Planning individually? Spotting international welfare trends in the field of rehabilitation in Norway

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International welfare trends are sweeping across the western world and have gained a lot of attention from researchers. However, few contributions have demonstrated the practical effects of these trends. This article will illustrate this using the individual plan as a case showing that some unintended forms of use can be regarded as traces of international welfare policy trends, and are not in line with the original ideologically based intentions.

Keywords: individual plan; rehabilitation; personalization; contractualism

Introduction

The individualization rhetoric that has swept across Western welfare policies recently have had the intention of putting the individual in the centre, tailoring services, enhancing participation and empowering the users to govern their own lives. This shift has become known as a *personalization* of welfare politics, which has been described as 'a mechanism to enable individuals to achieve their hopes and desires' (Lymbery 2012, 786). According to Boxall, Dowson, and Beresford (2009), the disability movement has strongly influenced this policy of personalization. Internationally, this trend has generated a series of technologies which have been developed by disabled people and their allies, such as person-centred planning (Duffy 2010). Duffy (2010, 265) claims that the implementation of such technologies is often undermined by chronic systemic weaknesses that will eventually pervert them. In Norway, person-centred planning has been labelled individual plan. In this article, I will illustrate empirically how unintended forms of use of these plans sometimes come into being, and I argue that the ideology of personalization has produced offspring that were not in line with the original vision.

In Norway, the field of rehabilitation has gone through significant changes during the past 15 years. The rehabilitation policy that was introduced in a White Paper on Rehabilitation in 1999 included a new definition of rehabilitation. This shift in perspective focused on coordination and cooperation between services, rather than specific single services for physical rehabilitation. The purpose was to create a more holistic perspective in order to include all services needed to assist the users in their journey towards 'the greatest possible functioning and coping capabilities, independence and participation in society' [White paper 19 (1998–1999)]. Another goal was to provide more individually adapted and tailor-made rehabilitation services. More recent

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habilitation and rehabilitation policies are characterized by an approach which the social sciences describe as 'individualization'. An important theme in the rehabilitation policy is the organization of the rehabilitation activities in the best interest of the user; Report no. 21 (1998–1999) to the Storting (1998). Statutory measures related to coordination both at the systemic and at the individual levels include planning, coordinating units, individual plans and personal coordinators (Thommesen, Sandvin, and Normann 2008; Breimo and Thommesen 2012). The composition of the support is to be based on the user's goals, wishes and needs, and this entails a holistic approach and a focus on coordination. A bottom-up perspective starting with the interests of the service user and with an emphasis on individually adapted services require each rehabilitation process to be unique. These characteristics of more recent rehabilitation policies are in line with the more general understanding of individualization as a feature of contemporary society (Beck and Beck-Gernsheim 2002). One means to achieve these goals was the legislative stipulation of organizational tools such as the coordinating units for rehabilitation and individual plans.

The regulation of the individual plan was one of the Norwegian government's responses to user surveys and research showing that many of the people who were in a rehabilitation process encountered problems connected to how rehabilitation was organized. Users experienced the services provided as fragmented, random, and lacking coordination and user involvement. The individual plan was launched as an organizing tool aimed at overcoming these obstacles. The goal was that the individual plan should result in the user receiving a holistic, coordinated and individually adapted set of services and benefits (Normann, Sandvin, and Thommesen 2003, 118). Additionally, the intention was that the individual plan would be the service user's own plan which should be used to govern and coordinate the services involved in the individual rehabilitation processes. For many people in a rehabilitation process, the individual plan has proved very useful (Thommesen, Sandvin, and Normann 2003). However, recent research has proved that there are various challenges with the use of the individual plan (Alve et al. 2013; Hansen 2007; Nilsen and Jensen 2012; Nilssen 2011; Røthing 2007; Slettebø et al. 2012). This article will describe some unintended forms of use that are not in line with the original intentions, and illustrate how this is in accordance with international welfare trends. The right to an individual plan is stipulated in Norwegian health and welfare law. The main purpose of this legislation is to improve service provision for people in need of long-term and coordinated assistance from various service providers. This article elaborates on some aspects of the implementation of the individual plan and how it is used as a coordination tool in rehabilitation processes. The article focuses on the experiences of service users and service providers who use the individual plan as a legal and administrative instrument and coordination tool.

