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# **Professional discretion and length of work experience: what findings from focus groups with care managers in elder care suggest**

**Anna Olaison <sup>\*</sup>, Sandra Torres <sup>\*\*</sup> and Emilia Forssell <sup>\*\*\*1</sup>**

## **Abstract**

Research has explored how care managers in elder care - who often function as 'street-level bureaucrats' - regard professional discretion. The way in which length of work experience affects care managers' use of professional discretion remains, however, unexplored. This article presents findings from 12 focus groups with 60 care managers. By bringing attention to how care managers experience the needs assessment process, this article sheds light on how these 'street-level bureaucrats' struggle when they try to balance their clients' needs against institutional frameworks and local guidelines. Length of work experience seems to play a role in how care managers claim to use professional discretion. Experienced care managers describe how they deviate from the guidelines at times in order to create an increased scope of action in their decision-making process. Those with less time in the profession describe greater difficulties in this respect. Findings suggest that research should explore if length of work experience plays a role in the actual way in which care managers assess needs and make decisions. As such, they contribute to our understanding of how needs assessment processes are navigated by professionals while also pointing toward the nature of professional discretion in gerontological social work.

Key words: social work, care manager, street-level bureaucrat, elder care, needs assessment practice, work experience, decision-making, professional discretion

## **Introduction**

The literature on needs assessment practice within elder care describes care managers as 'street-level bureaucrats' (Lipsky 2010) since they decide if the person seeking to access welfare services does in fact have needs that can be deemed to be legitimate enough to grant welfare eligibility. One distinguishing feature of street-level bureaucrats is that they have to

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meet increasing high demands on social services while also being gate keepers of welfare resources. As such, they often struggle with the economic constraints that the welfare institutions that employ them operate under (Lipsky 2010). The fact that they often have big caseloads and have to navigate unclear or conflicting guidelines and policies are also aspects that have been deemed to be characteristic of the street-level bureaucracy that care managers practice. The fact that care managers have to use their professional discretion is therefore a given (Ellis 2013, Taylor 2017).

In recent decades, adult social work has undergone great changes. In the context of this development – which have entailed, among others, market-differentiated welfare - different models for needs assessment in elder care have emerged (Lymbery & Postle 2015). Research has shown that these changes have affected the professional role that is care management and the various needs assessment practices that these street-level bureaucrats engage on as they go about deciding who gets access to the welfare services they are gate keepers to (Carey 2015, Evans 2012). In order to decide on a client's welfare eligibility, street-level bureaucrats need to assess their clients' needs against the rules and regulations that the welfare institutions they work for expect them to abide by. This means that care managers constantly interpret and apply rules to individual cases (Hasenfeld 1992, Lipsky 2010).

Research on street-level bureaucrats has examined how different professions use their discretion and respond to the conditions under which they work (such as the demands their clients make and the ways in which they handle resource constraints, legislative goals and regulations; see Lipsky 2010, Maynard-Moody & Musheno 2003). Research has also explored how professional discretion is strategically re-interpreted in decision-making processes as street-level bureaucrats navigate the demands they experience and the beliefs about good practice that they uphold (Jones 2001, Ellis 2013). Garrow and Grusky (2012) argue, for example, that street-level bureaucrats are not objective agents but rather institutionally constructed actors whose values, interests and practices are partially determined by the institutional logics that structure the fields in which they operate.

Research has shown also that the way in which street-level bureaucrats understand their professional role, and their approach to decision-making, affect what they think they should try to achieve (MacDonald *et al* 2008, Maynard Moody & Musheno 2012). Against this backdrop, it is perhaps easy to see that street-level bureaucrats use their professional discretion as they go about the business of making coherent professional judgements and

while deciding who should have access to the services that the institutions they work for can offer (Wallander & Molander 2014). Worth noting is that this article uses the definition of street-level bureaucrats' professional discretion that claims that discretion taps into the perceived freedom that a professional feels as they go about the business of making choices concerning the type and amount of services that they will make available to their clients (Evans 2015).

