the contents of the condensates and developing descriptions and concepts. This study aimed to develop a description of how rehabilitation was perceived and performed rather than new concepts or theories. We summarized the condensed text in each group into a précis, an analytical text that constitutes our results. Quotations from the interviews were selected to illustrate our points. The analysis is, in practice, not completed in a linear process as described here, but alternates between the various steps throughout the entire process.

Results

Patients were seldom rehabilitated in their home

In group meetings and individual interviews, we were told that patients were seldom rehabilitated in their own home in the two boroughs. However, that only one rehabilitation case was found after nine months had passed was surprising to the staff. Informants from the two collaborating university hospitals stated that there was not much home-based rehabilitation – either in these boroughs or in other boroughs or municipalities within the hospitals' catchment areas.

The staff in both boroughs expressed disagreement with regard to what rehabilitation is and whether a definition is appropriate. Many informants, especially the youngest, stated that they had not given the subject much thought before it was raised through this project. Opinions differed among the different professional groups. Physiotherapists and occupational therapists, in both home-based services and nursing homes, communicated a shared understanding of what rehabilitation is and broad agreement that it should be clearly defined and distinguished from other activities. The nursing staff presented varying descriptions of rehabilitation and

argued against a definition. An argument was that most of the home-based service's work had a rehabilitation effect, and that the aim of their work generally was to maintain the user's level of functioning and self-sufficiency. Managers, middle managers, and employees at purchasing offices were generally more negative in terms of defining rehabilitation than providers at the practical level. One purchaser said:

As I see it, here is a person with various needs. What can we do to enable them to manage as well as possible from day to day and be as self-sufficient as possible over time? Do we have to be so concerned with definitions? Isn't it more important to look at the unique situation of each individual, and manage to stand back and not help too much?

Several nurses talked about a new trend in home-based services aimed at helping as little as possible in order to make the elderly more self-sufficient.

A lack of time was constantly cited as a major constraint in rehabilitation work. In both boroughs, physiotherapists and occupational therapists talked about the rehabilitation plans prepared in 1989/90, but rehabilitation had not been on the agenda for many years now. Many described limited resources in home-based services and strict prioritizing. Several informants, particularly purchasing office staff, pointed out that rehabilitation must be viewed in connection with other healthcare services. One purchaser stressed that a home-based service must not provide assistance in excess of what the user needs. One manager said:

We have to keep to the budget. Occupational therapists and physiotherapists cannot work on their own with rehabilitation; there has to be endorsement from the top. We can identify users with rehabilitation potential – but how much are we willing to invest in them? What will it cost? We can provide a limited number of hours per month, and we have to have decisions approving these hours.

The significance of the purchaser-provider model for rehabilitation work

Many informants were generally critical about the purchaser-provider organization of home-based services

and held the view that the work of home-based services had become far more cumbersome and bureaucratic. One pointed out that many positions had been taken from practical work and placed in the purchasing office.

Several providers described the purchasing office's decisions formulated in detail with a time estimate for each task as causing stress and hampering rehabilitation work. The list of tasks must be adhered to, and the tasks that have been specified must be carried out. If other tasks are carried out, these have to be reported in order to obtain financial compensation for the time spent. One home helper provided an example:

She [the patient who was rehabilitated] had practised walking the stairs with the physiotherapist and wanted me to do the stairs with her. But there was neither a decision made by the purchaser nor time for this activity. I am allowed to perform extra tasks, but then I have to report these in order for the unit to be paid for them. I did the stairs with her without mentioning it to anyone; it takes too much time to report everything.

A number of practitioners said they often missed being able to make their own assessments and to give priority to certain tasks other than those on the order. One manager pointed out that, at an earlier time, home helpers used to play a central part in rehabilitation work by observing and assessing any decline in function and by helping with training, for example, by taking the patient out to the post box or to the shops. In this way, home helpers also received continuous training and practice in thinking in terms of rehabilitation. Today's decisions no longer provide scope for this.

A number of the informants emphasized that the purchasers have limited rehabilitation expertise, and neither the physiotherapist nor the occupational therapist was involved in the assessment of whether a patient is to be rehabilitated or not. One problem may be that potential rehabilitation patients are not identified, and rehabilitation is not started. Several believed that this was why patients were seldom rehabilitated in their home in these boroughs.

Collaboration and user participation in rehabilitation

Multidisciplinary collaboration was described in both individual and group interviews as crucial for rehabilitation, and the occupational therapists and physiotherapists especially missed interdisciplinary collaboration. A physiotherapist described how the purchaser-provider model affected the collaboration:

It's a problem that home nurses work according to decisions made by persons other than the service providers, and they aren't allowed to do anything

other than what is stated in the decision. [Patients'] needs change constantly during a rehabilitation process, and decisions have to be altered constantly by service providers sending an application to the purchaser office – we have to deal with a lot of red tape in order to get anything done together!

