Walking the talk?
Trust reforms in Norwegian municipalities

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Report from the research project “Understanding the role of trust in the institutions of the welfare state” (2020 – 2024)

- Recent surge of so-called ”trust reforms” in the Nordic countries
- Generally seen as reactions against New Public Management and excessive control in welfare services
  - Trust as alternative to control
  - Increased professional autonomy
  - NPG/Co-creation sometimes seen as part of trust reforms, but also as alternative or even opposition
- Longer history in Denmark and Sweden, Norwegian government is currently working on a national reform, but a number of municipalities are currently implementing self-initiated reforms
- Large diversity, both in the understanding of trust and in reforms

Types of measures

- Institutionalizing tripart collaboration (employer, unions and politicans)
- Different forms of enhancing dialog throughout the command chain from frontline to political leaders.
- Training programs for leaders, emphasizing trust based leadership
- **Decentralizing allocation of services (and budget responsibility) to frontline professionals**
- **Organization in interdisciplinary teams with increased professional autonomy**
- **Replacing activity based budgeting with block grants (search for new budgeting forms that also allow flexibility)**

Methods

Part of a larger project (survey data, mapping and ethnographic study)

Focus on WP2: Case studies in 6 Norwegian municipalities (interviews and document study)

Study the implementation of a selection of different trust reforms

Research question: What challenges and dilemmas do administrative actors, service leaders and union representatives encounter in their attempt to walk the talk of trust reform?

Types of measures in municipal health care services

Decentralizing allocation of services (and budget responsibility) to frontline professionals (getting rid of excessive and too detailed bureaucratic control)
Organization in interdisciplinary teams with increased professional autonomy
Replacing activity-based budgeting with block grants (new budgeting forms that also allow flexibility)
Reducing part-time positions and gaining a “full-time culture”

	Municipality C	Municipality D
Experiences of dilemmas	"I experienced that they (the politicians that initiated trust reform) didn't have as much knowledge about the legislation in relation to health services, that the patient has a right to get a decision on health services that is bound by the Public Administration Act, so you have the right to appeal if you disagree with the health services you are offered about. And.. yes.. so the trust reform was then.. the points that were set up then, it was that free user choice should come out, it was that healthcare services should be located closest to the user, that the executive.. professional staff should be the ones who then decide what kind of services the patient should have together with the patient" (Former case worker in the central allocation office)	"In the past it was the case that the administration always had to step in and make a new assessment. The health service team in the agency for home-based services now makes an assessment, it is that assessment that is made in writing by the case manager's office. They (case managers) do not make any independent professional assessment. They only ensure that that wording is written into a single decision in the right way. They no longer have any verification function. … The power to decide rests with the home service, and now it is also not the case that the budget is left to the agency for administration. It was before. Then all the money was there, and then it was portioned out by decision. Now the agency for home-based services is once again given a framework that they must ensure is distributed correctly. There is a system for a rough distribution, but it is the agency director's responsibility to make sure to... yes redistribute if necessary." (Administrative leader working on implementation

	Municipality C	Municipality D
Initiatives		
De-bureaucratization	Politically initiated reform (2018): Central allocation office closed—office where case managers with specialized competence in allocation of services and judicial competence makes allocation decisions is dissolved Established new positions for case managers within seperate welfare service areas (home care services, drug and mental care services, nursing home services, and welfare, work and inclusion services) Decisions regarding allocation of services are made by a team of services delivery personell with specialized care competence, where case managers are part of the decision team and in charge of formalizing decisions.	Reform initiated by the municipal chief and supported by the city council (2018) Imported principles of trust reform from Copenhagen, and rolled out the reform in home care services. Central allocation office closed—office where case managers with specialized competence in allocation of services and judicial competence makes allocation decisions is dissolved Established new evaluation teams where case managers from the former allocation office have responsibility for the formal parts of the decisions—'writing up' the decisions—whereas a team of professional staff with expert service delivery competence make the substantive decisions about allocation of services
Change in financing scheme	Organizational change was accompanied by a change in financing scheme—from effort-based to block grant allocation of budgets for service areas Aim of initiatives: • to limit overspending and allocation of excessive services and resources • to increase trust in services by including professional care delivery staff in decisions regarding allocations	Organizational change was accompanied by a change in financing scheme—from effort-based to block grant allocation of budgets for service areas, and move from activity-based allocation of time to block allocation of time spent on each user. Aim of initiative: • to limit overspending and allocation of excessive services and resources • to emphazize trust and professional expertise in service delivery
Interdisciplinary teams	*Coping at Home* (Mestring i hjemmet)—multiprofessional teams are established to facilitate collaboration when assessing users needs, and in delivery of integrated user services. Professional staff who are part of multiprofessional teams are relocated to work in proximity to home-care services, and have regular meetings where user needs are reassessed. Aim of project—to increase trust between users and welfare services through	New division of labor between professionals in home care services. Established *care teams* and *health services teams*. Care teams consist of health care workers with professional certificate training, while health services teams consist of nurses and staff with university and specialized medical training. Aim of project—to divide responsibility for tasks up in a more efficient way between professionals with different skills, and

Dilemmas

- Equality of services vs professional discretion
- Hierarcical coordination across services vs services ‘pushing’ users between themselves
- Legal competence versus professional competence
- Block grants versus the scalability of activity-based financing