### **Research on care managers' decision-making processes within elder care**

Studies have shown that care managers' lack of a common approach to the needs assessment process (Reilly et al. 2010, Challis et al. 2010). This variability leads to provider-dependent differences in quality and flexibility in the provision of services to people who are in need of help and support (Chester et al. 2010, Taylor 2012). Moreover, studies have shown that this has implications for specific aspects of the needs assessment process (for instance, how care managers deal with the personalization of services that individual budgets and economic prioritizations entail; Manthorpe et al. 2009, Gilbert & Powell 2012, Jacobs et al. 2013). This raises questions about how care managers use their professional discretion. Only a few international studies have explicitly focused, however, on care managers working in elder care.

Worth noting is also that Postle (2001, 2002) has shown that care managers have experienced a decrease in the social and advisory aspects of their work with older people. The same is true of some of the important qualities tied to the client-professional encounter itself such as, for example, care managers' possibility to take time to make well-considered decisions based on a holistic approach to their clients' situation. Several researchers have found also that care managers think that they spend too much time on risk management (e.g. Taylor & Donnelly 2006, Ceci & Purkis 2009, Green & Sawyer 2010). This contrasts sharply with the type of work that they engaged on when they spent a considerable amount of their time on building relationships with their clients as they strive to create a supportive and therapeutic environment for them. Postle (2001) and Lymbery & Postle (2015) have also shown that following the introduction of more bureaucratic routines, care managers experienced a considerable loss of freedom of action in their professional role. This means that it is not uncommon for care managers to experience a growing estrangement from their professional role. Ellis (2013) and Carey (2007) have complicated this picture further since they have shown that care managers feel that the actual job qualifications one needs to conduct care management are different now their administrative duties have increased as they work to ensure that their clients' legal rights are met in the assessment process. Evans

(2011) further highlights that care managers in elder care experience a growing cultural divide as they navigate different work logics: the logics of social work and the logics of management.

Studies that have shed light on care managers' experiences in Sweden are relevant to our inquiry as well (cf. Lindelöf & Rönnbäck 2004; Andersson 2007a, Norman 2010, Forssell, et al. 2014, 2015, Torres et al. 2015, Nordh & Nedlund 2016). These studies have all confirmed the general trends that the international literature hereby presented has shown. Most of them are, however, in Swedish and have not therefore been part of the international debate to which we are hoping to contribute. In summary, research has explored how care managers, as street-level bureaucrats working in elder care, perceive and experience decision-making in the needs assessment process. Most of this research has originated from the UK; a country that has been affected by managerialism to a greater extent than Sweden has. There is, in other words, a considerable knowledge gap not only in respect to the *nature of professional discretion* (cf. Evans 2015) in care management but also about how different aspects related to work experience affect how care managers deal with the needs assessment process. This is why this article focuses not only on professional discretion in needs assessment practice within elder care but also on the role that length of work experience seems to play.

### **Needs assessment within the context of Swedish elder care**

Many Swedish municipalities chose to introduce the purchaser-provider model when they introduced managerialism and the New Public Management (NPM) ideology into elder care back in the 1990's. As a result of this, a division of the former home care assistant role was created. This division led to the emergence of two new professions: care managers (in Swedish: "biståndshandläggare") who are responsible for, among others, the process of needs assessments and unit managers who have the actual deliverance of care services to older people in need of help and support as their responsibility (Blomberg & Pettersson 2011). Worth noting is that when these changes were introduced, it was envisioned that care managers would be on the older person's side, act as their counselor and spokesperson and monitor their rights (Dunér & Nordström 2006, Norman 2010).

Most of the Swedish research that in this field has focused on the implications that these changes have had for needs assessment practice (e.g. Dunér & Nordström 2010, Nordh & Nedlund 2016, Olaison 2017). Blomberg (2008) has, for example, shown that these changes have narrowed down the assessment criteria that care managers use to determine which

older people are eligible to access the services that the sector offers. Nowadays, it is often the most acute medical and care-related needs that are prioritized; social needs have lost, in other words, their 'legitimacy' as far as welfare eligibility is concerned (Olaison 2009). This has meant a reduction in the proportion of older people that access welfare services from the Swedish elder care sector (Meagher & Szhebehely 2013).

Swedish elder care has also implemented models for customer choice during the past decade. Concurrently with this development, private and competing contractors have been introduced as elder care service providers. The idea being that older people's ability to choose who will provide the services that they are granted will be increased by having private actors from which they can pick and choose as they please (Andersson & Kvist, 2015). The reality does not match this ideal (Moberg 2017) but that is at least what the intention has been. Thus, the developments in question have meant that Swedish elder care is now organized in such a way that the actual delivery of services is in part outsourced to contractors, voluntary organizations and foundations while the needs assessment process is done by municipally employed care managers.