The two GPs wanted to collaborate on rehabilitation with the home-based services but said they were too busy to attend meetings. A number of informants in both boroughs relayed that there is a lot of good work being performed in order to improve patients' functioning, but that there is parallel work without someone to coordinate it and without a common goal. In the rehabilitation case we were told about, the different services were in place from the start but were not coordinated. Not until several months had passed did the providers begin working out a plan and goals for the rehabilitation process.

Several stressed that the purchaser's function of splitting up the work hampers collaboration, especially in rehabilitation work, and that home nurses do not have time for it under the current system. "They run in and out again and don't have time to utter two sentences", as one informant put it.

Informants, primarily service providers, emphasized that user participation must be a premise for rehabilitation. Nevertheless, the patient or her next of kin in the actual rehabilitation case was not involved in working out a rehabilitation plan. A number of informants spoke of dilemmas associated with user participation, such as the fact that users' wishes and goals may differ from the assessment of the health professionals or from the boroughs' budgetary means. The users may therefore have greater expectations of help than the services are able to deliver.

It was emphasized that multidisciplinary collaboration presupposes meeting places with the possibility for the providers to get to know each other. The informants, however, reported that the managers aimed to increase efficiency by reducing direct face-to-face contact between healthcare professionals.

Discussion

Despite the fact that home-based rehabilitation has a well-documented positive effect and that Norwegian municipalities are required to provide rehabilitation services, our results show that rehabilitation received little attention in the home-based services of the boroughs, and that patients were seldom rehabilitated at home. Home-based rehabilitation was also reported to be rare in other boroughs/municipalities in the catchment area of the two university hospitals. There

is, in general, a lack of competence and capacity in home-based rehabilitation in Norwegian municipalities.[22] Despite comprehensive guidelines, the implementation of rehabilitation services has been disappointing in other countries as well.[23,24] The results show disagreement among staff as to what rehabilitation is and what it should be. In the following, we will focus on several dilemmas that may illustrate the challenges facing the municipalities with regard to establishing home-based rehabilitation.

Organizational framework conditions for home-based rehabilitation

Service providers felt that time pressures and a high rate of speed in the delivery of services made rehabilitation work difficult. This may be attributable to limited resources, but it may also be related to the generally rushed pace of the services. Segmenting the work into small tasks and establishing a certain number of minutes for each specific task were causes of stress. The purchaser-provider organization involves measuring, counting, and reporting, which places a heavy documentation burden on the individual service provider.[11] The purchaser determines how much and what sort of help patients need. This reflects a perception that the need for help is transparent, stable, and possible to define in advance. The results show that providers missed the responsibility for appraising the patients' needs continually and the possibility to initiate relevant tasks as patients' needs for help changed. The purchaser's authority in assessing patients' needs ignores the fact that patients' needs are complex, interwoven, and changing, and that continuity and expertise in assessing needs are required in the relationship between patient and provider in order to adapt the services to changing needs. Nursing and care services are based on judgement, which entails an ability to see and evaluate the individual person's varying situation and needs.[25] The results also show how splitting work up hampers the collaboration between the providers. Similar developments with a similar organization of home-based services are described in other Scandinavian countries.[12-14]

User participation, independence, and dignity

Rehabilitation is about the "user's own effort to achieve the best possible functioning and mastery...".[16] The user's values, wishes, and goals must form the basis for the rehabilitation process. The Norwegian Patients' Rights Act [17] gives patients the right to be involved in putting together the service package. In the actual

rehabilitation case, the patient and her next of kin were not involved in planning the rehabilitation process. Our results also show that the budget must be taken into account when considering patients' needs for rehabilitation. Physiotherapists and occupational therapists may assess a patient as needing rehabilitation, but they do not have the authority to make a decision. Conflicts may arise if the patient and the health professionals consider the patient's need for services to be greater than the purchaser does. As a result, helpers may be obliged to contribute to developing rehabilitation targets that take into account the economy and limited resources rather than the patient's wishes and needs. Rehabilitation workers are professionally, ethically, and morally devoted to their clients, but they are financially accountable to their employers and funding bodies.[23]

The goal of rehabilitation is "to achieve the best possible functioning and mastery, independence and participation socially and in the community".[16] The municipality shall provide care with dignity to the elderly.[18] The results indicate that the pre-eminent objective for home services seemed to be for the elderly to be self-sufficient and able to manage at home and for the providers to help as little as possible. The dignity guarantee, however, emphasizes "care for the elderly that assures the individual service user of a dignified and as far as possible meaningful life in accordance with his or her individual needs". Vetlesen [26] worries that, in our time, dignity is associated with self-sufficiency and independence. He holds that humans have dignity irrespective of what their achievements might be. The guarantee of dignity gives service users the right to elderly care with dignity but does not go into what this dignity implies. Based on the providers' descriptions of their work situation, it seems particularly challenging to shape a worthy service package within today's framework conditions for home-based services.