Some of the informants in the study found the individual plan to be useful at the beginning of the rehabilitation process because it allocates responsibility and work tasks, which is useful for both service users and service providers. However, later on in the process, the plans are used in ways that do not comply with the individual plan as a coordination tool. This article will present examples of incidents where individual plans boomerang on their creators. I argue that there are cases in which the individual plan does not work the way it is intended (as described in political documents). This proves problematic for both the persons who are in a rehabilitation process and for the service providers. As a coordination tool, it is only useful up to a point after which it grows out of proportion, is conquered by the system, and creates unintended consequences. The research question addressed in this article is: What unintended forms

of use does the individual plan create *and how are these related to international welfare trends?*

What is an individual plan in the Norwegian context?

In Norway, every person in need of long-term, coordinated assistance has the right to an individual plan. The individual plan should result in the user receiving a holistic, coordinated and individually adapted set of services and benefits. The planning should be carried out from the user's perspective, based on the individual's interest, desires, hopes or goals for life (Thommesen, Sandvin, and Normann 2003). The plan should be in writing. Some municipalities use online programmes where the service users can formulate plans. Others also have programmes that allow the service users access to the file and an opportunity to change it themselves, though this is not yet standard procedure. One of the important things about the individual plan that Thommesen, Sandvin, and Normann (2003) focus on is that it is the planning that is important. In other words, it is the process of creating the plan that is important, rather than the plan itself. Another aspect is that since it is the user's plan, it should be written in a language with which the user feels comfortable. Also, the planning must be based on a thorough evaluation of the person's situation and needs.

The personalization trend

The individual plan can be seen as an offspring of the global personalization welfare trend.

Duffy (2010, 255) refers to Leadbeater (2004) definition of personalization:

> [by] putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilising millions of people as co-producers of the public goods they value.

Spicker (2013, 1261) makes a distinction between three main competing interpretations of personalization. The first interpretation implies a process by which professionals match services to needs based on professional assessment. The second interpretation is based on the preferences of the service user who will make the decision. The third interpretation is a middle ground between the two models described here, i.e. user choice versus professional judgement.

Lymbery (2012) argues that the meaning of personalization in Britain varies by political party: while labour governments link the concept to citizenship, conservative-led coalitions link it to freedom of choice. Although Grover and Piggott (2013, 178) (referring to Ferguson 2007) argue that 'personalization is a positive sounding word, with many meanings and hard to be agaexts' Burton (2010, 301) is critical towards the personalization trend, calling it an oxymoron and 'a bureaucratic word for a bureaucratic response to the political failure of social care'. In this article, I will use the individual plan as a case illustrating that the ideologically based personalization trend has produced some offspring that are not in line with its origin.

Methods and materials

In this research, I use Dorothy Smith's (2005) institutional ethnography (IE) as a method of inquiry to examine how the individual plan is used in seven different rehabilitation

processes. The investigation of textually mediated social organization is central in IE and explicates how practices and procedures are used in the daily routines of institutional work. The objective is to investigate how work (in a broad sense) and work processes are coordinated by texts and discourses. The aim of this is to extend ethnography from people's experiences, and accounts of their experiences, into the work processes of institutions and institutional action (Turner 2006, 139). The experiences of people who were in a rehabilitation process provided the starting point of the investigation and the informants were interviewed twice, with interviews 1 year apart.

All of the persons who were in a rehabilitation process were interviewed twice. They all had a written decision granting them an individual plan, but their need for a plan was based on different challenges. Examples include neurological conditions, spinal cord lesions and psychiatric conditions. In total, 40 semi-structured interviews were conducted, recorded and transcribed for this study. The study was conducted over 1 year, starting at the beginning of the rehabilitation processes. The interviews with the service users had a biographical character and concentrated on the period they had been in a process of rehabilitation.