When NPM-related changes are discussed in international debates in relation to needs assessment practice it is not uncommon to draw attention to the personalization that has taken place thanks to the introduction of individual budgets (cf. Jacobs et al., 2013). Neither one of these changes have been implemented in Sweden. It is, however, worth noting that the NPM-related changes that have been introduced, are changes that were meant to increase older people's individual choice and control over the services they receive. This means that older people in need of help and support from Swedish elder care are nowadays regarded as customers or clients, instead of, as was previously the case, care recipients (Szebehely & Trydegård, 2012; Kröger, 2011). Care managers in Sweden – who used to be called needs assessors a decade or so ago - have therefore experienced numerous changes in their role as well as in the ways in which needs assessments are conducted. Thus, nowadays, Swedish care managers are administrators, communicators, gatekeepers, consumer educators, and collaborative partners with the different types of organizations that deliver elder care and not just needs assessors (cf. Norman 2010).

The legal foundations for the work that Swedish care managers do are found in the Social Services Act (SFS 2001:453), which is a framework legislation that does not contain detailed regulations concerning needs assessment. According to this Act, the formal services that older people access shall aim to promote a life with dignity and a feeling of well-being. In addition, this legislation stipulates that elder care should help people maintain "a reasonable

standard of living” which is a concept that has been highly contested by researchers who compare this legislation to the one that is used to regulate the care that disabled people in Sweden receive. The latter is namely much more concrete since it stipulates that the services provided should ensure that disabled people have favorable living conditions and receive services that are permanent, coordinated and well-adapted to their needs (Szebehely & Trydegård, 2007).

The work of Swedish care managers is also guided by local guidelines (Dunér & Nordström, 2006). Thus, overall, the changes discussed have generated numerous variations in the types of guidelines that can nowadays be found in Swedish municipalities and the degree of specification that characterizes the service catalogues that have been created when these guidelines have been formulated. These service catalogues list the services that the municipalities can provide and, in some cases, the time that can be allotted to them as well as the frequency in which these services can be provided when the services are provided by municipal organizations.

Worth mentioning is also that research has shown that local guidelines influence care managers’ assessments and decisions in ways that are not necessarily in line with the framework legislation mentioned earlier (Dunér & Nordström, 2010). To the best of our knowledge, however, nobody has specifically looked at whether length of work experience influences the ways in which care managers regard their role and use their professional discretion in the needs assessment process.

## **Methods**

This article uses data collected in a project that aimed to shed light on care managers’ experiences of cross-cultural interaction in the needs assessment process; an interaction that care managers have been found to regard as challenging (Andersson 2007b) and that could therefore shed light on the use of professional discretion. The empirical data consists of 12 focus group interviews with 60 care managers (two of them were interviewed individually) that work on a daily basis with the assessment of older people’s needs in seven different municipalities and city districts in the counties of Stockholm and Östergötland. The focus groups were carried out in September and October of 2011. Some of the initial contact we made with the care managers that participated in this project was made through the visits we made to their workplaces to present the project while others were originally contacted through the letters we sent to their superiors to ask if they could encourage their colleagues to participate. Those that expressed interest in the project received a more detailed letter

explaining what the project's aims were and how the focus group interviews were going to be carried out. Care managers who agreed to participate gave written informed consent.

The reason why we chose to collect data via focus groups is twofold. First, focus groups are an effective way of collecting data about professional practice since such practice is often decided upon through informal talk between peers, and focus groups are particularly conducive to bringing such talk to light (Vaughn et al., 1996). Second, focus groups are known to be particularly propitious for interviews that require informants to open up about practices that they are uncertain about and/or about issues that are highly debated and can be deemed controversial (Morgan 1997). In accordance with the literature on the ethical dilemmas associated with focus group interviews which recommends that one does not interview work colleagues simultaneously (Hofmeyer & Scott 2007), we grouped the informants in such a way that care managers from the same workplace were for the most part not interviewed at the same time.