Strength and weakness of the study

Different concepts are used for evaluating the scientific quality of qualitative research. Referring to Lincoln and Guba, Hamberg et al. suggest the criteria of trustworthiness, credibility, transferability, conformability, and dependability.[27] Trustworthiness is about how far the results can be trusted: is the chosen method suited for answering the research question? Was the study accurately conducted? Credibility deals with whether credible and truthful findings and interpretations are produced. Our study had an action research design. Meyer describes a challenge in action research that the researcher takes the actors' perspective into account but still maintains control, evaluating what is said against his or her own

frame of reference.[28] In spite of our awareness of this phenomenon, we may have influenced the informants with our perspectives in group discussions. There were, however, animated discussions and clear disagreements among participants in all the meetings, and they obviously forgot for longer periods that we were present. Dependability is a scientific indicator for solidly performed research, including that the study adapts to changes in the research process. We interviewed the same informants in the groups several times, and the same topics could be discussed in greater depth over time. Further topics from the group interviews were asked about in the individual interviews.

Informants for the study were recruited by employees in the boroughs, and this may have resulted in a skewed selection with informants especially positive to the boroughs' rehabilitation work. The results show, however, that different opinions existed and that many informants were rather critical. Without observation of rehabilitation in practice, we have not seen how the providers carry out their rehabilitation work in the patients' homes, and we had to rely on what they said. From the informants' identical descriptions and, especially, the discussions in the group interviews, we argue that we have a reasonably accurate picture of the rehabilitation work in the boroughs. The combination of individual interviews and group interviews gave us credible data in the form of useful information and nuanced perspectives on rehabilitation work in the boroughs. Conformability is about procedures to verify that the findings were founded in the data, and this requires the process to be described exactly. In this study, three researchers with different professions and perspectives performed the data analysis accurately according to the STC method. This process is described in detail in such a way that the reader can follow the analysis process and consider the interpretation. A limitation of the study was that, chiefly, professionals were interviewed, and that the needs of patients and families were not directly explored. However, five representatives of the Norwegian Association for Stroke Survivors attended three meetings with the researchers who were conducting the study. They contributed to interpreting the results and were of the opinion that we had pointed out the most important aspects of the services regarding meeting the needs of the patients and their close family members.

Conclusions made in qualitative research must be evaluated for their plausibility, inner logic, and ability to be communicated to others, i.e. transferability. That means that our findings must be recognizable to others in a clinical setting. Our results correspond to other findings, and we argue that the results can be relevant

for rehabilitation work in other municipalities as well as for home-based services in general.

Between ideals and realities in home-based rehabilitation

The dilemmas we have described can be seen as a squeeze between the health authorities' overarching guidelines and requirements, and the possibilities the practitioners have of achieving them. The discrepancy between the high level of ambition of the politicians and administrators, and the municipal employees' framework conditions put the primary healthcare staff in a difficult position. The providers in this study discussed stressful work situations and strict prioritizing in home services. Bakken et al. [29] describe how home helpers and home nurses become a buffer between increasing expectations and demands from the people, and lofty promises and statutory rights from politicians and administrators. The trait of being caring is strongly associated with the professional identity of care workers. It means that the providers feel a personal responsibility and often stretch themselves farther than their formal tasks require, that is, they do what they feel should be done in addition to the list of tasks from the purchaser. The providers often continued to function according to the old ideas of continuously assessing the user's condition and adjusting the level and type of assistance to match the user's changing needs. The home helper walked the stairs with the patient without mentioning this to anyone. Vabø calls this pattern of behaviour the home service's resistance to the new management regimes.[11] Wollscheid et al. also found that rules were undermined and that care providers used individual strategies to achieve flexibility and cooperation within the purchaser-provider split model.[30] Home-based services organized according to a purchaser-provider split model provide little scope for health personnel to make clinical judgements. These challenges may be especially noticeable in rehabilitation that is characterized by ambiguous, challenging, and unstable needs. The results of this study show that time pressures, the high speed of service delivery, and decreased possibility for assessing and providing care came into conflict with good rehabilitation work.

Implications

Rehabilitation did not receive much attention in the two boroughs, and the first need seems to be for the municipalities to place rehabilitation on the agenda. That the municipalities are increasingly given new tasks and the patients new rights indicates that higher

authorities are not at all familiar with home-based service practice in general and rehabilitation work in particular. Rehabilitation is in need of a professional identity and a sense of cohesion if it is to emerge as a discipline.[23] Conditions for developing rehabilitation as a discipline are that authorities understand the essential character of rehabilitation as clinical work and that the employees in the municipality are given sufficient autonomy and resources to develop the field of rehabilitation.

Ethics

The application was submitted to the Regional Committee for Medical and Health Research (2010/735). The project was not found to be part of the Committee's mandate since it is not regarded as medical or healthcare research conducted with the purpose of generating knowledge concerning illness or health. The project was approved by the Norwegian Social Science Data Services (2010/24245).

Disclosure statement

The authors declare that there is no conflict of interest.

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