I have not researched the individuals who receive services or provide services, but have rather used their experiences and descriptions of the work that is performed to identify the institutional issues from their point of view by mapping how the work is performed in practice and how their work is connected with the work of others. I have mapped rehabilitation processes by interviewing those involved. My interviews have been conducted as conversations, or in other words as unstructured interviews in which I have asked the informants to describe the rehabilitation process from their point of view. As recommended by McCoy (2006), I have encouraged them to talk in as much detail as possible about who is involved, the ways in which they have been involved, who has done what, who has contacted whom and how, who has initiated what and how it has been done in practice. For example, if the informant talked about having had a meeting, I asked who initiated the meeting, what was the purpose of the meeting, who participated, which tasks were allocated to those in attendance, etc. In other words, instead of asking 'How does your collaboration with agency x work?' I tried to map the procedures for collaboration in as much detail as possible by, for example, asking about a concrete course of events, or what DeVault and McCoy (2006, 39) call mapping institutional chains of action.

As mentioned, there were various reasons why they were in a rehabilitation process but their diagnosis or functional impairment was not the focus of the study. Instead, the study focused on the collaboration that took place between service providers and service recipients, and I therefore also interviewed the service providers involved. The number of service providers involved and the extent to which they were involved varied from person to person, but each service recipient had extensive contact with service-providing agencies. Additionally, I also interviewed next of kin in some instances.

After mapping the rehabilitation processes based in the service recipients' experiences, I next interviewed service providers who had been involved in the recipients' processes to explicate and further develop the map, which McCoy (2006) calls second-level informants. The service providers I interviewed included GPs, psychiatrists, psychiatric nurses, nurses, auxiliary nurses, physiotherapists, occupational therapists, social workers, user-controlled personal assistants, and employees in Norwegian Labour and Welfare Administration,[1] VOP,[2] employees in central decision-making offices and in the homecare service. Thus, they are also representatives of many different professions,

service providing agencies and levels. In total, I conducted 40 interviews lasting between 30 minutes and 4 hours. Additionally, I have had access to some written documentation that in one way or another has been used in connection with the rehabilitation processes, such as individual plans and written decisions.

As every rehabilitation process is unique in terms of which services are offered and which agencies are involved, I found it necessary to additionally interview the service providers that had been affiliated with the specific processes. This was a decision that I considered very carefully, as the interviews would be about actual persons and not just anonymous 'cases'. Nevertheless, I concluded that it would be difficult to map rehabilitation processes using a different method. I wanted to describe what was actually done in the concrete rehabilitation processes, not what the service providers' instructions were. The idea was that whatever people present as their theoretical work tasks often differ from what they do in practice. Thus, by interviewing the service providers about actual rehabilitation processes, I could gain a more realistic picture of how the work is performed. It was therefore very important to emphasize that it was the work performed that was of interest to the research, rather than personal information about diagnoses, disease progression, etc. I also asked service recipients about the service providers they thought I should interview (i.e. those they thought were relevant), and I asked them for permission to do so in writing (using informed consent) and verbally during the first interview.[3]

I did not find that the service recipients thought it problematic that I was to interview the service providers. Quite the contrary: they often said, 'you should ask her about this, because she knows a lot about it'. This response suggests that the service recipients who agreed to participate in the project saw my project as relevant: they wanted their experiences to be documented. Nevertheless, during the course of working on the study, I have carefully considered what I can include and what I should not include. When service recipients have criticized named service providers, I have either not quoted this or I have anonymized the comments by not linking the statements to the individuals in question. This also applies to statements service providers have made about service recipients, other service providers, the municipalities or other issues I have thought inadvisable to include.

The research project was approved by the Norwegian Social Science Data Services and research permits were given by the four municipalities participating in the study. The anonymity of the informants has been secured by excluding their names or any other identifying characteristics. The participants in the study were recruited indirectly via service workers in the municipalities. First, the persons who were in a process of rehabilitation were recruited and then the service workers who these persons had been mostly in contact with were recruited. Finally, the language in the fieldwork was Norwegian and therefore the quotes have been translated into spoken English.

In analysing the material, I focused on the work that the informants said that they did in the processes. Also, the focus was on analysing the written material that I gained access to (written decisions and individual plans) from a *performative* perspective, asking what the written documents *do* in the processes and how they relate to each other (Prior 2004). In the process of analysing the empirical material, I discovered that the individual plans were used in many different ways, some of which can be regarded and in this article I will demonstrate how this relates to international welfare trends.