The care managers that participated had varied length of work experience; 36 of them had up to 5 years of experience and 24 of them had 6+ years of experience. We asked for information on length of work experience because we suspected – based on previous research – that this could potentially play a role on how they experience cross-cultural interaction in the needs assessment process. Half of the groups were comprised of care managers who had six or more years of experience and half were comprised of people who had five or less. The reason why we grouped them that way had to do with when the NPM-related changes mentioned earlier had taken place in the municipalities and city districts included in the sample. This means that almost half of the care managers interviewed had worked in this field prior to the implementation of the changes described earlier, while the other half had started working in this field after these changes were in place. Although we did not ask about their educational backgrounds, and there are no official statistics on the professional backgrounds of care managers in this country, we presume that many of them are trained social workers<sup>2</sup>. Only two men participated in the project. This reflects the gender distribution found in care management.

The interviews lasted between 90 minutes and 2.5 hours and began when the moderator - the third author- asked the participants to write down five words that they thought described their professional role. This was done in order to allow the interviewer to ask the participants

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<sup>2</sup> There are also nurses and persons with a background in social and behavioral sciences who work as care managers. These people tend to have supplemental training in legislation.

– irrespective of how active they were inclined to be during the interviews – for their opinions and also to guarantee that opinions that were not discussed by the majority could be brought to fore. The interviews covered also the following topics: their views on their professional role, their experiences of the needs assessment process, the challenges they associated with it in general and with cross-cultural interaction in particular.

The interviews were tape recorded and transcribed verbatim. The third author carried out the initial analysis by organizing the material through coding (Neuman 2011). The predetermined topic areas covered by the interview questions were used while coding the material (in this analysis this pertained to the views on the professional role, including the challenges that were brought up explicitly in their discussions). We also used codes generated by interpretations and analytical insights in connection with the collection of the data itself, and while listening repeatedly to the audio-recorded material (Silverman, 2006). The first and second author double checked the process of analysis through peer-debriefing sessions (Creswell 2013) in order to ensure the trustworthiness of the findings.

## **Findings**

The following sections present the findings regarding how care managers perceive their professional role and the identity of care manager and how they experience decision-making in the needs assessment process and use professional discretion. Also accounted for are the similarities and differences that were found between care managers with less or more work experience.

### *An unclear role: what exactly do we do?*

Care managers, regardless of length of experience, stress their perception of lack of clarity regarding what work tasks are included in their professional role:

Our professional role feels... it feels a bit like a coordinating function. You're really...the spider in the web, you have contact with the individual and you're a person in authority and you kind of help the person. But you also coordinate between different providers and have contact with other authorities and... you're very... informative. You distribute a lot of information /.../ I think it is pretty hard to figure out/.../ hard to summarize (Focus group interview #5, care managers with up to five years' experience).

Several care managers stress the multifaceted nature of their duties while talking about taking on different roles in different situations: coordinator, information officer and guide through the system (cf. Norman 2010). They stress their pedagogical mission in relation to

providing information and explaining how elder care is organized. Worth noting is also that they mention that their professional role seem to be perceived as unclear by other professionals who work in elder care. Care managers discuss, for example, that most people do not know what is included in their professional role:

There is not that much information about it /.../ there are so many different expectations from... the individual, relatives, primary care /.../ so many different actors who don't really know what we do. I think we need to work with that much, much more (Focus group interview #10, care managers with up to five years experience).

This excerpt shows that the work that care managers do is not only unclear to other professionals with which they regularly come in contact but also to those whose needs they assess. Care managers seem to think that this uncertainty limits their scope of action and mention, for example, that when healthcare staff promise older people that they will receive various services via the care manager – even before the care manager has begun assessing their needs – they end up having to deal with clients' unrealistic expectations.

*An unclear professional identity: are we institutional representatives or social workers?*

One of the challenges that they often mention and seems tied to organizational prerequisites is the existence of different kinds of responsibility connected to the management part of their work title. They have a responsibility to both, the individual client who seeks assistance, and the institution they work for, the latter in the form of overall economic responsibility. This complex role, which in Swedish is called 'myndighetsrollen', can roughly be translated into "institutional role". The following excerpt shows how interviewees with less experience talk about this:

Of course we have the ultimate responsibility.../.../ I as an individual don't have so much to say about granting or turning down, that's of course tied to the guidelines and my boss/.../ we have the Social Services Act and our budget and these things are not at all compatible, I would say. We have limitations /.../ we don't really have so many possibilities to do social work! (Focus group interview #7, care managers with up to five years' experience).

Care managers describe their various areas of responsibility they have as limiting. The fact that they relate these limitations to their ability to do social work is interesting since they seem to regard what they do as bureaucratic work and not social work. This is probably related to the 'institutional role' mentioned earlier which has become more important in recent years. They seem, in other words, to associate this role with the management part of what

they do (i.e. the allocation of resources and the gate keeping that this entails). In doing so, they compare this to the needs assessment part of what they do which they talk about as being more about working together with older people in order to find an appropriate solution for their problems. Irrespective of their length of work experience, care managers claim that their ability to carry out social work has been greatly diminished as resource allocation has become more important (cf. Postle 2001).

Something else we would like to draw attention to is that the interviews contain reflections on various dimensions of power associated with the 'institutional role' mentioned earlier. The following quote illustrates this:

I can even control things during an investigation. I can control what happens in a meeting with someone. I really have an awful lot of power. /.../ even if I follow all the paragraphs and everything just our meeting is, you know, they meet with a person who has an entirely different position who they know that you're exposed to a lot of people so it's really... power... Maybe it's not such a pretty word, but I think we have an awful lot of power and that makes us vulnerable and isolated in our role too (Focus group interview #6, care managers with six or more years' experience).

Here care managers describe how difficult it is to handle the fact that they are in a position of power when they act on the basis of their 'institutional role'. They describe how they more or less implicitly use their power, at times in ways they regard as questionable. For example, by emphasizing a client's rights when one is trying to convince them to accept certain services or by arguing that if a client accepts the assistance offered he/she can save his/her strength and energy and do something they find more meaningful instead. Care managers mention also that they could point toward a client's relative good health, for instance, when they felt that a client was not morally entitled to the services that they were seeking. Thus, the care managers refer to the fact that there is an element of arbitrariness in needs assessment and that this is something they feel ambivalent towards.

Care managers complain that they often feel quite alone in making difficult decisions and find it burdening to have to choose sides. Deciding on the basis of their organization's interests or on the basis of what is actually best for the individual whose needs they are assessing was something they talk about as a challenge. The following illustrates this:

It takes a while to find yourself in your professional role...the authority...that you actually represent an authority... I don't represent myself... I represent the City of XXX. And I sort of have to find what my role is... try to relate to all the guidelines and laws... even though maybe you meet people you think need more help... or a different kind of help... but based on the

existing laws and guidelines, maybe it's difficult... (Focus group interview #7, care managers with up to five years' experience).

This quote alludes to the challenges embedded in the decision-making process when one is an institutional representative who has to follow guidelines and abide by legislation, while also making sure that one meets the needs of those in need of help and support. Worth noting is also that care managers with less experience express more often lacking a sense of empowerment and seem particularly likely to have pondered upon whether, and in what way, they are allowed to shape their professional role. The interviews also reveal that the more experienced care managers talk about asking for advice from colleagues or superiors less often and talk instead about finding solutions on their own.

*Decision-making and discretion in relation to an unclear legislation: what does 'a reasonable standard of living' mean?*

Interpreting the legislative goal of reaching 'a reasonable standard of living' was something that the care managers talk about at length. This seem to pose a great challenge for them since they have to determine, not only what is reasonable in each case, but also whether the needs of the older person seeking services are legitimate enough to award them welfare eligibility. They mention also that many older people's desires do not rhyme well with the local guidelines that are meant to guide their practice. The following quote illustrates this:

What is reasonable for me may not be reasonable for someone else /.../  
For instance, if a person has gone swimming three, four times a week...  
then I think it's reasonable for him or her to get help with that, even in old age, for example somebody with a companion, if the person can't get to the pool or something. But maybe the guidelines don't account for these things (Focus group interview #12, care managers with up to five years' experience).

Thus, determining what a 'reasonable standard of living' actually means is not an easy task and it is clear that care managers think about this in different ways. One of the challenges that they face concern therefore how to uphold the law since the framework legislation that they are supposed to abide by does not specifically address the needs assessment process. The fact that the service catalogues that some municipalities have created limit older people's possibility to access the services that they themselves feel they need is also something that the care managers discussed in the focus groups. The interviews reveal that care managers with longer work experience seem to deal with such difficult situations in a more pragmatic way than did those with less experience:

Sometimes you just can't be a bureaucrat. Instead you just have to like... stretch the boundaries. And take measures. And then you fix the rest later

(Focus group interview #6, care managers with six or more years' experience).