Privatizing individualization

As mentioned above, the individual plan was intended to secure user involvement and to provide more coordinated services, in accordance with what Spicker (2013) defines as the interpretation of personalization based on user choice. However, as I discovered studying the individual plans I got admission to, many of them were more in line with what he (Spicker 2013) refers to as the model of personalization based on professional assessment. Many of the individual plans were very detailed in their descriptions, especially the descriptions of the service user and his or her level of function. In some cases, the individual plan is used to justify legal claims the professional is making on behalf of the user. As a result, the service providers write detailed descriptions about the users and their functional level in the plans. Examples of such descriptions in the individual plans are 'his self-insight is relatively good', 'he has major learning disabilities in a wide range of areas'. Other examples illustrate that the plans are written in order to help the service workers remember their work tasks; 'she has partial urinary and faecal incontinence' and 'one has to observe that she wipes herself after visiting the toilet'. These descriptions may be humiliating for the service user to read in their own plan, and are not in line with the intentions neither of coordinating services nor securing user involvement.

What makes such descriptions problematic is that the individual plan is supposed to be the service user's own plan, the main purpose of which is to govern and coordinate services and service providers. These descriptions show that the service providers who write the plans often do this without the participation of the person who is in a rehabilitation process, and that there are other motives for writing the plans. In these cases, it becomes unclear what the purpose of the plan is and for whom it is written. One interpretation is that the plans are used for the service providers to remember what kind of impairment each person has, or to document the reasons for a course of action. However unintended, I would argue that the service providers appropriate the individual plan to use it for purposes other than the intended.

The fact that the individual plans often are very detailed in their description of the service user can also have positive effects. At the Centre for Assistive Technology, for example, the service user can leave a copy of the individual plan so that the officials responsible for handling applications can use the plan in their work. One service worker explains:

> in some cases, they keep a copy of the individual plan at the Center for Assistive Technology. I don't usually do that because the plan must be so detailed in the description of the needs of the user, much more detailed than I think a plan should be.

To leave a copy means that the service users do not have to write new applications each time they apply for a new form of assistance. Hence, it saves time and effort for service users and service providers alike. However, there are some drawbacks with such an arrangement. First of all, to serve this role, the individual plan must be very detailed in the description of functions. This may alienate the plan from the service user. Second, this may come into conflict with the protection of the service user's privacy. Many service users may not feel comfortable with having detailed descriptions about their function level and medical history lying around in various service offices; however, the more service offices that will use the plan in such a manner, the more detailed it will have to be.

Investigating the rehabilitation processes, I found that the individual plans were often used in the same way as other plans in the service system. The home services, for

example, use nursing plans which provide detailed instructions about diagnosis, function levels and how to nurse individual clients. Studying the individual plans, one can see that some service workers have been inspired by these plans when writing individual plans. The problem with this is that it becomes the plan of the service providers and not of the service user. The main purpose is not to coordinate services, but to inform the service providers about the individual characteristics of the service user. This makes the individual plans more *private* than *personal*, which arguably leads to an objectification of the service user that is not in line with the original intentions of securing and emphasizing the user voice in service provision.

Contractualizing individualization

The individual plan is sometimes used in conjunction with other documents produced in the rehabilitation process. The actions that are listed in the individual plan are often used as measures to assess whether the service user should receive financial support. One of the informants in the study told me in our first interview that she was very happy that she was granted the right to an individual plan and that the work had started. She told me that her financial situation depended on this plan, and therefore it was very important to her. She stated that:

> The individual plan is very important for my private financial situation. If I hadn't gotten the plan I wouldn't have had any money to support myself.

I was puzzled by this assertion, but studying the documents for her process I understood why she made this statement. The written decisions made by the Norwegian Labour and Welfare Administration (NAV) stressed that in order for her to receive financial support she had to follow up on the goals and actions that she had listed in her individual plan. In fact, in four out of seven of the written decisions she received from NAV, it was stated that she needed to follow up her individual plan in order to receive benefits. It states that 'if you do not follow up on your individual plan, you need to get this corrected or contact us'.