Care managers with longer work experience talk, for example, about transgressing the local guidelines in the decision-making process. Instead, they talk about prioritizing the overall goal of the legislation, which is that older person's needs shall be assessed individually. Care managers with less experience seem more stressed about investigating matters in what they described as the "correct manner". They express concerns about the challenges associated with making decisions according to the 'reasonable standard of living' guideline and point out that they actually lack the experience necessary to be able to make such judgments. These care managers also mention that some older people's expectations of what elder care can offer are too high and that the fact that they are not familiar with the 'reasonable standard of living' clause in the legislation is probably part of the reason why their expectations do not match the realities of the needs assessment process.

Irrespective of length of work experience, care managers express a desire for clearer guidelines concerning how to interpret 'a reasonable standard of living'. In their discussions about the decision-making processes that they engage in, they talked about the fact that it is practically impossible to distribute the limited funds that the sector has so that everyone has a 'reasonable standard of living'. Thus, although municipal budgets are not supposed to be guiding their practice formally speaking, they talk about the fact that they often base their reasoning on the principle of equal treatment when facing situations that are difficult to assess. This is a principle that they themselves seem to have created whereby the solutions offered need to be equal for everyone in an equivalent situation (Forssell, et al. 2015, Torres et al. 2015). Although this may seem fair at first glance, it is in fact not at all compatible with the guidelines that they are supposed to abide by since they should make *individual* assessments; their job is not, in other words, to allocate resources equally. Care managers with longer work experience seem more inclined to broadly question the meaning of 'a reasonable standard of living' which raises, of course, the question of whether they rely on the principle of equal treatment less often.

## **Discussion**

Before we discuss the findings, we want to acknowledge some of the study's limitations. First, there was a large spread in the number of years that the care managers in the groups hereby alluded to as more experienced. This division contributed to variations within these groups since the care managers who had the least experience within these groups (just over five years of experience) sometimes voiced experiences that resembled those in the less

experienced groups. Second, the fact that those who had worked longer had undergone many organizational changes as far as needs assessment practice is concerned is also worth noting since we cannot claim to know exactly what it is that lies behind some of their statements. This is why we have only mentioned the type of changes we referred to in the introduction when the care managers themselves have explicitly alluded to them in their discussions.

Another limitation that we would like to acknowledge is that we failed to ask them for their educational backgrounds. It is common knowledge, however, that most care managers working in Swedish elder care are either trained social workers or trained social care workers. Social care is an educational program that no longer exists at the university level since social work 'colonize' the social care programs a decade or so ago. All of these limitations inhibit us from being able to say whether educational or vocational training has anything to do with the use of professional discretion and/or whether actual length of work experience lead them to regard discretion as they did. What we can say, however, on the basis of our design, is that there are clear differences in how care managers in the two types of groups we grouped them into talked about professional discretion in needs assessment practice and that these differences were observed between groups and not as much within them. This is why we think that future research should explore the relationship between professional discretion and length of work experience in a more systematic fashion. Our findings suggest namely that the use professional discretion could have an impact on the decisions that care managers make.

As we move on to discuss our findings, we start by acknowledging some of the challenges that the care managers voiced irrespective of length of work experience. One of them had to do with the dilemmas they experience in the decision-making process because they have to navigate not only the legislation's call for holistic and individualized assessments, but also because they are expected not only to realize the 'reasonable standard of living' clause while following local guidelines. According to the care managers interviewed, one way of dealing with these challenges is to treat all cases as if they should receive equal treatment; a principle that is actually not part of their job description and which they seem to have formulated out of their own volition. The fact that this principle constitutes in fact a violation of the expectation that they will conduct individual assessments is something that they do not seem to consider (Forssell, et al. 2014, 2015). Something else worth noting is that the fuzziness surrounding what a legitimate need is complicates care management since the

legislation framework that they are expected to abide by does not actually address how to conduct needs assessments.

The care managers interviewed brought attention to the power they have when making decisions and talked about this as a challenge. Like previous results (cf. Carey, 2007; Nordh & Nedlund 2016), the present findings show that care managers' experiences of having power sometimes lead to feelings of uncertainty (cf. Ceci & Purkis, 2009; Spicker 2012). As street-level bureaucrats, they have interpretive privilege. They decide, in other words, what a legitimate need is and what is not be regarded as such. The fact that they also talked about the lack of *real* opportunities to make individualized assessments in the manner stipulated in the legislative framework that guides their practice is something worth mentioning. The care managers interviewed were portraying their professional role as containing contradictions and obscurities regarding not only its content but also the types of responsibilities they have as well as the possibilities they have to make an impact in people's lives. The consequences of this may seem antithetical. On the one hand, they seemed to think that they make too few assessments on their own. On the other hand, they called for clearer and more detailed guidelines. Here we noted some degree of difference in perceptions as a function of length of work experience.

Care managers with longer experience seemed more positively inclined to use their discretion in the decision-making process and deviate from the guidelines, thereby creating their own scope of action (cf. MacDonald et al 2008, Ellis, 2013) based on reasoned judgements (cf. Wallander & Molander 2014). Compared to those with fewer years of experience, they did not seem feel insufficient, seemed more aware of the actual parameters that they have to follow, and seemed to be more ready to act based on these conditions. Moreover, they seemed to have realistic ideas about what they can actually achieve given the conditions at hand. In contrast, care managers with less experience described having greater difficulty dealing with the existing guidelines and the limited resources that are available to them. They reported giving considerable thought to their responsibility and expressed uncertainty as to what their role actually entailed as well as about their possibilities to shape their professional role. They sometimes conveyed a feeling of resignation owing to perceived lack of empowerment when faced with difficult situations in decision-making. These subtle differences raise the question of whether or not care managers' length of work experience, and ideas regarding what the needs assessment process entails, have an impact in the actual assessments that they perform.

One factor that seemed to contribute to the uncertainty that some of them expressed concerned their perception that, more and more, their role as needs assessors is being pushed into the background while their 'institutional role' (understood in terms of resource allocation and management) is being prioritized. In this regard, it seems necessary to remind the reader that when the purchaser-provider model was introduced in Sweden as part of the NPM-related changes mentioned earlier, the expectation was that care managers would be on the older person's side. As stated earlier, this meant that they would act as their advocates and monitor their rights. The fact that the care managers expressed concerns regarding their increasingly diminished ability to act in this way can perhaps be understood against this backdrop. To this end, it seems worth noting that Lymbery and Postle (2015) have highlighted that care managers in the UK have experienced a decrease in the social and advisory aspects of work with older people. In the article with the poignant subtitle 'it started with us being called care managers', Postle (2001) talks, for example, about the changes in question in terms of the threats they have posed to the values of the social work profession. Drawing a parallel to the Swedish context is easy since care managers were called needs assessors before the changes in question were implemented. Against this backdrop, it is understandable that care managers with longer work experience felt they had transitioned from a need assessors role, which was about assessing older people's needs in a holistic sense, to merely exercising authority over cases as they go about the business of allocating welfare resources. The fact that they talked about feeling like gatekeepers at times is also worth mentioning since they stressed that sometimes feel like they are in charge of overseeing the allocation of welfare resources.

## **Conclusion**

Taken together, the findings showed that the care managers' perceptions of their professional role and its prerequisites in relation to decision-making are complex and to some degree imbued with oppositions. The interviewees – especially those with less experience - talked about experiencing difficulties finding their own professional identity. There were differences, however, in how they dealt with these difficulties and since these differences aligned with the differences in length of work experience used to group them into the focus groups in which they participated, we suggest that the difficulties experienced, and the manners in which they talked about handling them, may have something to do with work experience. The present study, thus, lends support to the critical debate on the ways in which street-level bureaucrats go about decision-making; a debate that claims that although they use discretion in the needs assessment process, they are in fact constrained by institutional logics (Garrow & Gursky 2012, Maynard & Musheno, 2012). This study adds therefore new

insights into this discussion not only because our data comes from a part of the world that has experienced less managerialism, but also because our findings suggest that length of work experience may play a role in how professional discretion is used in needs assessment practice. As such, the findings suggest that further research should explore if length of work (and other aspects of work experience) lead to variances in the actual assessments that care managers perform and the outcomes that these assessments lead to.

### **Ethical approval**

The project received ethical approval from one of the Regional Ethics Committees in Sweden (Dnr 2011/ 205).

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