The same informant has written in her individual plan that one of her goals is to lose weight. She told me in our first interview that she had been to the pain clinic in order to be treated for muscular pains that she had suffered from since she was a child. She explains, 'they told me I could come back when I had lost some weight. Maybe some of the pain would be gone then. I said I did not think so, but I would give it a try'. In other words, the people working at the pain clinic told her that she had to lose weight in order to receive treatment from the clinic. She told me that she did not believe that the pain was related to her weight since she had suffered from it since she was a child, but she was willing to give it a try. This is why one of the goals in her individual plan is to lose weight.

These two examples show that although the individual plan is supposed to be the service user's plan, there are many service providers who have other interests in the plan. The plan is used as a mechanism to state the reason for written decisions from state agencies and also in order to note the reason for the measures that are to be taken. In this case, the service user has to keep-to what she has promised in the individual plan in order to get financial benefits and various services. Ridzi writes about similar episodes from an American context, where 'employability plans' and 'personal care plans' are used in a manner that requires the service users to adjust their lives in accordance with the written

plans (2008, 228). Prior describes the role of written documents within the health services, explaining that 'medical professions can and do use "the files" as warrants for their actions in relation to their patients – showing that what they do to patients is warranted by the information in the record' (Prior 2004, 87). Put differently, written documents, such as the individual plan, are used by the system as a governance tool.

Nilssen (2011) presents a survey in which service providers were asked about their experiences with individual plans. Sixty-eight per cent of the service providers who participated in the survey stated that they regarded the individual plan as a contract between the service user and the municipality, while 79% of them regarded the individual plan as a contract between the service provider (or the unit they belong to) and the service user. Fifty-one per cent of the service workers stated that they regarded the individual plan to be an obligation for the service user to pursue. Fifty-three per cent of the service coordinators indicated that they had considered no longer working with a service user on their individual plan due to the user's lack of commitment or ability to follow up the stated goals. This study paints a picture of a widespread opinion among service providers that the individual plan is a contract between the service user and the service system.

This is a trend not only connected to the individual plan but also to a widespread global development within welfare policies. Andersen (2003) calls this a *contractualiza-tion* of service production that could be unfortunate. He explains that social contracts in the welfare system are often based on the ideology of empowerment, which claims that service users should have more power and be heard in their own processes. Problems arise because the relationship between the service user and the service provider or service system is not equal, that is, the power between them is not equally distributed. Slettebø et al. (2012) point to the fact that the asymmetric power relations in individual plan processes may be problematic as the service user often has to play the role that is expected of her in order to receive the services and benefits needed. The service user does not have an actual choice and the asymmetric power relations become visible as a result (Andersen 2008, 76).

Nilssen and Kildal (2009) argue that the contractualism trend in welfare systems may increase paternalism in these relationships because the contracts are used to change the behaviour of the service users. Also, it changes the relationship between citizens' rights and duties, emphasizing the responsibilities (often related to work) that have to be met in order to gain access to social benefits (Nilssen and Kildal 2009, 305). Another concern regarding the individual plan as a contract is that the terms of the contract are blurry and there is an unequal balance of power between the stakeholders. While the service providers may sanction the contract by declining applications for benefits, the service users have no opportunities to sanction service providers. The contract is not legally binding, but may still have consequences for the service user when broken.

Nilssen and Kildal (2009, 304) furthermore argue that the trend 'highlights a welfare state policy based on reciprocity, mutual agreement, freedom of choice and equality of power'. The relationship between the citizen's rights and duties are relevant here; in other words, social benefits are conditional on user responsibility for the users (Nilssen and Kildal 2009, 305; Critics fear that this trend will become just another way of controlling individual behaviour (Ramia 2002; Andersen 2008). In other words, in the politics of personalization and contractualism, there is a dividing line between the liberation and empowerment of individuals and the effort to make citizens accountable and responsible.

Discussion

The original intentions of individual plans and the emphasis on user participation can be understood as attempts at giving people the opportunity to create 'a life of one's own' as Beck and Beck-Gernsheim put it (2002). One of the main ideas behind the individual plan is empowerment of the service user, which is in line with the personalization trend. In this article, however, I illustrate that this is not always a given outcome in the processes of planning individually. On the contrary, in some cases, the plans are written in ways that clearly objectifies the service users, making the plans more private than personal. Also, I illustrate that the plans are used and perceived as contracts between the service users and the service system. People with impairments in present-day Norway both require and are expected to be equal to their peers in terms of their choice of lifestyles and ways of living, and their education and labour market adaptations (Anvik 2013). At the same time, the normative pressures on people with chronic illnesses and functional impairments suggest that work, integration and participation are the goals rehabilitation recipients are expected to reach. This means that each user must form their lives in a tension between the requirement that they make their own choices and strong normative pressures about what this life should look like. The relationship between rights and duties has been reinforced (Helgøy, Kjeldal, and Nilssen 2013, 154).

Villadsen (2003, 194) points out that there has been a move towards liberal management practices in which the individual is assumed to be autonomous and responsible and to have the capacity to make independent choices. There is a development towards the individual rather than the group being seen as the significant social actor. In many ways, this is descriptive of the developments that have taken place in the welfare sector in Norway (and many other western countries). While in the 1970s, the focus was on how to better coordinate services in the best interest of the *population as a whole,* in the 1980s discussions focused on how to organize services better for more specific *user groups,* and in the 1990s services should be coordinated around *individuals* (Breimo and Sandvin 2009). Ideas about each individual being unique and having unique preferences form the background for this shift. The individual's right to self-determination has emerged both as a result of an ideological shift but also as a result of statutory rights being enshrined in the UN Declaration of Human Rights (Hansen 2009, 229).

The personalization trend is part of a general development in the direction of greater individualization and a more liberal rights discourse (Mik-Meyer and Villadsen 2007). User participation and governance is a central theme in public services and is closely related to the principle of the inherent dignity of the person). However, this individualization and user-orientation arguably also has a downside. In her dissertation about user participation in the social services, Jenssen (2009) asks whether user participation is always in the user's best interest. She points out that user participation is often used as a tool to make the user assume more responsibility and does not necessarily ensure that the user can influence the process. Järvinen and Mik-Meyer (2005) reference Villadsen and Gruber (1999) when they argue that: 'while in the social work of the 1980s one discussed the client's living conditions, poverty issues and social marginalisation, today concepts such as motivation, willingness to change, development and individual responsibility are emphasised'. The focus is on treating the individual rather than treating social structures, a conclusion that Rosenberg and Lindqvist (2004) reach in their studies of rehabilitation for persons with cognitive impairments.

Making the service user accountable is not something that is distinct about the rehabilitation processes; the individualization of society, in general, has increased the

expectations society places on individuals. The work of rehabilitation becomes a work of changing the individual, which collides with the aim of making a coordinated tailor-made service system for all service users. This is consonant with Beck and Beck-Gernsheim's (2002) argument that the turn to individualization turn creates new forms of institutional dependencies.

Conclusion

Duffy (2010, 266) claims that service workers should 'embrace the technologies of personalization and find ways to make them work – and improve them when they break'. It might, however, be difficult for service workers who are dealing with this on a daily basis to identify when the tools of personalization break. This should therefore be the responsibility of researchers who have the possibility of acquiring a better overview of the terrain.

In this article, I have shown that although individual plans may have positive effects for people who are in the beginning of a rehabilitation process, the use of the plans is often 'perverted' during the process. The individual plan is an organizational tool, the mission of which is to secure holistic individually adapted services that are anchored in the needs of the service users. Analysing the empirical material, I argue that the tool also may produce unintended forms of use. I therefore argue that the individual plan may have a boomerang effect on its creators or to quote Czarniawska: 'they constructed this machine, but once constructed, the machine continues to construct them' (2007, 147). Instead of being a coordinating tool for the purpose of making a holistic rehabilitation process, it adopts other forms of use that may not correspond with the original aim. As Nilssen and Kildal (2009) argue, the use of welfare contracts can be viewed as a new form of control technology that changes the balance between rights and responsibilities in the welfare state. It also changes the power balance between the service worker and the service user, making the latter more dependent on the former.

Notes

1. Norwegian Labour and Welfare Administration. Established 1 July 2006.
2. Psychiatric outpatient clinic for adults.
3. A letter of information with a request for informed consent was sent to the informants ahead of time.

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